Making it work

Promoting participation of job seekers with multiple barriers through the Personal Support Programme

Daniel Perkins

Hanover
HOUSING - SUPPORT - RESEARCH

Brotherhood of St Laurence
Working for an Australia free of poverty

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Contents

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Daniel Perkins
Brotherhood of St Laurence

Abbreviations

CRS	Commonwealth Rehabilitation Service (initialism now used instead of full name)
CSP	Community Support Program
DEWR	Department of Employment and Workplace Relations
DOES	Disability Open Employment Services
DSP	Disability Support Pension
FaCSIA	Department of Families, Community Services and Indigenous Affairs (formerly Department of Family and Community Services (FaCS)
HILDA	Household, Income and Labour Dynamics in Australia [survey]
JCA	Job Capacity Assessor
JSSP	Job Seeker Support Panel
MIFS	More Intensive and Flexible Services
PSP	Personal Support Programme

1 Introduction

This report presents findings of an evaluation of the Personal Support Programme (PSP) undertaken by the Brotherhood of St Laurence, Melbourne Citymission and Hanover Welfare Services. The PSP provides case management support over a two-year period to job seekers facing multiple personal barriers and aims to achieve increased economic and social participation. Typical barriers faced by participants include mental health problems, homelessness, family breakdown, substance abuse, chronic health problems, and social isolation.

PSP is funded by the Department of Employment and Workplace Relations and delivered by contracted providers in the non-government and private sectors. In 2006–07, around 70,000 people received assistance through the program.

The aim of this study was to evaluate the extent to which the Personal Support Programme (PSP) enabled people with multiple non-vocational barriers to achieve economic and/or social outcomes. Results will be used to advocate for improvements to service delivery, inform reviews and development of the program itself, and influence the development of broader employment assistance and social participation policies to benefit disadvantaged income support recipients.

This report contains findings from a longitudinal survey carried out with participants in 2004–05 and 2005–06. One hundred and thirty-four participants completed the first survey and 120 of these completed at least part of the second survey. In-depth interviews were also undertaken with case managers across 15 PSP providers as well as with Centrelink workers, Job Capacity Assessors and PSP staff working at the Department of Family and Community Services (now FaCSIA) and the Department of Employment and Workplace Relations.

2 Disadvantage in the labour market

There is a growing recognition among policy makers in OECD countries that welfare recipients facing the greatest disadvantage in the labour market are not well served by traditional labour market programs. Research indicates that the predominant 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 (ESU 2000; Parkinson & Horn 2002; Pavetti et al. 1997). Other programs following a human capital development model, focusing on longer term interventions to improve education and skill levels, also struggle to address the multiple and complex needs of those facing the greatest hurdles to participation in the labour market (Kemp & Neale 2005).

Whilst there is agreement on the need to provide improved support to this group, there is some diversity in the approaches taken and terminology used. Program definitions include 'the hard-to-employ', 'hard to serve', 'difficult to serve', 'vulnerable to exclusion', 'facing multiple barriers' and 'very marginalised' (Danziger & Seefeldt 2002; European Foundation 2002; Gutman et al. 2003; O'Donnell et al. 2003; Social Research Institute 1999).

For a large proportion of these people, their lack of participation in employment is thought to be due not simply to attitudinal, demographic or human capital factors but also to a range of personal and family barriers. However, there is no standard definition of what is included in this category (Olson & Pavetti 1996).

These people are often some way from job readiness and suffer from multiple and interacting barriers that require intensive support not directly connected to work preparation (Kemp & Neale 2005). Indeed program evaluations suggest that the more personal and family barriers a participant faces, the lower the likelihood of benefiting from traditional labour market programs. Of concern, however, is evidence that traditional employment programs may be successful in pushing these clients off welfare but not into employment, leaving them vulnerable to severe poverty and disadvantage (Pavetti et al. 1997). US research has found that clients facing barriers are significantly more likely to be sanctioned (have benefits cut for not complying with welfare-to-work). Those who have a substance abuse, family health or mental health problem or have been a recent victim of domestic violence are between two and four times more likely to be sanctioned (Danziger & Seefeldt 2002; Goldberg 2002). This evidence is supported by other research showing that clients with mental health issues are unlikely to respond to harsher welfare-to-work rules (Johnson & Meckstroth 1998).

The role of employment barriers

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 Orzol (2004) suggest that the combination of personal barriers and human capital characteristics is more important in predicting medium and high levels of welfare accumulation than demographic factors.

In their early work looking at the impact of personal barriers, Olsen and Pavetti (1996) identified eight barriers that had the potential to affect labour market participation:

- physical disabilities and/or health limitations
- mental health problems

- health or behavioural problems of children
- substance abuse problems
- domestic violence
- involvement with the child welfare system
- housing instability
- low basic skills and learning disabilities.

While many later studies have found associations between personal barriers and welfare receipt or employment, there are sometimes limitations in the data. It is not always identified whether participants are moving from welfare to employment or to no employment and no welfare; and when associations are found between barriers and duration on welfare, causality is difficult to determine.

Research looking at long-term welfare recipients in the US (Social Research Institute 1999) found that a large proportion faced severe, persistent and multiple barriers and that 92% faced at least one severe barrier. 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).

Chandler et al. (2002) used longitudinal data to explore whether being on welfare caused people to experience barriers including substance abuse, depression, or functional impairment due to mental health. They found no causal connection.

Further evidence from the US suggests that welfare recipients facing personal barriers are less likely to secure employment (Goldberg 2002; Taylor & Barusch 2004) and that almost all of those with a potentially serious barrier who do work do so only intermittently. Olson and Pavetti (1996) found that only 7% of welfare recipients with a serious barrier had been employed for all of the current or previous years, compared with 25% of those without such a barrier. However, around half of those with a serious barrier had worked intermittently. Danziger and Seefeldt (2002) found that persistence of barriers over time was very rare for welfare recipients who worked nine months or more in the previous year. In developing a model to predict the likelihood of welfare recipients moving into employment, Danziger et al. (1999) found that incorporating personal barriers significantly improved predictive power, and that many barriers remained significant in the full model incorporating human capital and demographic characteristics.

Barriers as an approach

While focusing on personal and familial barriers appears to have the potential to improve services and support for highly disadvantaged welfare recipients, there is also a danger it may result in an increased focus on a 'deficit' model of the unemployed and divert attention away from structural causes of disadvantage. However, as Jayakody and Stauffer (2000, p.619) assert, 'pointing out the mental health problems of welfare recipients does not negate that societal factors may be the ultimate cause of these problems'. Nevertheless, it is an area where caution is needed.

Aside from this danger, the barriers approach does offer a number of potential advantages: it recognises a broad range of obstacles to employment and so encourages the development of programs that can address needs outside the traditional vocational domain. Butterworth (2003a) argues that by enhancing understanding of the extent of disadvantage among particular groups it can provide an incentive for action leading to improved engagement and participation. However, this relies on appropriate support and services.

Determining the number and severity of barriers an individual faces may be an effective method of determining the appropriate level of intervention (Danziger et al. 2000). Danziger et al. (1999) suggest that, for many clients, reducing the number of barriers by one or two could result in a

significant improvement in participation. In a US sample of female sole parents, Chandler (2002) estimates that removing all the remediable barriers would increase the proportion working at least 26 hours per week from 38% to 71%. Some writers also suggest that developing programs that can address personal barriers may be a simpler and more cost-effective approach than addressing human capital barriers (Butterworth 2003b).

In reducing disadvantage and social exclusion in the labour market overall, any programs to address barriers faced by individuals need to be integrated with broader labour market policies that ensure sufficient jobs are available and the existence of a framework of labour market regulations and institutions that promote an inclusive labour market (Perkins & Nelms 2004).

Mental health problems

Mental health problems are one of the most widely recognised personal barriers to employment, so they deserve particular attention. However, their impact on participation varies significantly depending on both type and severity of the condition, as well as demographic characteristics such as age (Waghorn & Lloyd 2005).

Studies in the US indicate that over half of welfare recipients are at risk of a clinically diagnosable mental disorder and between 35% and 45% have a clinically diagnosable 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. Recipients are also found to access medical services less frequently than the rest of the population, and have episodes that last longer on average (Kovess et al. 1999).

In Australia, mental health problems are responsible for a greater level of disability or impairment than any other type of disorder (Butterworth, Crosier & Rodgers 2004). Estimates of depression in the general population range from 5% to 15% (Butterworth 2003b; Butterworth, Crosier & Rodgers 2004). Butterworth (2003b) found that 57% of long-term welfare recipients reported depression and that around 15% suffered from post-traumatic stress disorder, and that among the unemployed generally 34% were suffering from an anxiety, depressive or substance use disorder. Looking at the Community Support Program (CSP), the forerunner to the Personal Support Programme (PSP), MacDonald and Jope (2000) found psychiatric problems were a barrier for around 36% of participants.

Waghorn and Lloyd (2005) argue that the vocational needs of people with mental health problems in Australia are not being adequately met, with around 75% of people with psychotic disorders and 47% of people with anxiety disorders not participating in employment, compared with 20% in the rest of the population. In the US and the UK, the rates of non-participation in employment for individuals with psychotic disorders are 61–73% and 75–90% respectively.

The extent to which mental health problems can act as a barrier to employment is clouded by evidence that causality may run in both directions and that being employed may also assist in overcoming mental health problems (Jayakody & Stauffer 2000). Butterworth et al. (2004) suggest that the relationship ‘becomes more complex and intertwined over time, with deteriorating mental health as both a consequence of unemployment and a growing barrier to efforts to end this state’. This picture is further complicated by low income and poverty (experienced by many welfare recipients) which have also been shown to be powerful predictors of mental health disorders (Derr, Hill & Pavetti 2000; Jayakody & Stauffer 2000).

Regardless of the causal links, mental health problems can act as severe barriers to employment; and Sanderson and Andrews (2002) found that around 94% of people suffering from an affective disorder, and 80% of people suffering from an anxiety disorder, experienced some level of disability. This can result in restrictions to the type of job or number of hours people can undertake, the need for a support person, and difficulty changing jobs (Waghorn & Lloyd 2005).

Mental health problems can result in cognitive, affective and interpersonal deficits that can impair psychological functioning and in turn can interfere with all stages of the employment process including attaining and maintaining work. In addition, almost all clinical symptoms are potential barriers to individuals; however they have also been found to be inconsistent predictors of whether an individual will be employed (Atkinson et al. 2003; Waghorn & Lloyd 2005).

Common ways in which mental health problems can impact on employment include:

- reduced ability to perform tasks
- impairment due to side-effects of medication
- reduced work quality
- limited work experience
- limited or disrupted educational attainment
- stigma and difficulties among co-workers
- employer discrimination
- issues related to the episodic nature of the condition
- impairments to social skills, personal confidence and self-efficacy
- lowered IQ
- reduced capacity for information processing
- impaired physical functioning and self-care (Derr, Hill & Pavetti 2000; Jayakody & Stauffer 2000; Waghorn & Lloyd 2005).

Reduced confidence, self-esteem and social skills can result in poor interview evaluations and difficulties in securing employment, as well as affecting job retention (Atkinson et al. 2003; Jayakody & Stauffer 2000). Depression, one of the most common mental health problems, has been shown to cause absenteeism, to impair work performance, motivation and decision making and to reduce the capacity to initiate a particular course of action (Waghorn & Lloyd 2005).

Other employment barriers for clients suffering mental health problems can result from community stigma, fear and misperceptions about abilities, which can influence clients' vocational decisions and goals (Atkinson et al. 2003). Similarly, unhelpful attitudes and low vocational expectations among health professionals and case workers are identified by Blankertz and Robinson (1996) as a significant barrier that can result in clients not receiving the required vocational rehabilitation and support services. Comparing 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, emphasised pre-vocational over vocational assistance, had delays in vocational assessments, pursued a narrower range of job opportunities, had less frequent employer contact and provided less ongoing support once clients were placed in employment.

Welfare and employment outcomes for people with mental health problems

Clients with mental health problems are more likely to receive welfare, and for a longer time, and 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). Mental health problems have also been shown to increase the risk of sanctioning and be associated with more rapid returns to welfare (Nam 2005; Social Research Institute 1999). Reviewing the literature, Derr et al. (2000) found that post-traumatic stress disorder, major depression and generalised anxiety all significantly increased the likelihood of long-term welfare receipt.

Many studies have documented the relationship between mental health conditions and employment outcomes. Jayakody and Stauffer (2000) found that the likelihood of working was 25% lower for those with mental health disorders including anxiety disorders, major depression, panic attacks or

agoraphobia. Corcoran et al. (2003) found that the presence of a mental health problem was associated with a lower level of employment over five years, while Danziger and Seefeldt (2002) found the presence of a mental health problem was associated with lower employment over three years. Chandler et al. (2002) found that only 16% of clients who report impaired functioning due to mental health symptoms for 5 or more of the last 30 days were working 26 hours per week or more one year later, compared with 47% who did not have these symptoms. In addition, long-term mental health impairment was associated with a significantly reduced likelihood of working.

In Australia, a recent survey of over 3000 job seekers at disability employment service providers found that those with psychological and psychiatric problems fared worse than any other category of disability in terms of securing and retaining employment. After 16 months of assistance, 44% remained unemployed and only 23% had durable employment outcomes (defined as 8 hours of work or more for the last 6 months) (FaCS 2002, cited in Waghorn & Lloyd 2005).

Despite these strong associations, a considerable number of those with a mental health problem do participate in employment, and this can often be assisted through appropriate job matching, vocational choices and other vocational interventions (Waghorn & Lloyd 2005). Interestingly, having one disorder such as major depression, panic attack, post traumatic stress disorder, social phobias, or generalised anxiety disorder is less predictive of not working than having two or more disorders (Chandler, Meisel & Jordan 2002). Similarly, Waghorn et al. (2002) found that those reporting a chronic or deteriorating condition were more likely to be unemployed than those reporting a single episode.

Jayakody and Stauffer (2000) suggest that mental health problems do have a significant impact on the probability of working, but this is less than the effect of education. They find that those with a mental health problem who have a high school education are twice as likely to be working as those who did not finish high school (39% compared with 19%). Similarly, in Australia, employment outcomes for people with psychotic disorders have been shown to vary significantly with educational attainment: employment rates for those not completing secondary school were 12%, completing secondary 22%, with vocational qualifications 34% and with bachelor degree or higher 47% (Jayakody & Stauffer 2000).

Multiple barriers

While a mental health problem or other single barrier has a significant impact on employment outcomes, the group likely to require the most additional assistance is welfare recipients suffering from multiple barriers. In the US, Danziger et al. (1999) found that those in their sample with only one barrier were almost as likely to work as those with no barriers and Gutman et al. (2003) found that few single barriers had a significant relationship with employment outcomes 12 months later.

The number of barriers faced by an individual has been shown to be negatively related to the likelihood of exiting welfare for work (Danziger et al. 1999; Nam 2005), being in work (Atkinson et al. 2003; Chandler, Meisel & Jordan 2002; Goldberg 2002; Taylor & Barusch 2004), sustaining work (Taylor & Barusch 2004) and returning to welfare (Nam 2005). Interestingly, the number of barriers faced has also been shown to increase the likelihood of exiting welfare to no work, suggesting that many highly disadvantaged clients leave welfare simply because the welfare-to-work requirements are too onerous (Taylor & Barusch 2004).

Table 2.1 shows results from a range of studies of the association between number of barriers faced and likelihood of employment (note that the figures for Berthoud (2003) represent the risk of not working). Despite differences in samples and the definitions of barriers, there is a clear negative relationship between the number of barriers faced and likelihood of working, with clients facing large numbers of barriers having very low likelihood of moving into employment. In practice, however, the effect for any individual depends on the type and severity of particular barriers.

Table 2.1 Number of barriers and likelihood of employment

Number of barriers	Danziger et al. (1999)	Chandler et al. (2002)	Atkinson et al. (2003)	Berthoud (2003)*
1	71%	-	-	*13%*
2	-	-	-	*28%*
2–3	62%	69%	-	-
3	-	-	-	*53%*
3–4	-	-	47%	-
4	-	-	-	*75%*
5	-	-	-	*88%*
4–6	41%	37%	-	-
56	-	-	24%	-
6	-	-	-	*94%*
7+	6%	13%	14%	-

*Berthoud assessed risk of *not being employed*

The limited Australian research in this area corresponds with these findings. Pearse (2000) found that single parents receiving Parenting Payment (Single) often experience multiple barriers to participation and that the number of barriers is correlated with time on payments; and Butterworth (2002) found the number of barriers for participants in the More Intensive and Flexible Services (MIFS) Pilot was correlated with time on the program and number of interventions required.

3 Policy responses to job seekers facing barriers in Australia and overseas

Australian employment assistance

In Australia, recognition of the importance of targeted employment programs to meet the needs of job seekers facing barriers dates back to the late 1980s. At this time a number of government policy reviews recommended a move towards more 'active' welfare policies for the unemployed generally (Cass 1988) and for job seekers with disabilities (Cass, Gibson & Tito 1988). This represented a shift from more passive forms of assistance, and the view that those facing barriers should be provided with long-term income support and exempted from job search requirements, to a belief that they should be kept in a more 'active' stream of assistance that would facilitate their participation in employment, education, labour market programs and community activities.

In the Social Security Review Issues Paper no. 5, *Towards enabling policies: income support for people with disabilities,* Cass, Gibson and Tito (1988) recommended abandoning the notion of 'permanent incapacity' and replacing it with a concept of 'reduced capacity for gainful employment'. They argued that enabling policies that supported 'participation and the enhancement of capabilities rather than the entrenchment of marginality and incapacity' should be pursued and that the extra costs of facilitating participation for this group needed to be recognised and provided (Cass, Gibson & Tito 1988b, p.26).

This approach was visible in the introduction of the Disability Reform Package in 1991 and in the *Working Nation* employment white paper in 1994. The approach was based on a belief that assisting people with disabilities to participate in employment and the wider community would reduce dependence, and expenditure, on welfare. However, in 1995 an interdepartmental working group found that case management was not enabling highly disadvantaged job seekers to overcome personal barriers before entering mainstream employment assistance. Case managers did not have the skills, funds, time or necessary service links to meet the needs of these clients (Krieg & Gregory 1998).

In response to these findings, Job Seeker Support Panels (JSPPs) were introduced in the following year. They represented the first move towards an alternative stream of assistance and provided a number of options for job seekers suffering from multiple and severe barriers. These included a combination of labour market assistance and other services targeted towards overcoming personal barriers, or the development of a program to stabilise an individual's circumstances before providing employment assistance. The major barriers addressed were physical disabilities, psychiatric disabilities, poor work history and poor literacy (Krieg & Gregory 1998).

JSSPs were abolished when the Howard government was elected in 1996. Under the initial proposals for restructuring employment services, a 'capacity to benefit' test would have limited the assistance for job seekers with low capacity to benefit to job matching (MacDonald & Jope 2000). This would have represented a move away from the previous active model; however, under pressure from welfare organisations the Community Support Program (CSP) was established as an alternative in 1998 (MacDonald & Jope 2000). The CSP (the direct predecessor of PSP) aimed to provide integrated assistance to allow disadvantaged job seekers to overcome personal barriers and achieve other outcomes. These outcomes included gaining employment or self-employment, moving to Intensive Assistance in the Job Network, entering education and training, or moving to a more appropriate benefit, such as the Disability Support Pension (DSP). The program was of two years' duration, was based on case management, and involved needs assessment, development of action plans, and the facilitation and coordination of access to required services.

An evaluation of the CSP undertaken by the Brotherhood of St Laurence, Melbourne City Mission, Hanover Welfare Services and Anglicare Tasmania (MacDonald & Jope 2000) concluded that it was a highly effective program. Many participants demonstrated reductions in the severity of barriers, increased ability to deal with their personal circumstances, and improved job search confidence and motivation. Elements which were seen to be important to the program's success included the integrated assistance, long-term support and continuity of assistance, reduced reporting requirements, focus on individual needs, and the voluntary nature of the program.

A separate initiative operating around the same time as CSP which also had a significant influence on the design of PSP was the More Intensive and Flexible Services (MIFS) pilot. From mid 1996 to mid 2000, MIFS provided assistance to people with multiple and severe barriers to employment who were receiving the DSP.

The MIFS program provided case management, psychological services, pre-vocational training and support services. Like the later PSP, it utilised the concept of social participation as an outcome, and also aimed to improve quality of life and to achieve vocational outcomes with those clients who became work-ready. Social participation was seen as part of a long-term pathway to employment by maintaining community engagement and helping clients to overcome barriers (Butterworth 2002). Unlike PSP, however, MIFS funding was based on the particular interventions required by the individual and the program was not time-limited, with some participants staying up to three years. Evaluation data suggests that the program achieved a range of 'quality of life' outcomes, increased social participation and led to increased employment and earnings (Reference Group on Welfare Reform 2000).

The Personal Support Programme (PSP)

The PSP replaced the CSP in June 2001, significantly increasing the number of participant places and involving a number of changes to the program model. These included introducing compulsory participation, including social outcomes and opening the program to eligible volunteer participants.

PSP was part of the Australians Working Together (AWT) package of reforms which were informed by the Reference Group on Welfare Reform report, *Participation support for a more equitable society* (Reference Group on Welfare Reform 2000). The Reference Group recommended that the social support system should aim to optimise people's capacity for participation and to minimise economic and social exclusion. It proposed the concept of 'economic and social participation' which would 'extend beyond the traditional focus on financial support and labour force status to recognise the value of the many other ways people can participate in society' (Reference Group on Welfare Reform 2000, p.7). Under this definition, social participation was viewed as valuable in its own right but also as fostering skills that could be transferred to paid employment.

The AWT package identified four pathways to independence: job search support; transition support for those who had been out of the labour market and required additional assistance; intensive support for those at risk of long-term unemployment; and community participation support for those with multiple or severe barriers. The Personal Support Programme was developed to work with people requiring this final pathway and to help them move to other pathways.

The objective of PSP is to assist people with multiple non-vocational barriers to achieve appropriate economic and/or social outcomes. These outcomes are expected to be matched to the abilities, capacities and circumstances of the participants. PSP recognises that an economic outcome will not always be possible and, while employment is seen as a desirable outcome, 'the focus of the program is the transition of participants to employment assistance programs such as IA [Intensive Assistance] or DEA [Disability Employment Assistance], when possible' (FaCS 2002). The program seeks to bridge the gap between short-term crisis assistance and employment-related assistance, and is based on the principles of flexibility to recognise different needs, one-to-one

relationships, collaboration of stakeholders, choice of provider and ongoing improvement (FaCS 2002).
PSP utilises a case management model emphasising strong connections with local services. It is delivered by contracted providers and is presently administered by the Department of Employment and Workplace Relations, but was administered by the Department of Family and Community Services until mid 2004.

Under the PSP model, the following core services are delivered by providers:

- counselling and personal support involving regular contact, guidance, assistance, personal support, and confidence/self-esteem building
- referral to, and coordination with, appropriate local services, and advocacy with other agencies as required
- practical support in attending interviews and appointments
- outreach activities, bringing participants to services or taking services to participants
- assessment involving strategies to establish goals, plans and objectives.

Participants are referred to PSP by a Job Capacity Assessor after being assessed as unable to benefit from regular Job Network labour market assistance. They are placed into PSP for a two-year period and an action plan is developed with a case manager with the aim of addressing identified barriers and increasing economic and social participation. While in the program, participants are exempt from activity test requirements applicable to other job seekers.

PSP focuses on addressing barriers *before* moving people into employment, rather than concurrently, although outcome payments are made to providers if participants are placed into work. There are no specific funds for training and education and no specific employment initiatives such as supported work placement.

Participants exit the program after two years, or earlier if they move into employment or education, enter an alternative labour market program or withdraw voluntarily. Those finishing PSP who are judged to be ready for employment will receive assistance through the Job Network, Disability Employment Assistance or CRS (formerly Commonwealth Rehabilitation Service). Others move on to the Disability Support Pension, or may just be assessed as exempt from activity test requirements and become 'inactive'.

PSP in a broader employment context

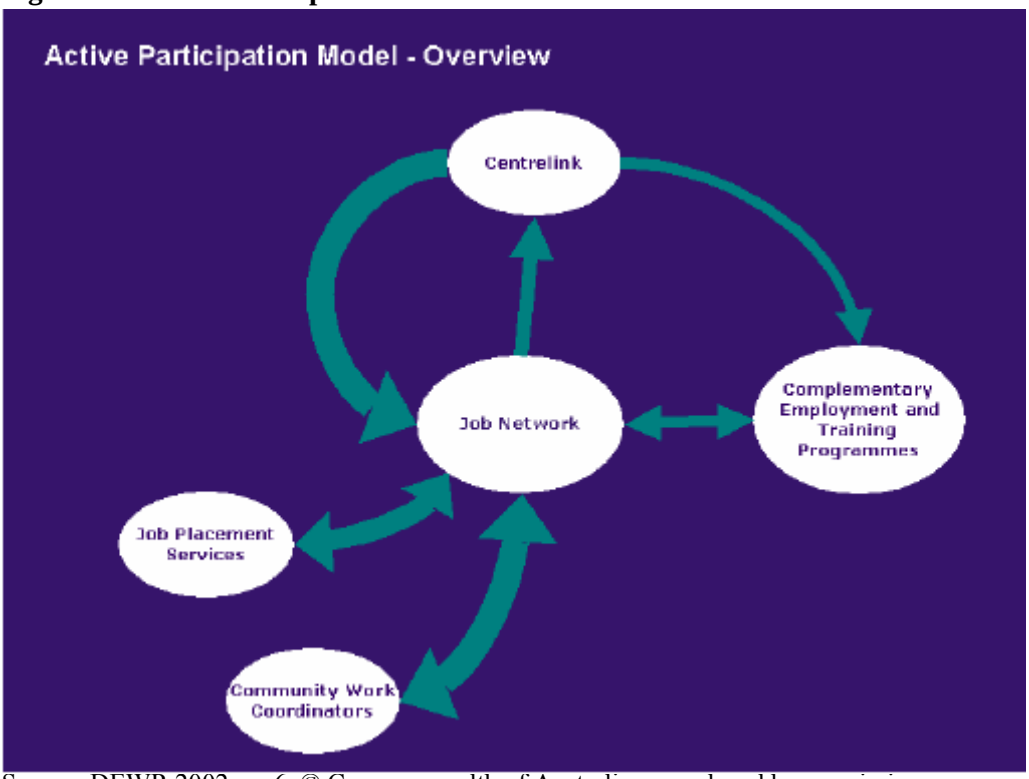
Employment policy in Australia is strongly supply-side driven and focuses on 'deregulation' of the labour market and welfare-to-work policy based around notions of activation and employability. Unemployment is framed primarily in terms of individual and behavioural deficits (Mendes 2000) rather than structural factors such as a lack of jobs. Welfare-to-work policy in this context is based around the government's 'Active Participation Model' which integrates employment assistance (mainly provided through the Job Network) with mutual obligation activities. It aims to provide targeted, timely assistance that addresses the job seekers' needs and ensures that they 'are engaged in ongoing employment focused activity and job search' (DEWR 2002a, p.1).

Figure 3.1 shows the connections between elements in the Active Participation Model. Centrelink is the 'gateway' to employment services and provides assessment and referral to appropriate employment programs, participation planning and development of initial Preparing for Work Agreements for job seekers, as well as income support assessment and payment (DEWR 2002a). Most job seekers are referred from Centrelink to the Job Network, which is the primary employment assistance mechanism and works with around 950,000 job seekers per year (ANAO 2005). However, job seekers who are judged to be unlikely to benefit from Job Network services or

to have extensive support needs are referred to complementary employment and training programs or in some cases are exempted from activity test requirements after providing a medical certificate.

Job Placement services are employer-oriented and focus on job matching, while Community Work Coordinators coordinate mutual obligation activities including Work for the Dole.

Figure 3.1 Active Participation Model



Source: DEWR 2002a, p.6. © Commonwealth of Australia, reproduced by permission

The delivery of Job Network services is contracted to private and non-government organisations, which are funded primarily on outcomes achieved. They provide varying levels of assistance depending on a job seeker's assessed disadvantage and length of time unemployed.

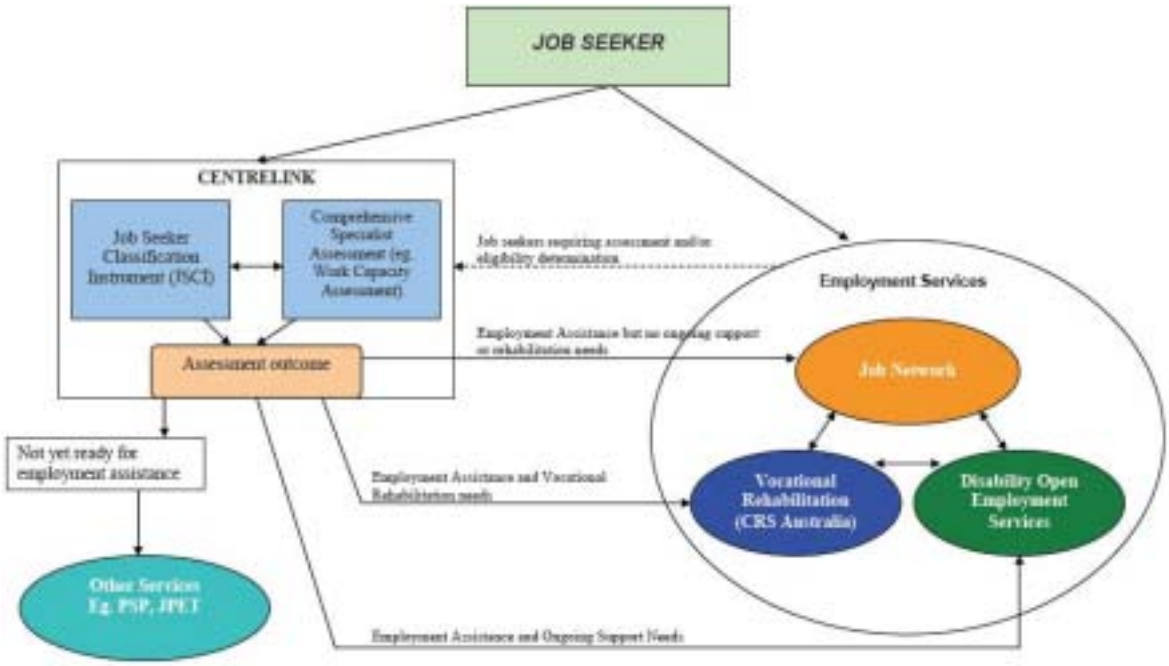
The Job Network has as its primary aim the rapid movement of people into employment, based on an approach described by Theodore and Peck as a Labour Force Attachment model (Theodore & Peck 2001). This typically includes active measures such as assisted job search, mandatory 'workfare' programs, short-term work preparation and threat of benefit withdrawal to push people into work as quickly as possible. Theodore and Peck suggest that such programs generally use high levels of pressure but offer only low-cost and minimum service interventions, which may achieve positive outcomes with more able job seekers but are too brief to help the most disadvantaged to move into stable, high-quality jobs.

The focus on rapid entry into employment allows for minimal investment in skill development and little focus on underlying barriers, while the outcome focus leads to a lack of investment in the most disadvantaged job seekers with little likelihood of gaining work (Perkins 2002).

In addition to Intensive Support provided through the Job Network, complementary employment programs for job seekers facing barriers include JPET (Job Placement Employment and Training program), Disability Open Employment services, and CRS (formerly Commonwealth

Rehabilitation Service). Figure 3.2 shows the interrelationships between these services in 2005.[1] While Job Network, CRS and Disability Open Employment are all seen as employment-focused services, JPET and PSP were conceived as programs for those not ready for employment assistance.

Figure 3.2 Operating environment for disability employment assistance



Source: DEWR 2005b, p.6, © Commonwealth of Australia, reproduced by permission.

JPET

JPET is the program closest to PSP in its scope and aims. It assists young people between 15 and 21, who face personal and social barriers severely limiting their capacity to:

- participate socially in the life of their communities
- participate in activities such as education, employment and vocational training
- benefit from employment assistance (DEWR 2005a).

The primary focus of JPET is young people who are homeless or at risk of homelessness. However, the program also works with young people in or leaving the juvenile justice system, refugees, young people who are particularly disadvantaged due to geographic isolation, young people in care and wards of the state. It provides assistance with similar issues to those addressed in PSP, including drug and alcohol abuse, mental health problems, low education levels, social isolation or alienation, and experience of sexual abuse or violence. Like PSP, JPET is based on a holistic model of working with clients that encompasses both social and economic outcomes; however, it has a much greater focus on education and employment (Butlin, Malcolm & Lloyd 2002).

[1] This diagram was produced prior to the Australian Government's 2005 welfare-to-work reforms so it does not include the Job Capacity Assessment (JCA process). Current information can be accessed on the JobAccess website at <http://www.jobaccess.gov.au/JOAC/Services/A-Z_list/Accessing_PAGES.htm>.

Responsibilities of JPET service providers include acting as a 'significant other', establishing links with local services, professional assessment of barriers, developing individual plans, identifying pathways for assistance and developing links with employers (Butlin, Malcolm & Lloyd 2002).

An evaluation in 2002 found that JPET achieved very positive outcomes for accommodation, education, training, employment and income support across all target groups and that these results were comparable to or better than similar government programs. Factors that were identified as contributing to the success of JPET included the use of a holistic case management model, the ability to spend money on training and other personal issues to support clients, referral to required local services and flexible program delivery (Butlin, Malcolm & Lloyd 2002).

Disability Open Employment Services (DOES)

Disability Open Employment Services are targeted to job seekers who have disabilities that are permanent or likely to be permanent, and who require ongoing support to gain and maintain employment. However, under changes announced in 2005, around 17,000 new places will be created for job seekers who are assessed as having the capacity to work 15 to 29 hours per week independently in the open labour market within two years of starting assistance.

Assistance includes:

- individual employment planning
- training, support and advice on jobs
- work experience
- help with job seeking such as writing a job application and interview skills
- promoting a job seeker's skills to employers
- on-the-job or off-site support to help job seekers settle into and keep their jobs
- wage subsidies and funds for workplace modifications for employers
- supported employment in commercial enterprises (Job Able 2005).

DOES focus on economic outcomes in the form of employment, rather than on social outcomes. However, the range of barriers addressed does overlap with those worked with under PSP, particularly in areas such as physical disability, ongoing medical condition or illness as well as mental health conditions such as depression. DOES do not focus on personal support or referral to external services.

CRS (formerly Commonwealth Rehabilitation Service)

CRS delivers vocational rehabilitation services to people who have an injury, disability or health condition, to enable them to find or retain unsupported paid employment, and to live independently. CRS is staffed by occupational therapists, physiotherapists, psychologists, social workers, rehabilitation counsellors and employment specialists. It provides assessments of clients' barriers, individualised rehabilitation programs, specialised job matching and placement, and personal and career counselling.

As with DOES, there is some overlap with barriers addressed through PSP, including physical disabilities or conditions, and mental health problems. CRS does not provide ongoing support once clients are placed into employment, but has a greater recognition of 'soft' outcomes such as increasing community participation and living independently than exists in DOES. Clients are required to have stable conditions and some motivation for finding work and taking part in the program before they are able to join (CRS 2004; Job Able 2005).

Research conducted in 2004 found that CRS was effective in moving people into employment, increasing earnings and reducing welfare receipt. Moreover, it was estimated to generate a combined public and private return of $33 for every $1 spent (Kenyon 2004).

Intensive Support

Intensive Support delivered through the Job Network aims to provide services that are 'intensive, substantial and tailored to the needs of the job seeker and to available job opportunities' (DEWR 2002a, p.8). It assists job seekers with disabilities or barriers that do not need ongoing support or rehabilitation to find or keep a job (Job Able 2005). Services provided include developing a job search plan, job search training (e.g. resume writing, interview skills), and financial support for things such as travel to appointments and work clothes. Job seekers in the customised assistance phase also have a more intensive contact regime, being required to see their provider once every two weeks (DEWR 2002b).

The primary focus is on moving people into work, rather than addressing personal barriers or referral to other required services. While there is some overlap with the issues faced in PSP, clients in PSP are likely to be more disadvantaged due to the presence of multiple and severe barriers. In practice, however, lack of disclosure or failure to identify barriers at Centrelink results in some clients facing significant barriers staying in the Job Network. Recent research by Parkinson and Horn (2002) found significant underreporting of housing instability, medical conditions or addictions, and other personal factors.

The Job Network's effectiveness for disadvantaged job seekers has long been questioned (Perkins 2002) and an internal evaluation in 2002 found that the likelihood of being in employment twelve months after referral to Intensive Support (then called Intensive Assistance) only improved marginally, with 25.6% of participants being employed, compared with 25% in a control group (DEWR 2002b, p.80). Further, a recent report by the Australian National Audit Office found that assessment of barriers and customisation of job search plans was limited, and that the level of contact rarely met contracted specifications. An overall concern was expressed about whether assistance provided to job seekers was actually intensive and personalised (ANAO 2005).

Job Capacity Assessment

The Job Capacity Assessment program commenced on 3 July 2007 and provides a new way to assess people's needs and refer them to the appropriate programs. There are expected to be 422,000 Job Capacity Assessments in the first year of operation.

Job Capacity Assessments are funded by the Department of Human Services, with 80% done by JCAs based in Centrelink and the remaining 20% contracted out to organisations in the not-for profit and for profit sectors.

In addition to conducting assessments, JCAs also have access to a new stream of funding called the Job Capacity Account that can be used to fund short-term services or support programs of up to 13 weeks that prepare people to receive assistance from the Job Network. Such services must be employment-focused and directly related to individuals moving into the Job Network but can address personal barriers that are preventing individuals making this move. They may include:

- cognitive behaviour therapy
- behaviour management and modification interventions
- pain management programs
- counselling programs such as motivational interviewing
- social case work support and intervention
- work conditioning (DHS 2006).

By October 2006, 121,734 referrals had been made to JCAs, of which 85,477 assessments have been submitted and finalised, with 62,884 of these being recommended for various support programs. Recommended referrals to employment programs were:

- Job Network – 18,061 (28.7%)
- Disability Employment Network – 12,374 (19.7%)
- Vocational Rehabilitation Services – 15,674 (24.9%)
- Personal Support Programme – 14,904 (23.7%)
- Job Placement, Employment & Training – 899 (1.4%) (DHS 2007).

YP[4]

The YP[4] model is being trialled at several sites in Victoria, and is designed to assist young homeless job seekers find sustainable employment. The approach is based on recognition of the failure of traditional programs and the need for a more integrated delivery of personal support, housing assistance and employment assistance. Core elements of the program include:

- continuity of support through a well resourced case manager
- individualised timely and flexible access to required programs and services
- a guarantee of secure tenure in affordable housing located to facilitate participation in employment or training programs
- the equivalent of a living wage, which is progressively constructed as participants move towards full economic and social participation (Horn 2004).

International approaches

United States and European Union policy contexts

Compared with Australia, states in the US have considerable flexibility in the use of federal funds (available under TANF (Temporary Assistance for Needy Families)) to develop programs to assist clients facing barriers to employment, resulting in a wide variety of approaches. They do, however, have to meet broad funding requirements and achieve specified increases in participation rates (Wagner et al. 1998). Federal funds can be used to provide income support, work incentives or transitional support, as well as employment and employment-related services.

TANF was introduced in 1996 after the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which transformed welfare support from 'a permanent support into a transitional subsidy' (Wagner et al. 1998). Strict work requirements have been implemented and all individuals, including those facing multiple barriers who were previously exempt, now face a five-year lifetime limit (although states can impose shorter limits) on the receipt of federal income support, whether cumulative or in one block (Office of Inspector General 2002). At the same time, eligibility for Supplemental Security Income, provided to people facing physical or mental health problems, has become stricter, resulting in only the very severely disabled being exempt from welfare-to-work requirements. As Dion et al. (1999, p.2) describe, 'PRWORA is rooted in the fundamental assumption that regardless of background or circumstance, all able-bodied adults are capable of gainful employment' and has as primary objectives the promotion of self-sufficiency and reduction in welfare rolls.

As with the TANF funding in the US, considerable flexibility is provided to develop programs at the local level in the EU, but these have to be consistent with broad policy guidelines. Funding is primarily allocated through the European Social Fund under the EQUAL initiative, part of which focuses on 'facilitating access and return to the labour market for those who have difficulty being integrated or reintegrated' (European Commission 2000a, p.3). There are currently around 430

projects across the EU that aim to enhance employability by developing work and social skills, self-confidence and adaptability in the labour market (European Commission 2000b).

The goals of the European Social Fund are informed by the European Employment Strategy, which in turn is informed by the EU's strategic vision of long-term economic growth, full employment, social cohesion and sustainable development in the knowledge economy (O'Donnell et al. 2003). Of the European Employment Strategy's ten specific guidelines, two are particularly relevant for policies relating to individuals with barriers to employment. Guideline 7 is to 'promote the integration of and combat discrimination against people at a disadvantage in the labour market', and guideline 8 is to 'make work pay through incentives to enhance work attractiveness' (European Commission 2003, p.8).

While these guidelines are not prescriptive, member states are required to conduct their employment policies in a way that will achieve the objectives and priorities for actions and to set out their strategy in their annual National Action Plans for employment.

The result is that programs to assist individuals facing barriers are encouraged through both the direct funding of the EQUAL initiative and the European Employment Guidelines. This framework provides a broader commitment to job seekers facing barriers than exists in Australia or the US. It also places a strong emphasis on social inclusion and cohesion, rather than simply promoting self-sufficiency and reduced welfare case loads as in the US. The social inclusion approach has some similarities with the goal of increasing social and economic participation in the Australian PSP. However, in Australia there is no broader commitment to reducing social exclusion of vulnerable groups and individuals in the labour market.

Program approaches and good practice

United States

Although TANF funding allows considerable flexibility in employment assistance programs, the five-year lifetime limit results in most programs placing primary emphasis on moving all clients rapidly into employment. Unlike in the Australian system, where clients with multiple barriers are effectively quarantined from the Job Network work-first approach, the rapid employment focus remains for US clients. What has occurred, however, are attempts to modify these services to better meet the needs of clients with barriers.

Brown (2001) suggests that three broad approaches have been developed in the US context to recognise the additional support required by this client group:

- modified work first
- supported work
- the incremental ladder.

Under the *modified work first* approach, case managers and participants develop employment plans, as under a conventional work first approach; however there is greater flexibility to incorporate diverse additional activities such as treatment or personal support, education or other activities. There is also greater emphasis on links with local providers such as mental health or substance abuse agencies, and with barrier-specific post-employment services. The aim is to pursue employment and barrier-related activities simultaneously, and if this is not possible to address barriers as a direct step towards finding employment.

The *supported work* approach provides individuals with employment experience in real world settings as a transitional step. Gaining employment is still the primary focus, but a broader range of 'hard' and 'soft' outcomes are seen as legitimate steps along this path. There is usually a highly structured work environment with close supervision and gradually increasing expectations.

The *incremental ladder* model supports people as they take gradual steps towards employment. It also recognises that some people are unable to directly enter unsubsidised employment, and the lower 'rungs' may include activities such as child-care responsibilities or addressing health problems.

Other strategies developed in US programs for working with clients facing barriers include:

- financial incentives or 'making work pay' strategies which pay earnings or welfare supplements or allow clients to retain more of their benefit when they move into employment
- transitional benefits such as child-care and health insurance
- increased focus on job retention and advancement through intensive follow-up and support services
- transitional jobs schemes which place participants in short-term, publicly subsidised jobs combining work, skill development and support services (Perkins & Nelms 2004).

In contrast to Australia's PSP, all of these approaches have a primary focus on the gaining of employment, rather than broader goals including increased social participation. Thirty-six states report that they strive to keep the focus of programs working with clients with multiple barriers on employment (Office of Inspector General 2002). This is due in part to the restrictions on federal cash assistance and the more punitive attitude towards welfare in general; but it also reflects a belief that support to families or individuals with barriers is not incompatible with rapid labour market entry and that work and work-related activities can be an important part of a client's therapy (Pavetti et al. 1996). Work-based strategies for clients facing barriers to employment include paid work experience programs, and transitional jobs programs in public, private and supported work environments (Pavetti et al. 2001).

Program reviews

A national review of state strategies for working with hard-to-place clients carried out by the US Office for the Inspector General found that most states screen all clients for domestic violence, substance abuse, physical disability and chronic health problems, and that over half use a formal tool to identify a wider range of barriers. All states utilise partnerships with other agencies; however, most states do not have specific strategies for assisting clients with more than one barrier to employment (Office of Inspector General 2002).

Other research suggests that, despite state flexibility in developing services, most recipients with barriers are not receiving the needed additional services. Screening is mostly inadequate and even when adequate it often does not result in barriers being addressed (Goldberg et al. 2001).

Researchers reviewing diverse programs have identified the following elements as important in the successful delivery of programs to clients facing barriers:

- flexibility to respond to the varied and complex needs
- strong partnerships with community agencies that can provide necessary support services
- specific and ongoing staff training to better understand and support client needs
- reduced staff case loads and more intensive case management
- clear expectations reinforced with financial penalties
- use of employment or community participation activities to increase work-related skills and self-esteem
- ongoing support to clients after employment is obtained
- creating a positive context and using a strengths-based approach (Brown 2001; Dion et al. 1999; Pavetti et al. 1996).

Overall, the US approach aims to promote self-sufficiency and reduce reliance on welfare, rather than to achieve broader goals such as reducing poverty and exclusion or increasing social participation, and this is reflected in the high poverty rates of those who leave welfare (Polit et al. 2001). There is a strong focus on active welfare and employment assistance for all, and an attempt to rapidly move people into employment, with post-placement support used to assist people to manage barriers and stay off welfare.

European Union

In the EU, approaches for groups facing barriers are shaped by broader goals than simple employment, in particular the objective of promoting social inclusion. There is greater emphasis and recognition of soft outcomes in program design and a broader range of interventions. The soft outcomes commonly targeted by programs operating under INTEGRA (the forerunner to EQUAL) initiatives included attitudinal outcomes, life skills, and other transferable skills more related to work, such as communication, language or problem-solving skills (ESU 1998).

Both the INTEGRA and now EQUAL initiatives have advocated a pathways approach, which recognises that barriers faced are often complex and cumulative, and can originate in a wide range of spheres (O'Donnell et al. 2003).

> The concept of 'pathways to integration' implies that successful integration into the labour market – particularly for the most vulnerable groups – is based on a multistage integration process which takes place at several levels. It involves integration on the economic, social and cultural levels. The approach integrates different types of expertise and involves a process of co-ordinating and managing the input of relevant services, agencies and employers (European Commission 2000c, p.2).

The pathways approach encompasses five main interventions:

Contacting and motivating participants: aims to facilitate opportunities for engagement with target groups through methods such as effective outreach

Developing skills: focuses on quality training, and development of vocational skills, as well as basic skills in areas such as literacy and communication

Ensuring support for social and cultural needs: recognises broader outcomes than employment and aims to empower participants to become active citizens and fully participate in society

Providing employment and career guidance services: aims to deliver these services in a flexible manner meeting the specific needs of disadvantaged clients

Developing employment progression measures: seeks to secure the move into employment and provide ongoing support including assessment of progress, personal planning, evaluating and recording learning outcomes and supporting mentors and supervisors (O'Donnell et al. 2003).

Another notion which has shaped program development for individuals facing barriers is that of empowerment. The empowerment approach links strategies for inclusion with strategies for employment (European Commission 1999). It has been defined as moving to a state of inclusion:

> the development of capacity and opportunity to play a full role, not only in economic terms, but also in social, psychological and political terms (ESU 2001, p.3).

Empowerment involves recognising that individuals need additional support to utilise newly acquired skills to control and overcome barriers they face, and that these individuals are often excluded from formal and informal information networks about employment and training opportunities. Projects aiming to empower individuals address elements such as:

- quality of life: accommodation, health, finance management
- wider employment support: basic skills, social skills, communication, teamwork

- personal development: confidence, motivation, self-identity, initiative taking
- participation: opportunities to participate in project design, delivery and evaluation; access to childcare, access to information and support to use it for decision making (ESU 2001).

The empowerment concept was identified as crucial by many INTEGRA projects; and all projects under the EQUAL initiative are required to show that it is an integral part of their approach.

In terms of connection to the labour market, the EU approach aims for much closer links than are seen in Australia under PSP, but does this as part of a much broader approach than the US work first model which focuses on rapid labour market entry. It emphasises employer involvement, and cooperation with business and industry in general, as an important aspect of developing effective pathways (European Commission 2000c) and also stresses the acquisition of skills and access to lifelong learning for disadvantaged groups (European Commission 2003). Support and training are means to participate in broader society rather than just a path to employment (European Foundation 2002). While activation does play a key role in EU employment and welfare policy, it is intended to be linked to empowerment of individuals and promotion of social inclusion rather than used as a means to cut welfare rolls and force people into poor-quality jobs (European Foundation 2003).

Research and good practice

A review of projects utilising a pathway approach by the European Commission found that a number of elements are important for their success.

- coordination and networking of all relevant agencies and actors to provide a coherent range of easily accessible services
- remedial and pre-vocational training
- support for job placement in the form of mediation and job brokerage services matching individuals with jobs
- identification and follow-up of individuals through tracking systems, outreach work, involvement of formal & informal mediators
- guidance and counselling based on a personalised flexible approach where the individual is seen as an equal partner
- monitoring and support throughout the integration process through mechanisms such as mentoring, tutoring, and personal support (European Commission 2000c).

A study of UK projects found that a pathway approach was appropriate for disadvantaged clients, and that developing soft and practical skills alongside vocational skills was important. However, a key weakness was inadequate linkages with employers (O'Donnell et al. 2003).

In broader research into good practice in working with disadvantaged clients, the following factors have been identified as important.

- recognising multiple and complex needs of vulnerable clients
- developing high-quality intensive programs for clients with the most diverse and complex needs
- involving end-users in program design, implementation, operation and monitoring
- providing access to a wide range of local support services
- underpinning programs with adequate resources in terms of people, money and information
- adapting coordination arrangements to the needs of clients
- promoting inclusion with the commitment of all actors
- utilising partnerships for action involving clients, public, private and non-government sectors (Ditch & Roberts 2002; European Foundation 2002 & 2003).

It is also suggested, however, that knowledge of vulnerable and excluded groups and program effectiveness needs to be improved, through better qualitative and quantitative data collection, and ongoing evaluation and monitoring that takes into account the multi-dimensional nature of client needs (European Foundation 2003).

4 Personal Support Programme evaluation

Research objective

The aim of this study is to evaluate the extent to which the Personal Support Programme is enabling people with multiple non-vocational barriers to achieve economic and/or social outcomes. The participating agencies seek an understanding of the effectiveness of the PSP in order to:

- advocate improvements to service delivery by providers
- inform reviews and development of the program itself
- influence the development of broader employment assistance and social participation policies to benefit disadvantaged incomes support recipients generally.

Research questions

1. What are the nature and extent of non-vocational and employment barriers faced by PSP participants?
2. To what extent is PSP enabling people with multiple barriers to achieve economic and/or social outcomes?
3. What are PSP's strengths and weakness in terms of service delivery to participants?
4. To what extent have the program changes over time improved assistance?
5. What are the values and meanings of 'social outcomes' and how are they assessed?
6. To what extent is the program model resulting in positive outcomes for participants?
7. How integrated is PSP with the suite of employment assistance and support programs?
8. Are there other services or forms of assistance needed by PSP participants but not provided in the current arrangements?
9. What are the longer term outcomes for PSP participants after exiting the program?

Method

Surveys were carried out with 134 PSP participants who had been on the program between two and twelve months. The surveys contained three sections, the first to be filled out by the case manager and participant together, the second by the case manager alone and the third by the participant alone where possible. When this was not possible for literacy or other reasons, the third section was completed with the case manager. Surveys were completed by participants at 12 metropolitan and non-metropolitan PSP providers in Victoria. Three focus groups were conducted with PSP participants that had been on the program between two and twelve months.

In-depth interviews were carried out with case managers across 15 PSP providers in 2004–05 and again with staff in 8 PSP providers in the second half of 2006. Interviews were also carried out with Centrelink Psychologists in 2004 and Job Capacity Assessors in the second half of 2006. PSP staff in the Department of Employment and Workplace Relations were also interviewed.

Administrative data was also collected for 238 participants at two PSP providers who had been referred to PSP between mid 2005 and the end of 2006. For these individuals, data from the Centrelink assessment page of the PSP system (EA3000) was recorded directly to allow comparison with the survey sample. Data collected included barriers present on referral, age, level of education and gender.

Survey two

Survey two was conducted with participants after they had been on the program for 12 months, or earlier if they were leaving the program due to completing their two years, finding employment or other reasons. As with survey one there was three sections to the survey: a section that the case manager and participant would complete together; a section the case manager would complete without the participant present and a self-complete section that the participant would complete alone, unless this was not possible due to literacy problems. If a participant left the program unexpectedly and an exit interview could not be carried out, the case manager would still complete the case manager part of the survey and the other two sections were posted to the former participant by the researchers.

Of survey one participants at least one section of survey two was completed for 91% (122 people). All parts of survey two were completed by 84% (112 people) of participants. Another 6% (8 people) had only the case manager section completed and 1.5% (2 people) had only the participant section completed.

Around two-thirds of people that completed survey two remained on PSP, 18% were being suspended, 13% were formally exiting and 3% had informally exited (see Table 4.1).

Table 4.1 PSP status at survey two

Status	Number	Percentage
Remains on PSP	77	64
Being suspended	22	18
Formally exiting	16	13
Informally exited	4	3
Missing	1	1

Case managers were asked to complete the second survey with participants after 12 months on PSP, or earlier if the participant left the program or the provider. The actual times between the completion of survey one and two ranged from 4 to 16 months, with an average of 11 months. However, more than 75% of participants completed the second survey at least 10 months after survey one.

Survey data was analysed using SPSS statistical package. Non-parametric tests were used were appropriate.

Differences between lost participants and rest of sample

Statistical tests conducted showed little observable difference between participants that completed or did not complete survey two.

Non-parametric tests revealed no differences between lost participants and the rest of the sample on the following attributes: level of education (Pearson's chi-square = 9.78, p ns), whether the participant was living alone (Pearson's chi-square = 1.74, p ns), whether the participant had been homeless in the last five years (Pearson's chi-square = .46, p ns), and whether English language was spoken at home (Pearson's chi-square = .603, p ns).

Independent t-tests showed no differences between lost participants and the rest of the sample on the following measures: length of time since last worked ($t(128) = .004$, p ns), total number of barriers identified at survey one (Centrelink or provider; $t(132) = 1.47$, p ns), total barrier score at survey one ($t(132) = .86$, p ns).

5 Participant characteristics

Overview

Participants in the sample had an average age of just over 35 and were around two-thirds male and one-third female. There was a low representation of people from culturally and linguistically diverse (CALD) backgrounds, with almost 90% being born in Australia and 80% reporting that neither of their parents was from a non-English speaking background.

Participants generally had low levels of education. Around one-third had reached year 9 or less and just over two-thirds reported year 11 or less to be their highest level of education. Basic literacy levels were slightly lower than amongst the broader population, with case managers reporting that 10% of people were unable to write well and 5% unable to read well.

Participants appeared to face an elevated risk of social isolation, with 71% not in a relationship and almost half living alone, more than five times the average for the Australian population. Private rental was the most common housing type reported by 33% of people, with 22% living in public rental housing, and 22% living in supported accommodation or a rooming or boarding house or moving frequently between temporary accommodation. The finding that fully 50% of had been homeless in the last five years suggests an entrenched pattern of disadvantage.

As expected, almost all participants (98%) reported that some type of benefit was their main source on income. For most people this was the Newstart Allowance (82%).

Age and gender

The participants in the survey ranged from 16 to 60 years of age at the time of the first interview with an average age of 35 for females and 36 for males. This corresponded closely with the administrative data collected, which had an age range of 17–61 and an average age of 36 for females and 37 for males.

Among survey participants 63% were male and 37% female, compared with 70% male and 30% female in the administrative sample. The age distribution of males between the two samples was similar, but there was a greater proportion of younger females in the survey sample.

Country of origin

The sample had limited representation of PSP clients from CALD (culturally and linguistically diverse) backgrounds, with 89% born in Australia and 80% having neither of their parents from a non-English speaking background. Moreover, only 2% of respondents reported that English was not the main language spoken at home.

For those not born in Australia, the most common places of origin were the UK (6 people), New Zealand (3) and Turkey (2); there was one person from each of Ireland, Vietnam, the Philippines and Holland. Around 3% of participants reported that they were of Aboriginal or Torres Strait Islander descent.

Data about origin and language of the administrative sample was not available.

Education

Participants generally had very low levels of education: 33% had completed year 9 or less and the vast majority (69%) listed the completion of year 11 or lower as their highest level of education (see Table 5.1). Twelve per cent of people had completed year 12, 13% had completed a trade or TAFE qualification, 2% a diploma or advanced diploma, and 3% a qualification at degree level. As indicated in Table 5.1, these figures correspond closely to those obtained from the administrative data sample.

Table 5.1 Highest level of education

	Survey sample % (n=133)	Administrative data % (n=211)
Completed year 9 or less	33	32
Completed year 10	20	28
Completed year 11	16	11
(Total less than year 12)	(69)	(71)
Completed year 12	12	10
TAFE/trade qualification	13	10
Associate diploma	2	2
Degree	3	5
Other	0	0

As can be seen in Table 5.2, some differences exist in levels of education by provider location. This is particularly pronounced for the completed year 9 or less category, which makes up 41% participants at non-metropolitan providers, 31% at outer metropolitan providers and 18% at inner metropolitan providers. Nevertheless, non-metropolitan providers also have slightly more participants with year 12 or higher, 33% compared with 29% at both inner and outer metropolitan providers.

Table 5.2 Highest level of education by provider location (n=133)

	Inner metropolitan %	Outer metropolitan %	Non-metropolitan %
Completed year 9 or less	18	31	41
Completed year 10	21	24	17
Completed year 11	32	17	8
(Total less than year 12)	(71)	(71)	(67)
Completed year 12	11	7	16
TAFE/trade qualification	14	17	11
Associate diploma	0	2	3
Degree	4	2	3

Pearson chi-squared test found differences not to be significant.

Case managers' ratings of participants' English language abilities are shown in Table 5.3. Spoken English did not appear to be a major problem for any participants, but case managers listed 5% of respondents as not reading well and 9% as not writing well. This compares with 4% and 6% of the general population that report a poor ability to read and write well respectively (ABS 1997).

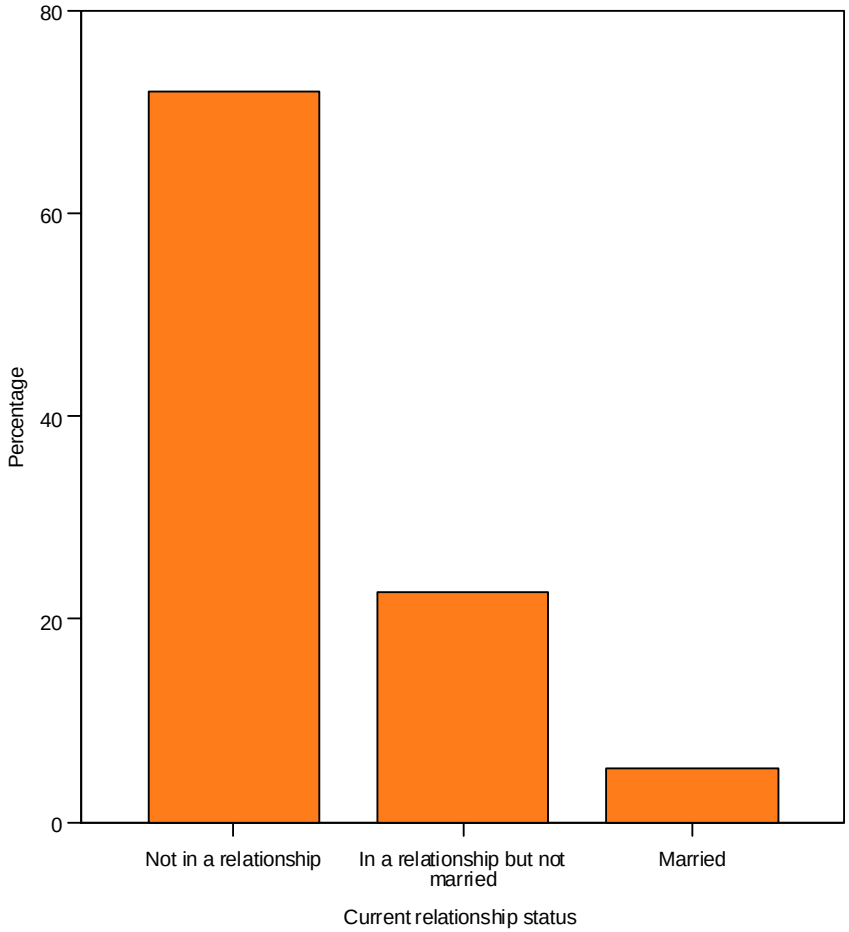
Table 5.3 Clients' English language abilities, rated by case managers

Rating	Speaks English % (n=132)	Reads English % (n=131)	Writes English % (n=130)
Very well	69	57	52
Well	31	37	38
Not well	-	5	9
Not at all	-	-	-
Don't know	n/a	1	1
Total			

Living arrangements

As Figure 5.1 shows, at the time of the first survey approximately 71% of the sample were not in a relationship, 23% were in a relationship but not married and 6% were married.

Figure 5.1 Participants' relationship status (n=132)



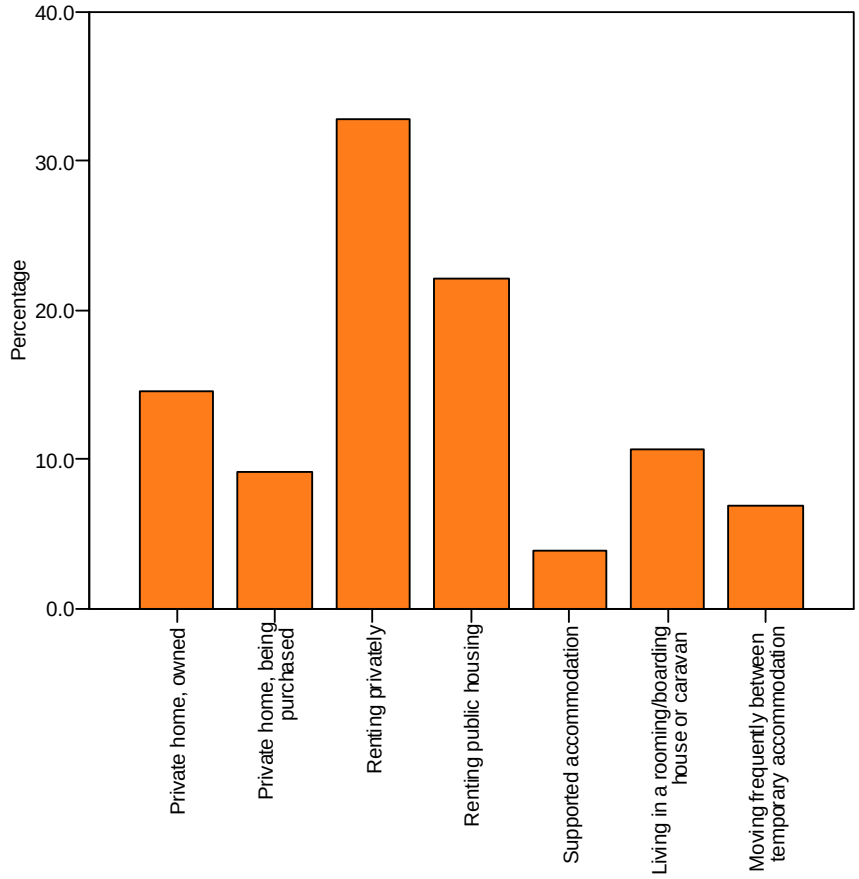
Almost half (49%) of the sample reported living alone, more than six times the percentage living alone in the broader Australian population (8%) (Australian Bureau of Statistics. 2002). The rate is also considerably higher than among unemployed Australians aged 16–60 that are not full-time students (14%) (HILDA 2003).

The most common living arrangement for those who were not living alone was living with non family (24%), then with parents (19%) or living with a partner (19%).

Most participants (81%) were not living with dependent children, while 19% reported that they were living with dependent children, and 4% reported living with independent children.

The most common housing arrangement, reported by one-third of the sample, was renting privately (see Figure 5.2). This was followed by private home owned/being purchased by client or client's parents (23%) and public housing rental (22%). Approximately 22% reported less stable housing arrangements: living in a rooming/boarding house or caravan (11%), moving frequently between temporary forms of accommodation (7%), or supported accommodation (4%).

Figure 5.2 Participants' housing arrangement at survey one (n=131)



No respondents reported they were currently living on the street, but a significant finding was that 50% had experienced homelessness in the previous five years. Table 5.4 shows the proportion of respondents who identified various factors contributing to their homelessness. Only 9% reported that they had been working at the time of becoming homeless.

Table 5.4 Factors contributing to homelessness* (n=66)

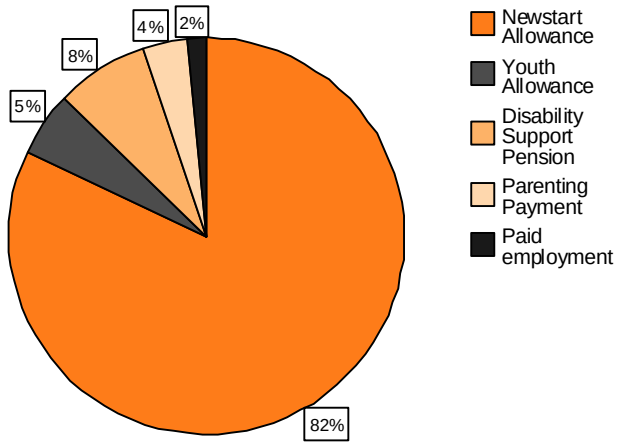
Factor	Percentage
Financial difficulty	42
Family issues or breakdown	41
Unemployment	39
Mental health	28
Social isolation	24
Drug and alcohol problems	13
Physical/sexual abuse	12
Gambling	6
Other	11

*Multiple responses possible

Income

As expected, the most commonly reported main source of income for participants was Newstart (82%), followed by the Disability Support Pension (8%), Youth Allowance (7%) and Parenting Payment (5%) (see Table 5.5). Just 2% reported other main income sources.

Table 5.5 Participants' main source of income (n=133)



6 Barriers

Overview

Barriers data illustrate the severe and multiple levels of disadvantage experienced by PSP participants. Individuals in the sample faced from 1 to 21 barriers, and on average, 8.5 barriers, when the first survey was undertaken.

The four most common barriers were family relationship breakdown, confidence or self-esteem problems, mood disorders including depression, and social isolation or alienation, all of which affected more than half of participants in the sample. Anxiety conditions, drug problems, financial management problems and homelessness were also common, affecting 30–50% of individuals. In addition, nearly 4 out of every 5 (78%) participants suffered from some type of mental health problem (depression, anxiety or a personality disorder).

Eight of the 42 possible barriers were found (based on case manager ratings) to have a greater than average impact on individuals' social or economic participation, the greatest of these being periods in custody or a criminal record, lack of access to transport, very long term unemployment and family relationship breakdown.

Change between survey one and two

Measures of the impact and prevalence of barriers at survey one and survey two identified positive but limited change. Of the 26 barriers with at least 10 people with valid data at survey one and two, 15 barriers showed statistically significant reduced impact on participation (see Table 6.1). Greatest reductions in impact were found for homelessness, alcohol problems, significant legal issues, and significant grief issues.

Table 6.1 Significant change in impact of barriers on participation

Impact of barriers on participation	*Change* [a, b]
Family relationship breakdown or issues	▼
Confidence or self-esteem problems	▼▼
Mood disorders	▼
Social isolation	▼
Anxiety conditions	▼
Drug problems	▼
Homelessness	▼▼▼
Alcohol problems	▼▼
Motivational problems	▼
Facing significant grief issues	▼▼
Limited education, training or skills	▼
Significant legal issues	▼▼
Periods in custody/criminal record	▼▼▼

[a] Only statistically significant changes identified
[b] ▲= smaller change, ▲▲= medium change, ▲▲▲=larger change

Although many barriers showed reduced impact, only a small number of people experiencing each barrier at survey one were not experiencing the barrier at all at survey two pointing to a strong persistence of barriers over time. In addition, the average number of barriers actually increased from 8.5 to 9.6. It is not possible to tell from the data to what extent this reflects the onset of new barriers or detection of pre-existing barriers.

Despite the reduced average impact ratings, only one barrier (homelessness) showed an overall reduction in prevalence at survey two (see Table 6.2). Even more concerning was the increase in prevalence of five other barriers: motivational problems, lack of confidence or skills seeking work, anxiety conditions, poor communication or language skills, and age.

Table 6.2 Significant change in prevalence of barriers

Prevalence of barriers in the sample	Change [a, b]
Homelessness	▼▼
Motivational problems	▲
Age	▲▲
Anxiety conditions	▲
Lack of confidence and skills in seeking work	▲
Poor communication/language skills	▲

[a] Only statistically significant changes identified
[b] ▲= smaller change, ▲▲= medium change, ▲▲▲=larger change

Other barrier measures

Of the 13 factors identified by participants as holding them back from work, mental health problems was the most common, followed by physical health problems and confidence or motivation problems. At survey two there had been little change in the proportion of participants identifying each factor (see Table 6.3), other than a reduction in those reporting family or personal problems and a large increase (1% to 14%) in those reporting nothing was holding them back from work.

Table 6.3 Significant change in the proportion of participants reporting factors holding them back from work

Factors holding back from work	Change [a, b]
Family/personal problems	▼
Nothing	▲▲▲

Questions measuring how close participants felt to their goals they identified at survey one provide another assessment of the change in the impact of barriers at survey two. Of the 12 goal types identified, seven showed statistically significant improvements in average scores at survey two. These were generally larger than the improvements in barrier ratings reported by case managers. Of concern, however, was participants' lack of perceived improvement in two of the three most common goal types, addressing personal or emotional issues and improving skills or study.

Table 6.4 Change in participant perception of closeness to goals

How close participants feel to their goals	Change [a, b]
Find work/improve work readiness	▲▲
Improve confidence/self-esteem	▲▲
Improve housing situation	▲▲▲
Improve health/lifestyle	▲▲
Resolve family issues	▲
Improve mental health	▲▲
Address financial/legal problems	▲▲

[a] Only statistically significant changes identified
[b] ▲= smaller change, ▲▲= medium change, ▲▲▲=larger change

There was also a reduced proportion of clients requiring four assistance types (self-esteem or confidence training, drug and alcohol assistance, accommodation assistance, assessments) at survey two compared with survey one, suggesting an improvement in the related barriers.

Table 6.5 Significant change in assistance types required

Assistance type required	Change [a, b]
Self-esteem/confidence training	▼▼
Drug and alcohol program	▼▼
Accommodation/housing	▼▼
Assessments	▼

[a] Only statistically significant changes identified
[b] ▲= smaller change, ▲▲= medium change, ▲▲▲=larger change

Evidence of changes in barriers can also be gleaned from case manager and participant comments about things gained from PSP. Participants most commonly mentioned improved

confidence/motivation/positive outlook (38%), followed by support/advice (26%) and new options/direction/goals (18%). Case managers' perspectives were somewhat different, with improved personal or family situation (25%) the most common achievement while on PSP, followed by increased confidence or self-esteem (23%) and improved housing situation.

Survey findings: prevalence of barriers

Estimates of the prevalence of each barrier among survey participants were obtained from case managers. They were first asked to report all of the barriers that had been identified by Centrelink when referring the client, and then to report any **additional** barriers that they had identified since. For each barrier, they were also asked to rate its impact on the respondent's economic and social participation on a scale of 1 to 10 (where 10=extreme impact and 1=no impact). For the administrative data sample, the presence of barriers was recorded directly from the Centrelink assessment page of the PSP system, EA3000.

The method of survey data collection relied on the case manager's assessment of barriers and did not use any clinical assessment of barriers such as depression, anxiety or personality disorders. While this may affect the accuracy of some barrier measurements, the established relationship between the case manager and participant should have assisted with accuracy and disclosure of information relating to other barriers.

As Table 6.6 and Table 6.7 show, the list of barriers used by Centrelink is made up of personal or family barriers, while the additional barriers used in the present study include some human capital/labour market and situational barriers.

Table 6.6 indicates that the four barriers (Centrelink or provider-identified) most commonly reported in the survey sample were family relationship breakdown, confidence or self-esteem problems, mood disorders including depression, and social isolation or alienation. All of these affected more than half the participants in the sample. Anxiety conditions, drug problems, financial management problems and homelessness affected 30–50% of individuals, while personality disorders, learning disorders, gambling problems, acquired brain injury and intellectual disability were the least common barriers, present in 6% of the sample or less.

The rate of depression found (62%) was substantially higher than that estimated for the general population (5–15%) (Butterworth 2003b), but consistent with that estimated for long-term welfare recipients (57%) (Waghorn & Lloyd 2005). When mental health was treated as a composite barrier comprising mood disorders including depression, anxiety conditions including agoraphobia and panic disorders, and personality disorders, this barrier affected 78% of respondents.

The most common barrier identified by Centrelink on referral in the survey sample (column A in Table 6.6) was mood disorders including depression (50% of cases), followed by family relationship breakdown (41%), anxiety conditions (38%) and confidence or self-esteem problems. Additional barriers most commonly identified by providers after referral (column C in Table 6.6) include confidence or self-esteem problems, social isolation or alienation, family relationship breakdown and financial management problems, all identified after referral in around one-quarter of cases.

Columns A and B in Table 6.6 provide a comparison of the proportion of clients identified by Centrelink as facing each barrier in the survey sample and the administrative data sample. While the order of barriers is roughly similar in the two samples, the survey sample records higher proportions of individuals with all barriers except drug problems. Given the similarity between the two samples on gender, age and level of education, this difference is unexpected. It may reflect other differences in the samples, but is more likely to come about from case managers not listing only barriers identified in client referral reports but also other barriers presenting on referral but not specifically identified by Centrelink.

Table 6.6 Proportion of clients facing barriers (Centrelink barrier list)

Barrier (n=134)	Survey sample: barriers identified by Centrelink (A)	Administrative sample: barriers identified by Centrelink (B)	Survey sample: additional barriers identified by providers (C)	Survey sample: total (D = A + C)
	%	%	%	%
Family relationship breakdown	41	24	24	**65**
Confidence or self-esteem problems	36	26	27	**63**
Mood disorders including depression	50	43	12	**62**
Social isolation/alienation	28	10	26	**54**
Anxiety conditions including agoraphobia & panic disorder	38	33	8	**46**
Drug problems	26	33	13	**39**
Financial management problems	15	8	22	**37**
Homelessness	23	19	10	**33**
Alcohol problems	21	14	7	**28**
Physical disability	17	10	6	**23**
Anger/conflict/behavioural difficulties	14	8	8	**22**
Literacy/numeracy problems	10	3	5	**15**
Domestic violence	9	0	4	**13**
Torture or trauma	6	4	4	**10**
Poor communication/language skills	4	1	3	**7**
Personality disorders	3	1	3	**6**
Learning disorder	5	1	1	**6**
Gambling problems	3	1	3	**6**
Acquired brain injury	2	1	2	**4**
Intellectual disability	2	1	0	**2**

In the set of additional barriers, lack of local jobs was the most common barrier, present in 40% of cases, followed by very long term unemployment; lack of confidence or skills in seeking work; motivational problems; limited education, training or skills; insufficient work experience; an ongoing medical or dental condition; and periods in custody or criminal records, all present in 20–30% of cases. Interestingly the skills or employment-related barriers are all in this top cluster and make up six of the seven barriers affecting more than 20% of individuals. Difficulties accessing childcare, post-migration adjustment difficulties and limited English skills were all uncommon. The latter two of these may reflect survey bias towards people with reasonable English language comprehension. Difficulties accessing childcare may become more important as more sole parents enter PSP due to the changes requiring parents with their youngest child over 8 years to be looking for work since 1 July 2006.

Table 6.7 Proportion of clients facing barriers (additional barriers) (n=131)

Barrier	Percentage
Lack of suitable jobs in area	40
Very long term unemployment (more than two years)	29
Lack of confidence and skills in seeking work	28
Motivational problems	27
Limited education, training or skills	21
Insufficient work experience	21
Facing significant grief or loss issues	21
Ongoing medical or dental condition	20
Lack of access to private or public transport	17
Significant legal issues	17
Periods in custody and/or criminal record	11
Age	9
Caring responsibilities	9
Experienced/experiencing sexual abuse or assault	9
Experienced/experiencing physical abuse or assault	8
Limited independent living skills	6
Workplace injury	6
Difficulties in accessing childcare	2
Significant post-migration adjustment difficulties	1
Limited English language skills	1

The barrier data illustrates the very high level of disadvantage experienced by PSP participants. Individuals in the sample faced from 1 to 21 barriers, and on average, 8.5 barriers, when the first survey was undertaken. The average single barrier score was 6.45 (on a 1 to 10 scale where 1=no impact and 10=extreme impact) and the average total barrier score was 54.8.

Table 6.8 shows the average barrier score by barrier, and gives some measure of which barriers most adversely affected participants' economic and social participation. A one sample t-test found eight barriers to have scores significantly higher than the average (6.45). Periods in custody and/or a criminal record was reported to have the greatest negative impact on participation (7.9), followed by lack of access to private or public transport (7.6), very long term unemployment (7.2), family breakdown (7.1), lack of suitable jobs (7.1) and mood disorders including depression (7.0). Anxiety conditions was significantly above average only at the 10% level, while confidence or self-esteem problems was closer to the average of 6.45 but was still statistically significant at the 5% level.

Interestingly, the three barriers with the highest barrier scores are all additional barriers used in this study and not presently included on the Centrelink barrier list. These results provide some support for these being added. In addition, the presence of several structural or employment barriers (lack of access to transport, very long term unemployment and lack of suitable jobs in the area) in the top scoring group highlights the need for policy response to focus more broadly than just individual personal barriers.

Three barriers had significantly less impact on participation than average: gambling problems, poor communication or language skills and limited independent living skills. However, each affected fewer than 10 people, so results should be interpreted with care.

Table 6.8 Average barrier scores for barriers (on a 1 to 10 scale where 1=no impact and 10=extreme impact)

Barrier[a]	Number of cases	Average barrier score
Periods in custody and/or criminal record	14	7.9**
Lack of access to private or public transport	22	7.6**
Very long term unemployment	37	7.2*
Family relationship breakdown or issues	82	7.1**
Lack of suitable jobs in area	51	7.1*
Mood disorders including depression	79	7.1**
Facing significant grief and loss issues	27	7.0
Anxiety conditions including agoraphobia and panic disorder	58	6.9#
Confidence or self-esteem problems	80	6.8*
Alcohol problems	36	6.8
Personality disorders	8	6.8
Homelessness	42	6.7
Social isolation/alienation	69	6.6
Literacy/numeracy problems	19	6.6
Motivational problems	34	6.6
Age	11	6.5
Learning disorder	7	6.4
Significant legal issues	21	6.4
Ongoing medical or dental condition	25	6.3
Torture or trauma experience and stress disorders	13	6.2
Lack of confidence and skills in seeking work	35	6.2
Anger/conflict/behavioural difficulties	28	6.2
Limited education, training or skills	27	6.2
Drug problems	49	6.2
Physical disability	29	6.2
Experienced/experiencing sexual abuse or assault	11	6.1
Insufficient work experience	27	6.0
Experienced/experiencing domestic violence	17	6.0
Financial management problems	47	6.0
Caring responsibilities	11	5.8
Workplace injury	7	5.6
Experienced/experiencing physical abuse or assault	10	5.3
Gambling problems	6	4.7*
Poor communication/language skills	9	4.4*
Limited independent living skills	7	4.0*

# p< .10, * p < .05, ** p < .01 (one sample t-test, test value = 6.45)

[a] Only barriers affecting more than 5 people are reported.

Co-occurrence of barriers

In the survey sample, statistically significant associations were found between 75 pairs of barriers using the Kendall's tau-b test[2]. Selected co-occurring barriers are presented in Table 6.9 with the tau-b value, the proportion of those people with each barrier in the pair that also experience the other barrier and the percentage of the whole sample experiencing both barriers (see Appendix Table 10.1 for full list of pairs with significant associations). The two barrier pairs with the strongest association were sexual abuse or assault and physical abuse or assault, and having a learning disorder with literacy or numeracy problems. However, both of these were present in only 5% of the overall sample. Very long term unemployment as a barrier was associated with an increased likelihood of a range of other barriers, including periods in custody, motivational problems, lack of confidence or skills seeking work, mood disorders, ongoing medical or dental

[2] The tau-b value can range from -1 to +1 and measures the strength of association: values further from zero indicate a stronger relationship. Eighteen pairs of variables recorded tau-b values of less than .20, 34 pairs from .20 to .24, 11 pairs from .25 to .29 and 12 pairs from .30 to .55.

problems, alcohol problems and confidence or self-esteem problems. This frequent co-occurrence adds further weight to the case for adding very long term unemployment to the Centrelink barrier list, and making it a PSP-eligible barrier. Homelessness and alcohol problems were more likely to co-occur, with 45% of people facing homelessness having alcohol problems and 53% of people with alcohol problems facing homelessness.

Insufficient work experience was positively associated with limited education, training or skills and confidence or self-esteem problems. In the latter pair, 85% of people with insufficient work also experience confidence or self-esteem problems, while 29% of people with confidence or self-esteem problems also had insufficient work experience.

Table 6.9 Selected co-occurring barriers (survey sample)

Survey sample co-occurring barriers (overall survey proportions in brackets)	Kendall's tau-b	Percentage of those with barrier A also experiencing barrier B	Percentage of those with barrier B also experiencing barrier A	Percentage of sample experiencing both barriers
A Experienced/experiencing sexual abuse/assault (9%) B Experienced/experiencing physical abuse/assault (8%)	**.53***	**55**	**60**	**5**
A Learning disorder (6%) B Literacy/numeracy problems (16%)	**.46***	**86**	**30**	**5**
A Motivational problems (27%) B Lack of confidence/skills seeking work (28%)	**.34****	**53**	**51**	**14**
A Very long term unemployment (29%) B Periods in custody (11%)	**.33****	**27**	**71**	**8**
A Very long term unemployment (29%) B- Motivational problems (27%)	**.32****	**49**	**53**	**14**
A Homelessness (33%) B Alcohol problems (28%)	**.26****	**45**	**53**	**15**
A Very long term unemployment (29%) B Lack of confidence/skills seeking work (28%)	**.26****	**46**	**49**	**13**
A Very long term unemployment (29%) B Mood disorder (61%)	**.26****	**81**	**39**	**24**
A Very long term unemployment (29%) B Ongoing medical/dental problem (20%)	**.25***	**35**	**52**	**10**
A Very long term unemployment (29%) B Alcohol problems (28%)	**.25****	**46**	**47**	**13**
A Limited education, training or skills (21%) B Insufficient work experience (21%)	**.25***	**41**	**41**	**8**
A Very long term unemployment (29%) B Confidence/self-esteem (63)	**.24****	**81**	**38**	**24**
A Drug problems (39%) B Anger/conflict/behaviour management problems (22%)	**.24****	**35**	**61**	**13**
A Confidence/self-esteem problems (63%) B Insufficient work experience (21%)	**.24****	**29**	**85**	**18**
A Motivational problems (27%) B Social alienation/isolation (54%)	**.23****	**74**	**36**	**20**
A Motivational problems (27%) B Mood disorder (61%)	**.22****	**79**	**35**	**21**
A Very long term unemployment (29%) B Family relationship breakdown/issues (65%)	**.22****	**81**	**37**	**24**
A Confidence/self-esteem problems (63%) B Motivational problems (27%)	**.21***	**34**	**79**	**21**
A Confidence/self-esteem problems (63%) B Social alienation/isolation (54%)	**.21***	**63**	**73**	**39**

* $p < .05$, ** $p < .01$

In the administrative sample, only two pairs of barriers had a statistically significant likelihood of co-occurring using the Kendall's tau-b test (see Table 6.10).

Table 6.10 Co-occurring barriers (administrative sample)

Admin data sample co-occurring barriers (overall proportions in brackets)	Kendall's tau-b	Percentage of those with barrier A also experiencing barrier B	Percentage of those with barrier B also experiencing barrier A	Percentage of sample experiencing both barriers
A Confidence/self-esteem problems (26%) B Social alienation/isolation (10%)	**.23****	**22**	**56**	**6**
A Homelessness (18%) B Drug problems (33%)	**.17***	**50**	**28**	**9**

* p < .05, ** p < .01

Barrier identification by Centrelink

Due to their ongoing intensive work with clients, case managers would be expected to be in a better position to uncover some barriers than a Centrelink Psychologist or JCA doing a one-off assessment. Other factors that may impact on the identification or reporting of barriers include the specialisation or background of the Centrelink Psychologist, as well as clients' requests that information not be recorded on the system.

Table 6.11 gives some indication of the relative accuracy of Centrelink Psychologist procedures for identifying client barriers, by showing the proportion of all cases with each barrier that were identified by Centrelink. Barriers which appeared to be less commonly identified by Centrelink Psychologists include financial management problems, social isolation or alienation, confidence or self-esteem problems, literacy or numeracy problems and family relationship breakdown, all of which they identified in two-thirds of cases or less (see Table 6.11). Barriers better identified by Centrelink were mood disorders including depression and anxiety conditions including agoraphobia and panic disorder, for which Centrelink identified 80% or more of all cases. These differences may also reflect different working definitions of barriers.

Further issues are the non-disclosure or non-identification of personal barriers by front-line Centrelink staff, and in some cases failure to refer for supplementary assessments (now done by a Job Capacity Assessor), that have been shown to be a significant problem in other research (Parkinson & Horn 2002).

Table 6.11 Proportion of cases identified by Centrelink (for barriers where n>5)

Barriers	Percentage
Learning disorder	83
Anxiety conditions including agoraphobia and panic disorder	83
Mood disorders including depression	81
Alcohol problems	75
Physical disability	74
Homelessness	70
Domestic violence	69
Drug problems	67
Literacy/numeracy problems	67
Anger/conflict/behavioural difficulties	64
Family relationship breakdown	63
Torture or trauma	60
Confidence or self-esteem problems	57
Poor communication/language skills	57
Social isolation/alienation	52
Personality disorders	50
Gambling problems	50
Financial management problems	41

Barriers by location

Table 6.12 shows barriers with a statistically significant difference in prevalence between metropolitan and non-metropolitan providers. Three barriers from the Centrelink list and three of the additional barriers show significant differences. Surprisingly, given transport and distance issues, social isolation or alienation was lower among respondents in non-metropolitan areas (47%) than metropolitan areas (62%); however this difference was only significant at the 10% level. Literacy or numeracy problems and poor communication or language skills were barriers for 25% and 13% of participants at non-metropolitan providers respectively but only 7% and 2% at metropolitan providers. This difference may reflect the higher proportion of non-metropolitan participants with a level of education lower than year 10.

Lack of suitable local jobs was reported as a barrier for 63% of participants at non-metropolitan providers, compared with only 18% at metropolitan providers. Lack of access to public or private transport followed an expected pattern, being a barrier for only 6% of respondents at metropolitan providers, but 28% at non-metropolitan providers. Finally, a period in custody or a criminal record was more than three times more common among participants at metropolitan providers.

Table 6.12 Prevalence of barriers by location

Barriers	Provider location	
	Metropolitan (n=70)	Non-metropolitan (n=64)
	%	%
Social isolation/alienation	62	47#
Literacy/numeracy problems	7	25***
Poor communication/language skills	2	13**[a]
Lack of suitable jobs in area	18	63***
Lack of access to private or public transport	6	28***
Periods in custody and/or criminal record	18	5**

# p<.10, * p < .051, ** p < .01, *** p < .001, Pearson's chi-square

[a] Fisher's exact test used due to low cell counts

Barrier scores by provider

One-way ANOVA tests were carried out for differences in total barrier scores, total number of barriers and average barrier score among the providers in the sample. Results identified significant differences among providers' total barrier scores (p< .001 F[10, 116]=6.910) number of barriers identified (p< .001, F[10,116]=6.9) and average barrier scores (p<.05, F[10, 116]=3.091). Post-hoc comparisons using the Tukey HSD test found significant differences between several providers in total barrier score and number of barriers, but only one provider that recorded an average barrier score different at a statistically significant level. No significant differences were detected between providers in inner, outer or non-metropolitan areas. Despite the differences in barrier scores, other measures such as highest level of education (F[11, 121]= .766, p=.63), time since last worked (F[11,118] = 1.33, p= .22), frequency of socialising with friends (F[11,121]= .737, p= .70) and self-assessed readiness for work (F[11,121]= .675, p= .76) did not show statistically significant differences between providers, suggesting that apparent differences may reflect inconsistency in barrier reporting or interpretation.

Changes in barriers between survey one and two

Table 6.13 presents the average barrier score for each barrier that had valid cases for survey one and survey two. Fifteen barriers (including 11 of the 15 most common barriers) recorded statistically significant reduced effects on participation. The four barriers with no reduction were lack of suitable jobs in the area, financial management problems, lack of confidence or skills seeking work and physical disability.

Barriers with the greatest proportional reduction in average scores included homelessness (which reduced by 34%), alcohol problems (26%), significant legal issues (26%), significant grief issues

(24%) and confidence or self-esteem problems (21%). On the other hand, seven barriers showed increased average barrier scores, although none of these was statistically significant.

Personal barriers generally improved more than other types of barriers. The employment or human capital barriers of lack of suitable jobs in area, lack of confidence or skills seeking work, insufficient work experience and literacy or numeracy problems all showed no reduction (or slight increases) in average barrier scores, but very long term unemployment and limited education, training or skills both demonstrated statistically significant improvements.

Although many barriers recorded statistically significant reductions in *impact*, a relatively small number of people that experienced each barrier at survey one were not experiencing it at all at survey two (see Table 6.13). The barrier with the greatest reduction in number of people affected at survey two was homelessness, for which nine people no longer recorded any impact. This was followed by drug problems and lack of suitable jobs in the area, each no longer affecting four people (10%). Other barriers had no more than two people that no longer experienced them. The strong persistence of barriers over time highlights the need for continued barrier-related support in other programs into which participants are transferred after PSP.

Table 6.13 Change in barrier scores (on a scale from 1=no impact to 10=extreme impact)

Barrier[a]	n	Survey 1 barrier score	Survey 2 barrier score	Percentage reduction in barrier score (or percentage increase in brackets)	Number of people for whom barrier had no impact at survey 2
Family relationship breakdown or issues	73	7.08	6.00**	15	1
Confidence or self-esteem problems	67	6.84	5.42***	21	2
Mood disorders	66	7.12	6.23*	13	1
Social isolation	60	6.55	5.43**	17	1
Anxiety conditions	51	7.06	5.84**	17	0
Lack of suitable jobs in area	45	7.07	6.71	5	4
Drug problems	42	6.4	5.29*	17	4
Financial management problems	41	6.02	5.98	1	0
Homelessness	37	6.84	4.54**	34	9
Very long term unemployment	33	7.18	6.33#	12	2
Alcohol problems	32	6.69	4.97**	26	3
Motivational problems	30	6.5	5.27*	19	0
Lack of confidence and skills seeking work	28	6.14	6.68	(9)	1
Physical disability	26	6.12	5.54	9	1
Facing significant grief issues	25	6.96	5.32**	24	0
Limited education, training or skills	22	6.09	5.18*	15	0
Anger/conflict/behavioural difficulties	22	6.41	6.50	(1)	0
Insufficient work experience	22	5.19	6.00	(16)	1
Lack of access to transport	20	7.55	6.60	13	1
Ongoing medical or dental condition	20	6.25	6.50	(4)	0
Significant legal issues	19	6.58	4.89*	26	1
Literacy/numeracy problems	16	6.56	6.75	(3)	0
Domestic violence	13	5.77	5.85	(1)	0
Torture/trauma or stress disorder	10	6.1	3.70*	39	1
Periods in custody/criminal record	10	8.2	7.10	13	0
Age	10	6.4	6.60	(3)	1

*** p < .001, ** p < .015, * p < .051, # p < .10 (paired sample t-tests)

[a] Only barriers affecting 10 or more people are reported.

The average total barrier score for those completing survey two was 55.3, almost unchanged from the same group's score in survey one of 55.4 (see Table 6.14). This partly reflected the discovery or onset of new barriers between the two surveys. The average total score for Centrelink identified

barriers (which could only be identified in survey one) fell significantly from 24.6 in survey one to 20.3 in survey two.

The average number of barriers increased from 8.5 to 9.6, while the average number of Centrelink barriers decreased from 3.6 to 3.1. Both of these changes were statistically significant using a paired samples t-test.

Table 6.14 Change in average total barrier scores and number of barriers among participants (n=113)

Measure	Survey 1	Survey 2
Average total barrier score (Centrelink identified barriers only)	24.6	20.3***
Average total barrier score (Centrelink or provider identified barriers)	55.4	55.3
Average number of barriers (Centrelink identified only)	3.6	3.1***
Average number of barriers (Centrelink or provider identified)	8.5	9.6***

*** p < .001, ** p < .01, * p < .05 (paired sample t-tests)

Changes in the *prevalence* of barriers among those who completed both surveys are shown in Table 6.15. For almost all barriers, the number of people no longer facing the barrier at all was more than outweighed by either the discovery or onset of new barriers. It is not possible to tell from data available whether new barriers were pre-existing but not yet apparent or had developed since survey one. Only one barrier, homelessness, recorded significantly reduced prevalence between survey one and two. On the other hand, five barriers significantly increased in prevalence: motivational problems, age, anxiety conditions, lack of confidence and skills in seeking work, and poor communication or language skills. Interestingly, two of these barriers (motivational problems, anxiety conditions) were found to have statistically significant improvements in impact among those participants with the barriers present at survey one, but very few participants (0% to 2%) were not experiencing the barriers at all at survey two.

Table 6.15 Prevalence of barriers among people who completed both surveys

Barrier (n=113)	Survey 1 percentage	Survey 2 percentage
Homelessness	35	27**
Very long term unemployment	30	33
Periods in custody and/or criminal record	10	12
Drug problems	37	37
Alcohol problems	29	30
Social isolation	56	55
Confidence or self-esteem problems	61	66
Motivational problems	27	34**
Age	9	15**
Family relationship breakdown or issues	66	70
Caring responsibilities	9	12
Limited independent living skills	4	5
Financial management problems	39	42
Significant legal issues	18	18
Gambling problems	6	6
Anger/conflict/behavioural difficulties	20	22
Personality disorders	6	10
Anxiety conditions	45	50**
Mood disorders	59	60
Acquired brain injury/organic mental disorder	4	4
Physical disability	24	25
Intellectual disability	2	4
Learning disorder	5	6
Workplace injury	6	5
Domestic violence	12	12
Sexual abuse or assault	9	12
Physical abuse/assault	7	9

Torture or trauma/other stress disorder	11	11
Facing significant grief issues	23	26
Ongoing medical or dental condition	20	20
Limited education, training or skills	21	27
Literacy/numeracy problems	15	19
Insufficient work experience	21	20
Lack of confidence and skills in seeking work	26	31*
Poor communication/language skills	8	12*
Lack of access to transport	20	22
Lack of suitable jobs in area	44	48
Difficulties in accessing child care	2	3

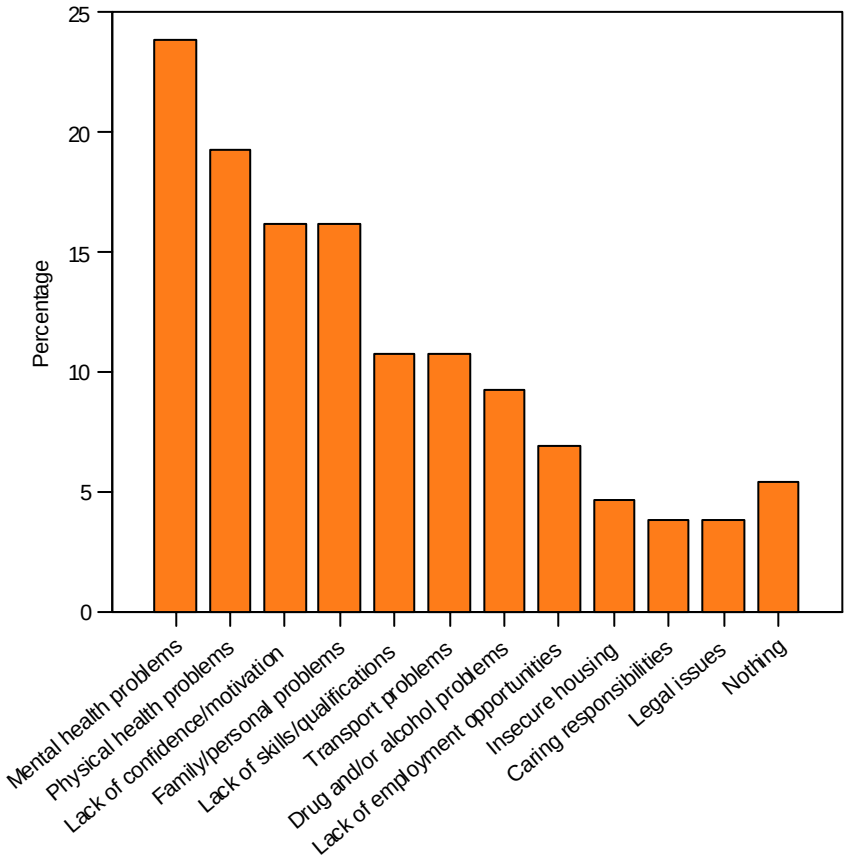
* p < .1, ** p < .05, *** p < .01 (McNemar's test)

Other barrier indicators

Several other measures were also used to explore barriers and change in barriers between survey one and two.

In addition to barriers identified by case managers, participants were also asked to describe the main thing they felt was holding them back from work. Participant responses were then coded into the categories in Figure 6.1 (multiple responses were possible). Percentages were lower than case manager identified barriers, due to most participants identifying one rather than multiple factors. The most common barrier identified, by just less than one quarter of participants, was some type of mental health problem. This was followed by physical health problems (19%), then confidence or motivation problems and family or personal problems (both 16%). The relatively high proportion of participants identifying physical health problems was interesting, given that this was one of the barriers less frequently identified by case managers. Factors that were least commonly named as holding participants back from work (each by 4% of participants) were insecure housing, legal issues and caring responsibilities. Five per cent of people reported that nothing was holding them back from work.

Figure 6.1 Factors participants felt were holding them back from work at survey one (n=131)



Between surveys there was little change in the prevalence of factors participants felt were holding them back from work. Slightly more people reported the two most common barriers, mental health problems and physical health problems (but this was not statistically significant), while fewer reported confidence or motivation problems (7% compared with 13%), also not statistically significant due to the small numbers. The greatest change was in the proportion of people reporting that nothing was holding them back from work, which increased substantially from 1% at survey one to 14% at survey two. The proportion of people reporting family or personal problems holding them back from work also decreased significantly (at the p<.10 level) from 16% to 9%.

Table 6.16 Change in proportion of participants reporting things holding them back from work (n=105, multiple responses possible)

Factor holding back	Survey 1 percentage	Survey 2 percentage
Mental health	26	28
Physical health	21	23
Confidence/motivation	13	7
Family/personal problems	16	9#
Transport problems	12	9
Lack of skills/qualifications	10	9
Drug and/or alcohol	9	5
Lack of employment opportunities	9	8
Nothing	1	14***
Unstable housing	4	4
Legal issues	3	1
Caring responsibilities	5	8
Other	11	11

*** p < .01; # p < .10 (McNemar's test)

Participant goals

The PSP aims to assist participants to achieve goals that are relevant and appropriate to them. To capture these in the evaluation, participants were asked to specify up to three goals that they wanted to achieve while on PSP and how close they felt to these (on a scale of 1 to 10 where 1='a long way off' and 10='very close'). The goals were printed on the second survey and participants were asked to again rate how close they felt to the goals they specified at survey one. These responses were then coded for analysis.

As Table 6.17 shows, the results highlight the strong desire of participants to be undertaking work or study. Finding work or improving work readiness was the most popular goal (44% of participants), with improving skills or study (28%) the third most common goal.

Goals related to common personal barriers were also mentioned by many participants. Resolving personal or emotional issues was the second most frequently described goal (32% of participants), followed by improving confidence or self-esteem (24%) and improving mental health (19%). Although case managers listed drug or alcohol problems as a barrier for 55% of participants, only 14% of participants listed stopping or controlling drug or alcohol use as a PSP goal. Similarly, family breakdown was the barrier most commonly identified by case managers (67%), but resolving family issues was only mentioned as a goal by 11% of participants.

Table 6.17 Goals participants wanted to achieve while on PSP (n=133)

Goal	Number	Percentage
Find work/improve work readiness	59	44
Resolve personal/emotional issues	43	32
Improve skills/study	37	28
Improve confidence self/esteem	32	24
Improve mental health	25	19
Improve housing arrangement	23	17
Improve health/lifestyle	21	16
Stop/control drug/alcohol use	18	14
Resolve family issues	15	11
Improve transport situation	10	8
Address financial/legal problems	10	8
Other	13	10

Substantial improvements in average closeness to goals 1, 2 and 3, and average closeness to all goals, were recorded between survey one and two (see Table 6.18).

Table 6.18 Ratings of closeness to goal (n=107)

	Survey 1	Survey 2
Goal 1	4.86	6.09**
Goal 2	4.64	5.62**
Goal 3	4.65	5.85*
Average	4.75	5.74**

* $p < .01$, ** $p < .001$ (paired samples t-test)

Seven of the twelve categories recorded a statistically significant improvement between survey one and survey two. The greatest change was for the goal of improved housing situation which increased from the lowest survey one score (3.53) to the second highest score at survey two (7.12). Among the four most common goals, finding work or improving work readiness and improving confidence or self-esteem both recorded statistically significant improvements, but addressing personal or emotional problems and improving skills or study did not (see Table 6.19). The lack of improvement in skills or study is likely to reflect the lack of resources available to PSP providers to access education and training. Stopping or controlling drug and alcohol use did not show a statistically significant improvement at survey two, but was the goal participants felt closest to

achieving at both surveys (although the numbers were relatively small), while improving transport situation was the only goal participants felt further from achieving at survey two.

Table 6.19 Change in closeness to goals between survey one and two

Goals	n	Survey 1	Survey 2
Find work/improve work readiness	46	4.52	5.65*
Address personal/emotional issues	35	4.60	5.05
Improve skills/study	31	5.10	5.23
Improve confidence/self-esteem	27	4.85	6.11**
Improve housing situation	17	3.53	7.12***
Stop/control drug/alcohol use	14	6.00	7.21
Improve health/lifestyle	16	4.50	6.31*
Resolve family issues	13	4.92	6.69#
Improve mental health	18	3.56	5.78**
Address financial/legal problems	9	4.22	7.11*
Improve transport situation	9	6.00	5.56
Other	8	5.75	6.62

*** p < .001, ** p < .01, * p < .05, # p < .10 (paired sample t-tests)

Change in assistance required

Case managers' assessments of assistance types required provide an additional means of assessing change in barriers. Between survey one and survey two there was a statistically significant reduction in the proportion of clients requiring three assistance types, suggesting some reduction in the presence or severity of these barriers in the sample.

The proportion of clients requiring self-esteem or confidence training fell from 61% to 34%, drug and alcohol programs reduced from 37% to 23% and accommodation or housing dropped from 35% to 21%. The first two of these changes are surprising given that the prevalence of these barriers in the sample increased slightly for self-esteem or confidence, from 61% to 67% (although this was not statistically significant) and remained constant for drug problems (37%). However, this may reflect the reduced *impact* of these barriers reported by case managers. A significant proportion of individuals who listed improving self-confidence or self-esteem as a goal at survey one also reported feeling closer to the goal at survey two, also suggesting a reduced need for this type of assistance.

Table 6.20 Case managers' assessment of assistance required by clients (n=120, multiple responses possible)

Type of assistance	Survey 1	Survey 2[a]
Counselling	66	57
Self-esteem/confidence training	61	34***
Study/training opportunities	51	43
Goal setting/decision making	41	34
Drug and alcohol program	37	23**
Job search skills/support	37	43
Social activities/skills	35	27
Accommodation/housing	35	21**
Work experience/voluntary work	30	32
Financial/budgeting skills	30	23
Health/fitness	24	29
Mental health support services	26	22
Assessments	20	12#
Anger management/behaviour management	16	10
Legal assistance	13	12
Independent living skills	7	3

*** p<.001, ** p<.01, # p<.10 (using McNemar's test)

[a] Assistance types required in the 12 months after survey two

Participants' achievements on PSP

Participant and case manager views about what people have achieved on PSP provide further evidence of change relating to many common barriers. Coded responses in Table 6.21 indicate that the gain most reported from PSP, by 38% of participants, was increased confidence or motivation or a more positive outlook. This is in line with other data discussed above indicating that participants felt significantly closer to achieving the goal of improved confidence or self-esteem; that considerably fewer people listed confidence or motivation as a factor holding them back from work; and that fewer people requiring confidence or self-esteem assistance. Support or advice was the second most reported gain from PSP, followed by new options/directions/goals (18%) and coping skills or improved self-awareness (14%). Things least mentioned included housing support, improved personal or family situation, skills/education/employment, and other barriers having improved or been overcome. Three people said they had gained not much or nothing.

Table 6.21 What participants gained from PSP (self-assessed) (n=109, multiple responses possible)

Self-assessed gain	Number	Percentage
Increased confidence/motivation/positive outlook	41	38
Support/advice	28	26
New options/direction/goals	20	18
Coping skills/self-awareness	15	14
Time to address problems/reduced pressure	14	13
Increased social/community networks	10	9
Housing support	8	7
Improved personal/family situation	8	7
Skills/education/employment	8	7
Other barriers improved/overcome	6	6
Nothing/not much	3	3
Other	9	8

Case manager assessments of participants' major achievements on PSP varied somewhat from participants' assessments (see Table 6.22). Improved personal or family situation was most commonly mentioned by 25% of case managers, in contrast to only 7% of participants who reported it. Improved confidence or self-esteem was the second most common achievement, according to both case managers and participants. Other common achievements included stopping or controlling drug and/or alcohol misuse (17%), improving skills or undertaking education or training (16%), improved emotional state (15%) and a more active or healthy lifestyle (14%).

Table 6.22 Participants' major achievements on PSP (case manager assessed) (n=110, multiple responses possible)

Achievement	Number	Percentage
Improved personal/family situation	27	25
Improved confidence/self-esteem	25	23
Improved housing situation	24	22
Stopped/controlled drug and/or alcohol misuse	19	17
Skills/education/training	18	16
Improved emotional/mental state	17	15
More active/healthy lifestyle	15	14
Overcoming/managing other barriers	13	12
Undertaking employment	12	11
Developed goals/direction	12	11
Improved life/coping skills	12	11
Accessing required additional services	11	10
Increased self-awareness	6	5

7 Economic participation and work

Overview

Much research indicates that a large proportion of people facing severe or multiple barriers nevertheless have a strong desire to work and see employment as an integral part of their recovery. Appropriate paid work (meeting the preferences and capabilities of individuals) has been found to provide benefits to mental health and well-being and can also contribute to improvements in other barriers such as drug use, health problems, and criminal behaviour.

In concurrence with similar studies, PSP participants demonstrated a strong desire for economic participation, with 73% of participants at survey one identifying paid work (40%) or study or training (33%) as the activity they would most like to be doing. In addition, work or improving work readiness was the most common PSP goal of participants and the most common thing that participants could see themselves doing after PSP.

However, despite the desire to work, many participants had relatively low levels of self-perceived work readiness and over 90% identified at least one thing that was holding them back from work. This points to the need for intensive support to help people take this step. Moreover, almost 90% of those wanting to work reported wanting to stay on PSP after doing so.

Work readiness was higher among females than males and was strongly negatively related to the amount of time since people last worked. No associations were found between Centrelink or provider-identified barriers and work readiness, but participants' own assessment of what was holding them back from work was related to work readiness. Those identifying lack of opportunities, transport or insecure housing as hindrances felt most work-ready, while those identifying drug or alcohol problems, mental health problems and caring for children felt least work-ready. The extent to which physical health or emotional problems interfered with normal social activities was also negatively related to work readiness. However, social interaction, housing arrangements and education were not.

Many participants in focus groups expressed a strong desire to be working and discussed negative impacts of not working on self-confidence, social isolation and family relations. However, there was an almost unanimous view that the type of work was crucial in making this step and that the wrong job could have severe adverse effects. Among case managers, however, there were mixed views about whether working was realistic or beneficial for their clients and whether it was the role of PSP to move people into work.

Participants' employment histories indicated a tenuous connection to the labour market. At survey one, 4% of people reported doing some paid work and around 45% had worked in the past 2 years. The average time since last working was 2.9 years, with 60% of participants reporting their last job was casual and 56% stating it lasted 6 months or less.

Change between survey one and two

Between survey one and survey two, the proportion of people doing some type of paid work increased substantially from 3.7% to 23.5%. The most common type of work, being done by around half of those working, was casual work. The proportion of people not receiving benefit also increased from 1% to 8.3%.

Survey one predictors of people working at survey two were a higher self-perceived readiness for work, reporting a desire to work, a shorter time since last working, and being closer (at survey one) to the goals they wanted to achieve while on PSP. Those with year 12 education were more likely to be working at survey two, and those with year 8 or below less likely to be working, than the sample average. Interestingly, in contrast to other studies, the number of barriers faced was not related to being in work at survey two, but this may be related to the barrier measures used.

There was no statistically significant change in the proportion of people stating that work was their preferred activity, but there was a decrease in the proportion choosing study or training.

There was a modest increase in self-assessed readiness for work, with 50% of people feeling more ready for work, 29% less ready and 21% no different.

Table 7.1 Economic participation change indicators

Indicator	Change [a, b]
Number of people doing paid work	▲▲▲
Number of people off benefits	▲▲
Proportion choosing work as their preferred activity	-
Proportion choosing study as their preferred activity	▼
Readiness for work	▲

[a] Only statistically significant changes identified

[b] ▲/▼ small increase/decrease, ▲▲/▼▼ medium increase/decrease, ▲▲▲/▼▼▼ large increase/decrease

Evidence from the literature

Desire to work

Despite their poor employment outcomes and high level of disadvantage, there is substantial evidence that appropriate work is desired by, and beneficial for, a large proportion of people facing severe personal barriers (see Perkins 2005). In a large UK study, Singh (2005) reported that 77 per cent of homeless people wanted to work now and that 97 per cent wanted to work in the future, and in a recent Australian study Horn and Jordan (2006, p.6) reported that disadvantaged unemployed people sampled 'were enthusiastic about the prospect of working, with the majority listing employment as one of their main goals for the next twelve months'. Reviewing the research for people with mental health problems, Evans (2000, p.15) observed an 'overwhelming consensus from surveys, case studies and personal accounts that service users want to work'. Many people with (even serious) mental health problems report wanting to work and see employment as feasible, important to their recovery, and as an often unmet need (Waghorn & Lloyd 2005).

However, it is also important to note that a sizeable minority of clients facing personal barriers 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 (Waghorn & Lloyd 2005).

Benefits of employment

Research suggests that appropriate employment can provide a range of benefits (Honey 2004). Even for people with severe mental illness, appropriate competitive employment has been found both to be feasible and not to be detrimental. Marrone and Golowka (1999) argue that given the evidence suggesting that people with mental health problems can work, employment should be viewed as both a right and a responsibility. However, they caution that this is not intended to deny the real barriers people face or to advocate a 'get tough' approach, but to place greater accountability on government and program staff to ensure appropriate vocational support.

Several studies have provided qualitative reports of the high value that diverse participants place on moving into work (Perkins 2006). Reported benefits include improved self-esteem or self-image and mental well-being; pride in working; a sense of purpose, independence and place in society; increased ability to organise daily life and break the dependency culture; reduced chaos, boredom and depression; and opportunities for personal growth, the development of competencies and forming of new friendships. On the negative side, participants have reported restrictions on other activities, problems adjusting to the routine, negative social experiences, stress, and experiences that reduce self-esteem. 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 (Perkins 2006).

Quantitative studies have confirmed the positive effects, and none have reported overall negative effects, from gaining competitive employment (Perkins 2006). Benefits reported include increased self-esteem, improved psychological and social functioning, increased motivation for recovery, realistic rather than negative appraisals of the future, and improved health outcomes.

Employment or vocational rehabilitation can also assist participants in overcoming other barriers. Benefits for recovering drug users have included aiding recovery from substance abuse (Becker, Drake & Naughton 2005; Richards & Morrison 2001), motivating the control of substance abuse (Becker, Drake & Naughton 2005), and reduced levels of drug use (Shepard & Reif 2004). 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 distress. This improvement could then lead to an increase in 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.

An additional reason for moving people with personal barriers into employment is the connection between unemployment and poorer mental health and well-being. While some of this association comes about through people with mental health disorders being more likely to become unemployed in the first place, there is strong evidence for unemployment causing poorer mental health (Mathers & Schofield 1998). Australian research indicates that unemployment has a negative impact on mental health and can impede a move back into employment (Ganley 2002), and data from the Australian Longitudinal Survey showed unemployment to be causally linked to a 50% increase in psychological disturbance (Flatau, Galea & Petridis 2000). Overseas researchers have reported similar results. Clark 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.

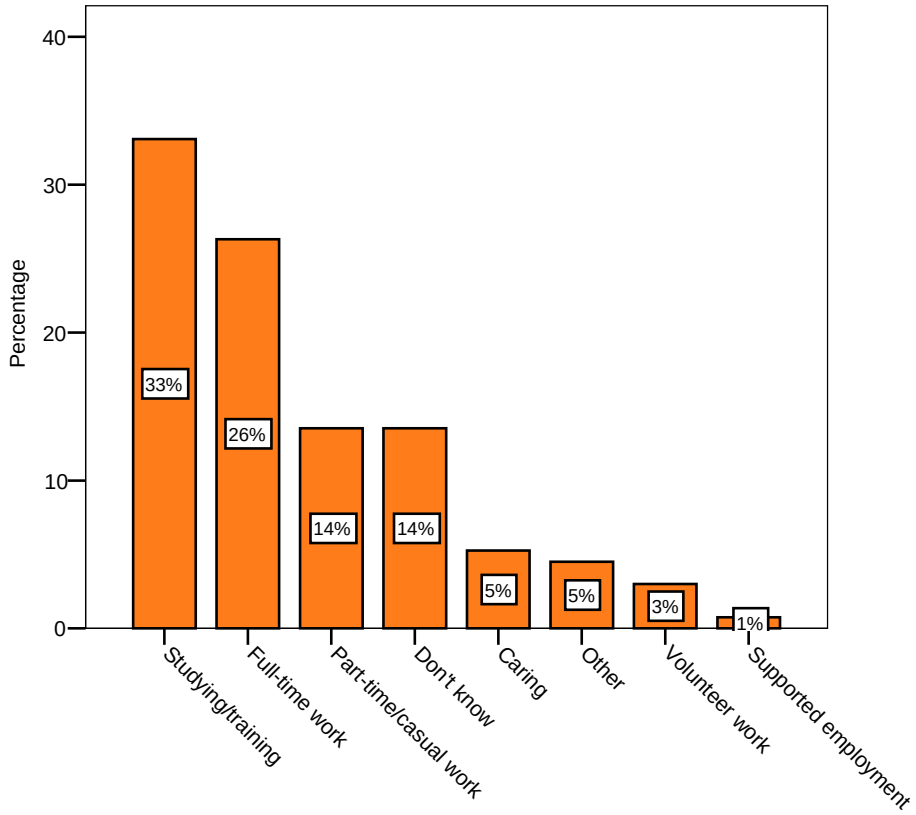
Survey findings: level of economic participation

Attitudes to employment

In concurrence with results of similar studies, almost 75% of PSP participants in our sample indicated that employment or education and training was the activity they would most like to be undertaking ‘now’ (see Figure 7.1). Forty per cent wanted to be working either full-time or part-time and an additional 33% wanted to be studying. Among those wanting to work, there was a clear preference for full-time employment, which was selected by around twice the number of people that wanted part-time or casual employment. Moreover, as the data records only the activity participants would most like to be doing, it understates the total number of people who want to work by not capturing those who would select it combined with other activities such as studying or caring. The strong desire to be working was also evident in ‘work or improving work readiness’ being identified as the most common goal that participants wanted to achieve while on PSP.

Apart from work or education and training, small proportions of people chose caring for children or others (5%), voluntary work (3%), supported employment programs (1%), or ‘other’ activities (5%) as their preferred activity. Around 14% did not know what they would like to be doing now.

Figure 7.1 Activity respondents would most like to be doing at survey one (n=134)

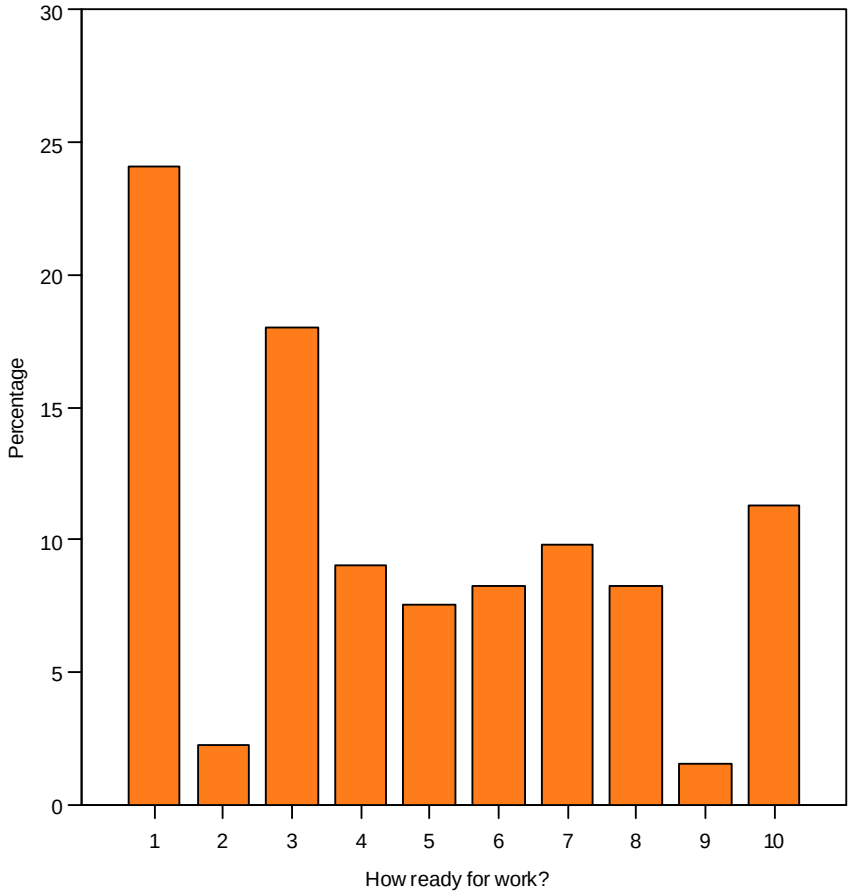


However, 84% of participants overall, and 87% of those wanting to work, said that they would like to stay on PSP while pursuing their selected activity, indicating a strong need for ongoing support.

Readiness for work

Participants were asked to rate how ready they felt for work (on a scale of 1 to 10, where 1=not ready and 10=very ready). The average score was 4.7 (with the median 4), with 61% of people rating themselves in the lower half of the readiness for work scale (1–5). Further, almost one-quarter of the sample rated their readiness for work as 1 (not ready) and 44% rated themselves at 3 or lower. At the other end of the scale, 11% rated their readiness for work as 10 (very ready), and 21% at 8 or higher. This diversity in self-perceived readiness for work suggests that integrated employment assistance needs to be available within PSP if and when individuals reach this point. Asked whether things were holding them back from working, 93% identified one or more factors.

Figure 7.2 Participants' readiness for work (n=133)



Note: Scale of work readiness from 1=not ready to 10=very ready

Males reported a higher average work readiness (5.1) than females (4.0). This difference was statistically significant at the p<.05 level using an independent samples t-test (t[131]=2.10, p=.04).

As can be seen in Table 7.2, average readiness for work was negatively related to time since most recently worked. Those who were currently working reported the highest work readiness (8.60), followed by those who had worked in the last 6 months (6.58), and in the last 7–12 months (4.68). The lowest work readiness (3.22) was reported by those who had never worked. These findings point to the need to maintain connections with work while people are addressing other issues.

Table 7.2 Readiness for work by time since most recently employed

Length of most recent unemployment	n	Average work readiness*
Employed now	5	8.60
Up to 6 months	19	6.58
7–12 months	19	4.68
13–24 months	29	4.21
24–60 months	34	3.97
Over 60 months	14	3.36
Never employed	9	3.22

*Difference significant using Kruskal-Wallis test ($X^2 = 24.14$, $p < .001$)

Participant barriers (total number of barriers categorised, and the total barrier score categorised) were found to have no impact on participants' readiness for work using a one-way ANOVA test. However, a Kruskal-Wallis test found statistically significant differences in readiness for work based on the participants' own description of what was holding them back. As Table 7.3 shows, the

highest average readiness for work (9.2) was reported by those people that saw lack of employment opportunities as the main thing holding them back from work. Those identifying transport, 'nothing', or insecure housing all rated themselves between 7.3 and 7.6. Those that reported being least ready for work were people identifying the main hindrance as drug or alcohol problems (2.6), mental health problems (3.0) and caring for children.

Table 7.3 Readiness for work by main barrier identified by participant

Barrier	n	Average readiness for work*
Lack of employment opportunities	5	9.2
Transport	10	7.6
Nothing	7	7.6
Insecure housing	3	7.3
Skills/qualifications	10	6.7
Legal issues	4	4.3
Lack of confidence/motivation	13	4.2
Family/personal problems	11	4
Physical health problems	17	3.8
Other	9	3.6
Caring for children	4	3.5
Mental health problems	27	3.0
Drug/alcohol problems	10	2.6

*Difference significant using Kruskal-Wallis test, ($X^2 = 47.86$, $p < .001$)

An alternative measure of the severity of individuals' barriers, the extent to which physical health or emotional problems interfered with normal social activities (self-reported), was also found to have a statistically significant relationship with readiness for work. This was a medium to large effect (eta-squared value of .09). As Table 7.4 shows, lower interference of physical health or emotional problems on normal social activities is generally associated with higher levels of work readiness.

Table 7.4 Readiness for work by extent to which physical or emotional problems impact on normal social activities

Interference of health problems with normal social activities	n	Readiness for work*
Not at all	19	6.42
Slightly	14	5.57
Moderately	29	4.93
Quite a bit	51	3.88
Extremely	20	4.00

* Difference significant using one-way ANOVA test, ($F[4,132]=3.30$, $p=.01$)

A statistically significant negative relationship was also found between participants' readiness for work and the level of social exclusion experienced, using the Spearman's rank correlation coefficient ($r=.280$, $p<.001$).

One-way ANOVA tests found no statistically significant differences in readiness for work by the following variables:

- level of social interaction
- current housing arrangement
- provider location (inner metropolitan/outer metropolitan/non-metropolitan)
- provider
- level of education.

Participant attitudes

Views from participant focus groups reinforced the notion that for many people finding a job was an important goal, even if they felt things were currently holding them back.

> A job is the main priority, I'm always trying to … because I've got to work, because not working is killing me. It's too much time to try and kill, and that's the killer, it's killing me. I'm looking forward to work next year—I need it.

Others, such as this person, felt that they were trapped outside the labour market and that their ability to contribute was not recognised:

> You don't want to feel that like you're out on a ledge and you can't get back inside, sort of thing. And that's what we are. I think that's what we all are. Forgotten and ignored. Because we *can* function, but *they* don't realise it.

Not being in work was seen as having negative impacts on many areas including self-confidence, family relations and social isolation:

> Yeah, look I'd love a five-day-a-week job … It [not working] affects you in every way. It affects you with your children, because you have problems with connecting with them and discipline and so forth …

> I think that's [finding work] the biggest thing that needs to be looked at, because you're home alone … and you know, it's just pure boredom. I mean I write music, I write songs, I do all sorts of things at home, but it's the contact with people that I think you need …

Although finding work was a common goal, many people made comments about the type of work being important, and not wanting to end up in jobs which did not match their skills and preferences:

> Your work's got to be satisfying too. To make you a whole person and to be happy with life, and to have the self-esteem and to have the get up and go to get there every morning, you've got to enjoy what you're doing.

> Person 1: Nothing worse than hating your job …
> Person 2: It drives you to drink, it drives you to drugs.
> Person 3: And you become very miserable and depressed about the whole thing.

Others suggested that the wrong job could have severe adverse effects given the other issues they were facing:

> We have all these difficulties and issues and everything and it's like carrying a shitload of weight and being forced to take on a job that isn't suited to you and you're going to have difficulty with is just too much, it throws you out of balance … It's like a jumper unravelling, you get the wrong job and it all starts to come apart and you end up back at the beginning.

People also commented about the things holding them back from gaining work, and the negative effects on self-confidence and self-esteem:

> I was a national manager at a large company a few years ago before I suffered a mental illness, I guess that's what you call it. People don't understand it, but I have it and I've got to live with it. I'm great some days, and I'm shocking others. And it's basically getting the self-confidence back ... Because we all feel like we're worthless.

> Now when I went back to school I did a computer course, an office course, I even did a youth workers' course, and I still couldn't get work. Every time I told them I was fifty, it was like 'At the moment there are no positions going, but we'll keep you in mind'. You know it's like, you walk out of there and you feel like, nuh … so in the end I got scared to

> go for jobs. And that's how I am now. Every day I look in the paper for a job, and each time I find one I might go for, it's like nuh, can't do it.

When asked about the possibility of being able to stay on PSP after finding work, participants were in general agreement that it would make this step easier and remove some risk.

Some participants had been undertaking volunteer work and spoke of the benefits of getting out and interacting with people again, and the satisfaction they felt in helping people and being valued by the organisations they were working for.

Case managers' attitudes

A division existed between case managers who believed that a number of their clients would be ready for work if they could find an appropriate position and others who felt that work was beyond almost all clients. The latter group often felt that moving people into employment before they had resolved their issues could be unhelpful, with a high likelihood of people being unable to maintain the job and damaging their confidence further. One PSP manager commented that 'the role of PSP is to get through non-vocational issues before tackling employment'. She encouraged the approach among staff that if other issues were worked out earlier than two years then job search could start earlier, but that achieving stable employment required primary issues to be sorted out first.

Case managers who were more positive about work felt that it had the potential to assist participants to overcome barriers and regain a sense of self-sufficiency. One case manager who had worked in employment services said she did not like pushing people into work they did not want, 'but I think there's a lot to be said for activity and meaningful activity'.

Some case managers felt that the structure of PSP was conducive to people getting work because it involved less rigid activity requirements and less pressure and allowed clients to find a job 'more or less on their own terms'. Other aspects seen as conducive to people finding work included better accommodating fluctuations in people's energy and motivation when dealing with mental health issues or other crises and allowing them time to work out their plans.

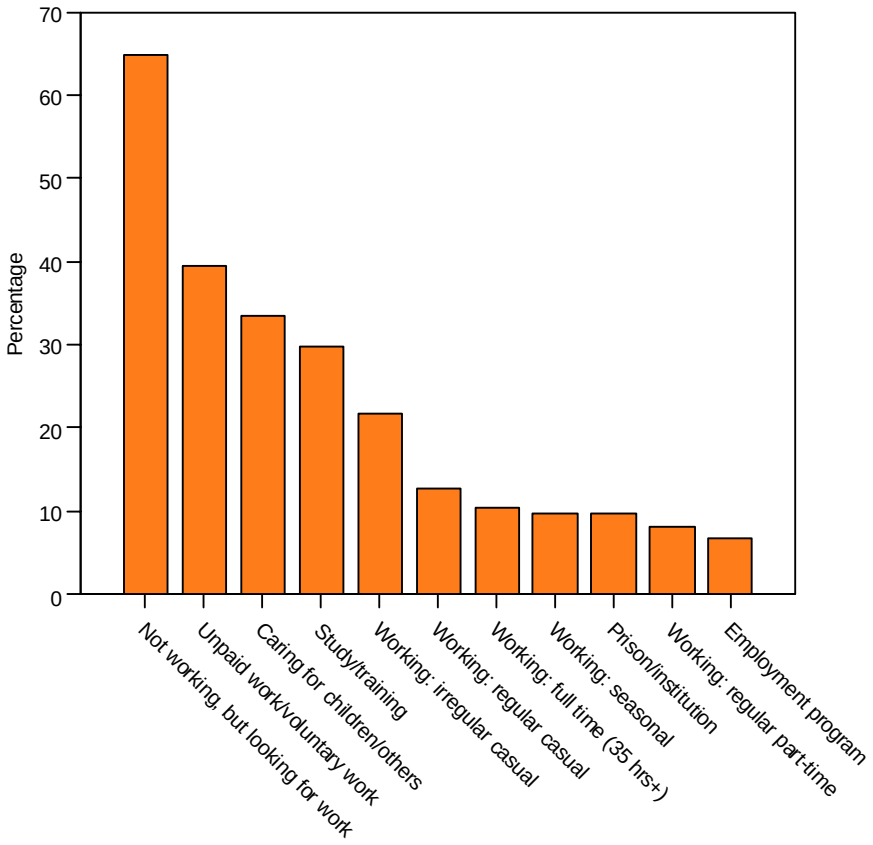
Voluntary work was seen as useful by some case managers and less so by others. Some reported that it had helped quite a lot of people with socialisation, confidence and getting back into the pattern of normal life. Others had not found volunteering appropriate for many people or said that finding a good match was difficult and that many options were unattractive. One case manager thought some clients lacked the skills required to take up volunteering opportunities.

Another suggested that forcing people to do voluntary work would be counterproductive, but that if it helped them pursue an overall direction then it could 'be the absolute start of them getting back into everything'.

Recent activities

Figure 7.3 shows the proportion of respondents who took part in various activities over the last two years. The most common activities were looking for work, unpaid or voluntary work, caring for children or others and studying or training. Within paid work, the most common form was irregular casual work, reported by 22% of the sample. Regular casual work was the second most common (13%), followed by full-time and seasonal work (each 10%), and regular part-time work (8%).

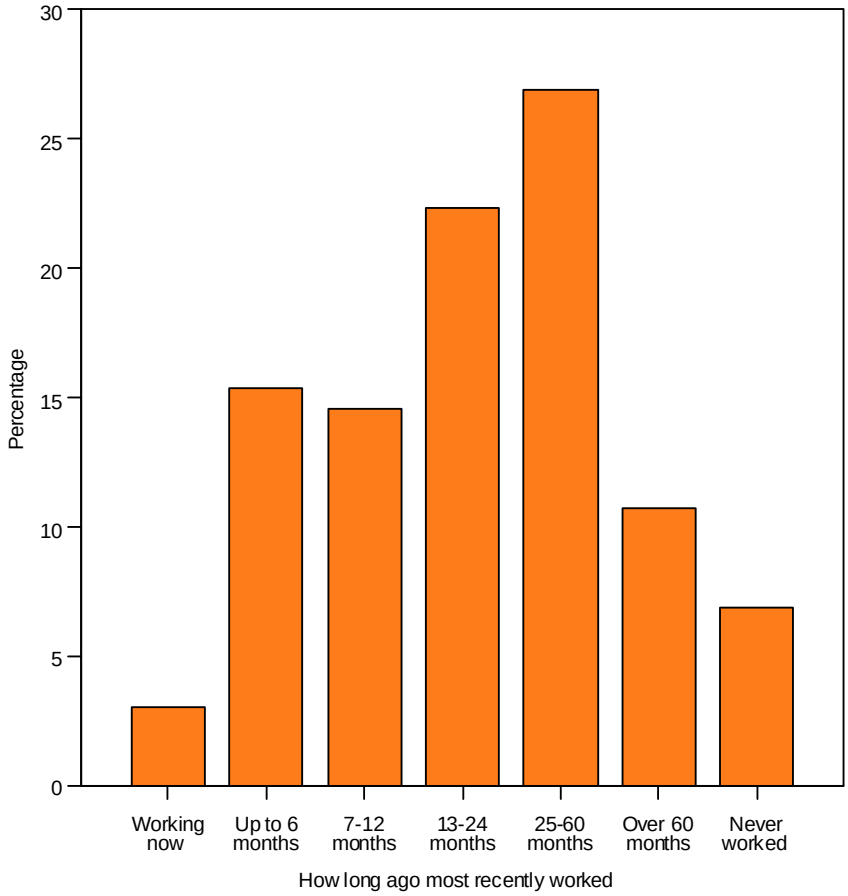
Figure 7.3 Participants' activities over the last 2 years (n=134)



Employment history

At survey one, 4% of people reported being in paid work, and a further 14% had engaged in some paid work over the past 6 months (see Figure 7.4). In total, 55% reported some type of paid employment during the past two years and 93% had engaged in some paid work at some time. For those who were or had been employed, the average time since last undertaking paid work was 2.9 years, but this was affected by five individuals who had not worked for 10 years or more. The median time since last working was 1.7 years.

Figure 7.4 How recently engaged in paid work (n=130)



Among those who had been employed, casual work was by far the most common experience, reported by 59% of individuals. Around half this group were employed on a permanent basis and just over 10% on contract (see Table 7.5).

Table 7.5 Basis of employment in participant's last job

	Number	Percentage
Casual	69	59
Permanent	36	31
Contract	13	11

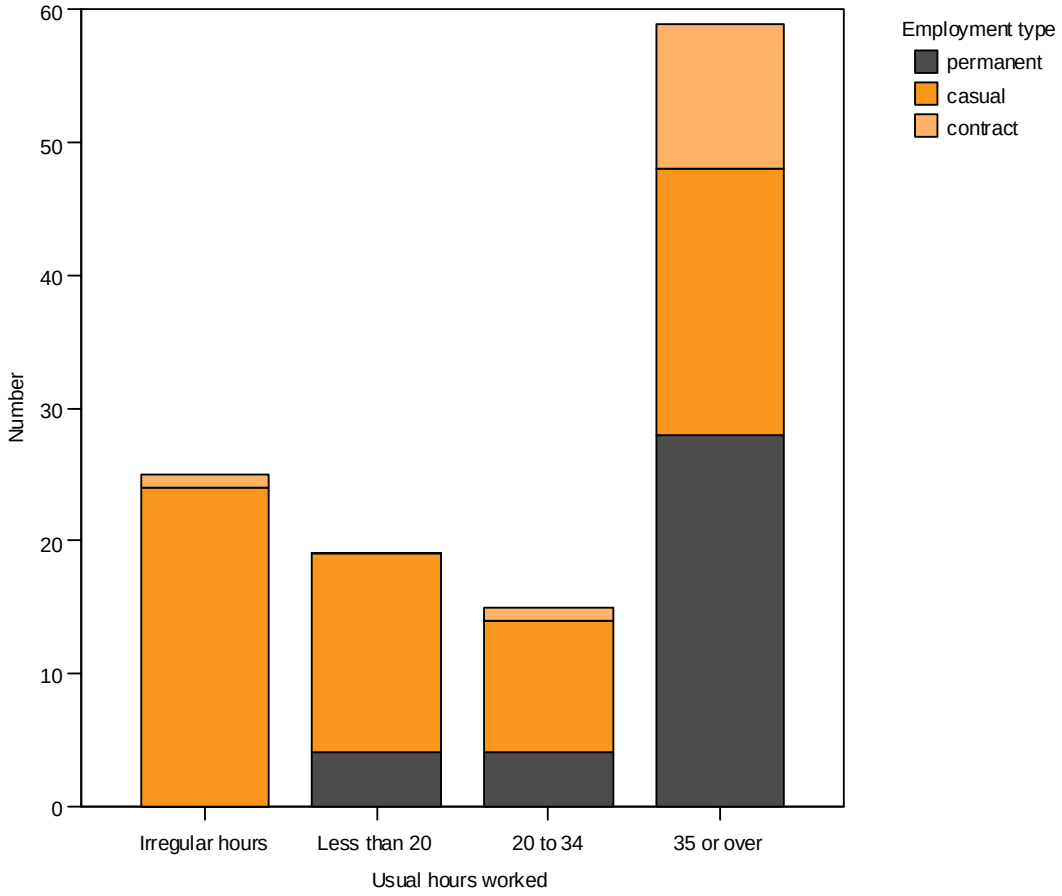
Despite the high proportion of casual employment, 50% of people were working 35 hours per week or more (see Table 7.6). Twenty-nine per cent of people were working less than 35 hours per week and the remaining 21% reported working irregular hours.

Table 7.6 Usual hours worked

	Number	Percentage
Irregular	26	21
Less than 20	19	16
20 to 34	16	13
Over 35	61	50

Figure 7.5 shows the small share of employment that was permanent. Even among those working 35+ hours per week, less than half (48%) were in permanent employment and 34% were employed casually. This compares with only 8% of employees working 35+ hours per week that are employed on a casual basis across the entire workforce (ABS 2007).

Figure 7.5 Employment type by usual hours worked in last job (n=118)



The average time spent in the last job was around 15 months, although this was skewed by a small number of long stayers, and 56% of people had spent 6 months or less in their last job.

Changes in employment indicators between survey one and two

At survey two the proportion of people that were in some type of paid work had increased substantially from 4% to 24% of participants. This increase was statistically significant using McNemar's chi-squared test. All of those people employed at survey one were also employed at survey two. Three of those working were also undertaking some education or training, while an additional 14% of people were undertaking study or training without working. The total proportion of people in work or education at survey two was 38%.

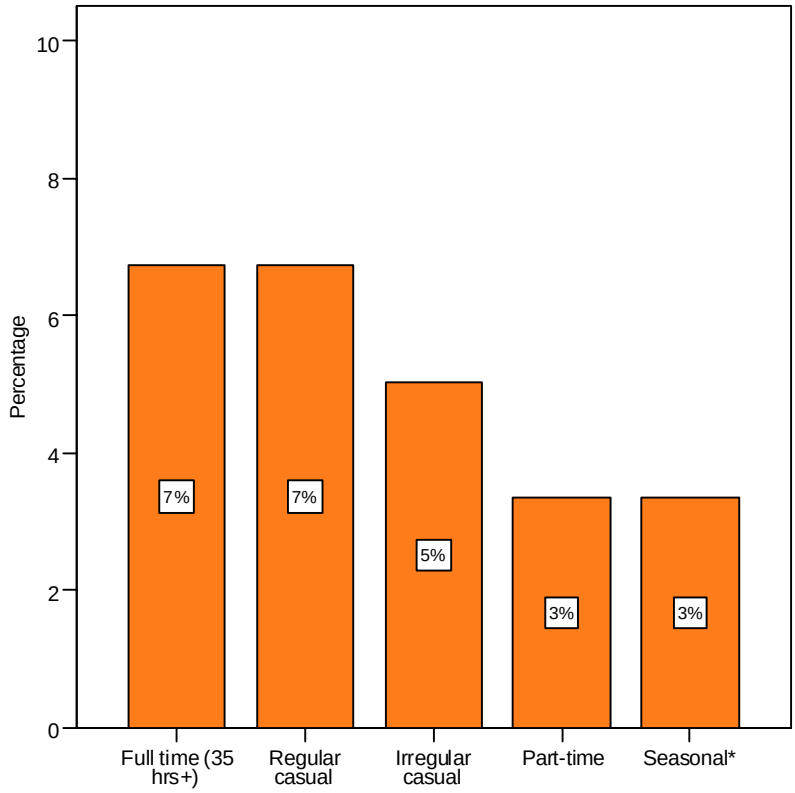
Table 7.7 Change in employment status (n=117)

Status	Survey 1 percentage	Survey 2 percentage
Working	4	24***

*** p<.001 (McNemar's chi-squared test)

Casual work was the most common type of employment, being reported by 12% of participants (see Figure 7.6). Just over half of these people were in regular casual work (7%) and the rest were in irregular casual work (5%). Full-time work (7%) was the second most common type of employment and around twice as common as part-time (3%) or seasonal work (3%). It is not possible to tell from the data what proportion of full-time workers were permanent, the average hours worked by those in casual employment, or the duration of employment.

Figure 7.6 Percentage of sample working at survey two by work type (n=119)



* Two people doing seasonal work also reported doing casual work

Although 24% of participants were doing some type of paid work at survey two, only one-third of these people (8%) had enough work to stop receiving benefits (see Table 7.8). The increase in the percentage of people off benefits from 1% at survey one was statistically significant at the 10% level using the Fisher exact test. All those who had left benefits had done so due to gaining work.

Table 7.8 Change in benefit receipt (n=120)

n=117	Survey 1 percentage	Survey 2 percentage
Off benefit	1	8#

# p<.10 using Fisher exact test

Differences between those working and not working

Table 7.9 (and Table 7.12 and Table 7.13 below) shows mean differences between those working and not working at survey two on a range of variables; however due to the relatively small number of people in work these results should be seen as indicative only. Employment-related characteristics including work history, readiness and desire to work seemed to be most predictive of being employed at survey two.

As a group, those in work at survey two had reported a higher readiness for work (on a scale of 1 to 10) at survey one, more recent work (1.5 years before compared with 3 years) and shorter duration of unemployment before going on to PSP (1.7 years compared with 2.7 years), than those that were not working at survey two. These differences were all statistically significant. Surprisingly, more participants at providers in non-metropolitan areas found work (27%) than those in metropolitan areas (20%), but the difference was not statistically significant. No significant differences existed in the proportion of males and females, or average age of those working and not working at survey two.

Table 7.9 Comparison of those working and not working at survey two (n=117), by survey one data averages

Variable	Working	Not working
How ready for work (score)	6.3	4.2***
How long ago most recently worked (years)	1.5	3.0#
Time unemployed before PSP (years)	1.7	2.7#
Time between completing survey 1 and 2 (months)	11.1	10.6

*** p < .001, ** p < .01, * p < .05, # p<.10 (independent samples t-test)

The proportion of people with year 12 as their highest level of education that were in employment at survey two (44%) was significantly above the average of 24% (see Table 7.10). On the other hand, none of the 16 people educated to year 8 or less was working at survey two, significantly below the average (p<.01). The only other group with a statistically significant difference from the average employment level of 24%, and only at the p<.10 level, was people with trade or TAFE qualifications, of whom only one was in work. This is surprising given the current skills shortage in the trades.

Table 7.10 Percentage of people in work at survey two by highest level of education (n=119)

Level of education	Percentage of people in work at survey 2
Completed year 8 or less (n=16)	0**
Completed year 9 (n=26)	27
Completed year 10 (n=22)	27
Completed year 11 (n=16)	25
Completed year 12 (n=16)	44#
Trade or TAFE qualification (n=17)	6#
Assoc. diploma/diploma/adv. diploma (n=3)	100
Degree or higher (n=3)	0
All education levels	**24**

** p < .01, # p<.10 (binomial test, test proportion .235)

As Table 7.11 shows, the desire to work (measured by participants selecting paid work as their most preferred activity at survey one) was also a strong predictor of being employed at survey two. Almost twice the number of people who selected work as their preferred activity at survey one were in paid work at survey two (33%), compared with those selecting other activities (17%).

Table 7.11 Desire to work at survey one as predictor of in work at survey two

Most like to be working (paid, any type) at survey 1	Percentage in work at survey 2
Yes (n=49)	33**
No (n=70)	17

* p < .05 chi-squared test

Participants in work had slightly fewer barriers than those not in work and a slight lower total barrier score at survey one (see Table 7.12). However, in contrast to other studies, these differences were not statistically significant. Other measures of barriers, including interference by physical health or emotional problems and support required, also showed no statistically significant differences between the two groups. The average closeness to up to three PSP goals (on a 1 to 10 scale where 1=a long way off and 10=very close) was significantly higher among those working than not working. A composite social exclusion variable (made up of indicators of labour market, social, service and income/resource exclusion) also showed significantly lower levels of exclusion among those in work.

Table 7.12 Work status at survey two, by average scores of selected variables at survey one

Variable	Working	Not working
Total number of barriers at survey 1 (n=119)	8	9
Total barrier score at survey 1 (n=119)	54	59
Clients' engagement level (1–10 scale) (n=118)	8	8
Level of support required (1–10 scale) (n=118)	7	7
Level of insight into barriers (1–10 scale) (n=118)	7	7
Physical health/emotional problems interfere with normal social activities (1–7 scale) (n=119)	3	3
Average closeness to goals 1, 2, 3 at survey 1 (1–10 scale) (n=117)	6	5**
Social exclusion (n=119)	2	3*

** p < .01, * p < .05, (independent samples t-test)

As Table 7.13 shows, in terms of case managers' rating of clients' abilities at survey one, those working at survey two had a higher average rating in their ability to organise their life as they want it, to manage day-to-day living and to manage money. Their abilities to achieve their goals, cope with stressful situations and cope with emotional issues were also rated higher, but the differences were not statistically significant. The sum of case managers' ratings for the 6 variables was higher for those in work at survey two and statistically significant. Participants' self-ratings on the same set of abilities did not show any significant differences.

Table 7.13 Work status at survey two by average client ability rating (by case manager) at survey one

Client ability	Working	Not working
	Rating	Rating
Client ability to organise life as they want it (n=119)	5	4**
Client ability to manage day-to-day living (n=118)	6	5*
Client ability to manage money/budget (n=119)	5	4#
Client ability to achieve their goals (n=119)	5	5
Client ability to cope with stressful events/situations (n=119)	4	4
Client ability to cope with emotional issues (n=117)	4	4
Total client abilities (sum of 6 variables above) (n=117)	*29*	*27**

** p < .01, * p < .05, # p<.10 (independent samples t-test)
Case manager ratings on scale from 1=not able to 7=very able

Work preferences and readiness

As Table 7.14 shows, the proportion of participants who selected work as the activity they most wanted to do increased from 38% at survey one to 42% at survey two, but this change was not statistically significant. The proportion wanting to study decreased from 35% at survey one to 23% at survey two, and this change was significant. There was some change of individuals choosing work as their desired activity: 17 people (25%) of the 69 who had chosen other activities at survey one selected work at survey two, while 12 people (29%) of the 42 who had selected work at survey one chose other activities at survey two.

Table 7.14 Most desired activity now, percentage (n=110)

Activity	Survey 1 percentage	Survey 2 percentage
Studying/training	35	23**
Working full-time	24	23
Working casually/part-time	14	20
(Working (any type))	(38)	(42)

** McNemar's chi-squared test (X^2 [109]=4.65, p< .05)

Table 7.15 displays the percentages of people choosing work as their preferred activity at survey one and two, by work status at survey two. Among those working at survey two there was a substantial increase (although not statistically significant using McNemar's chi-squared test) in those choosing work as their preferred activity from 54% to 75%, suggesting a self-reinforcing effect of employment. No change occurred among those not working at survey two. However even among this group, paid work was still the most preferred activity, followed by study or training (24%).

Table 7.15 Percentage preferring to be working, by employment status at survey two

Employment status	Percentage reporting work to as preferred activity at survey 1	Percentage reporting work as preferred activity at survey 2
Working at survey 2 (n=24)	54	75
Not working at survey 2 (n=86)	34	34

After PSP

When asked to describe what they see themselves doing after PSP, 70% of respondents gave answers based on work/looking for work or study/training. Some people simply stated 'work', but many gave answers such as 'hopefully working', 'hopefully having a job' or 'hopefully working full time' (see Table 7.16). Others mentioned particular jobs, such as being an apprentice chef, rendering, or starting their own business. A number of people mentioned some combination of work and/or employment'. Three people mentioned a combination of working/looking for work and having resolved personal issues, and two a combination of caring and work or study.

Table 7.16 Activities participants see themselves doing after PSP (n=92) (multiple responses possible)

Activity	Percentage of responses
Working or looking for work	57
Study/training	27
(Work or looking for work AND/OR study)	(70)
Caring for children or others	10
Volunteer work	4
Continuing with personal problems	2
Having resolved personal problems	5
Other	5
Don't know	12

Readiness for work

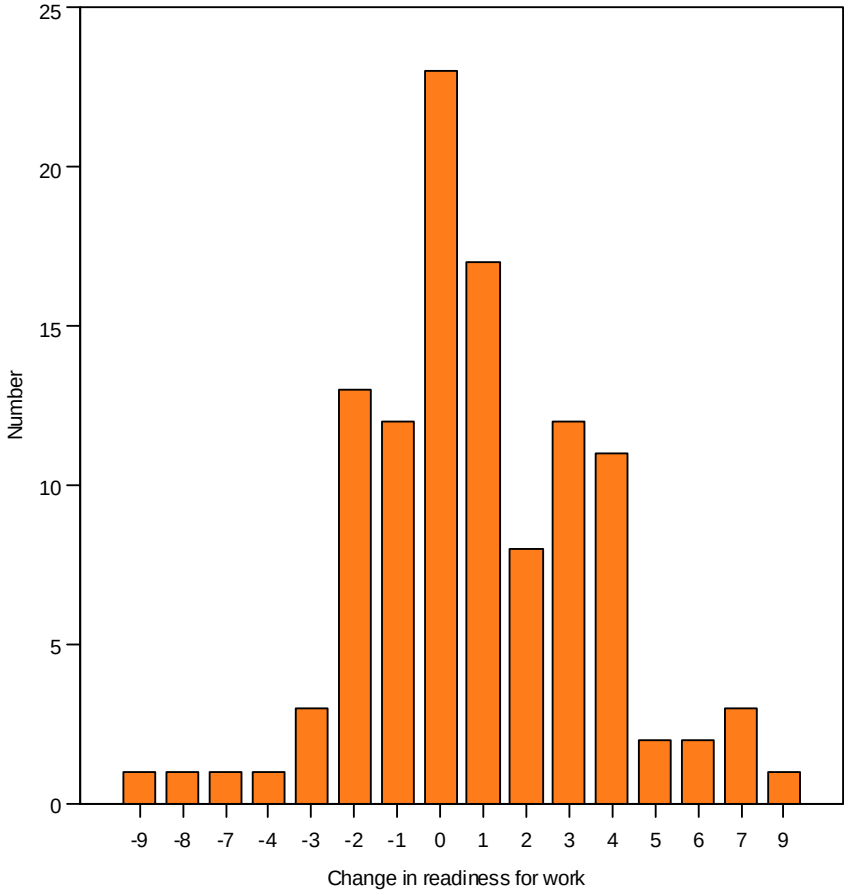
Participants' average self-reported readiness for work increased from 4.55 in survey one to 5.36 in survey two ($t[110] = 2.968$, $p<.001$). The percentage of participants rating themselves in the lower half of the scale (1–5) decreased from 62% to 51% (see Table 7.17). Overall 50% rated themselves more ready for work, 29% less ready for work and 21% no different.

Table 7.17 Readiness for work (n=111)

Participants' rating of readiness	Survey 1 percentage	Survey 2 percentage
1 (Not ready)	25	16
2	2	8
3	20	10
4	9	9
5	6	8
6	8	9
7	10	14
8	8	7
9	1	6
10 (Very ready)	11	14

Figure 7.7 shows the change in readiness for work between survey one and survey two. The most common experience was no change in self-perceived work readiness (23 people), followed by a one-point increase (17). Few people showed greater change than three points.

Figure 7.7 Change in work readiness between survey one and survey two (n=111)



No significant difference in work readiness change was associated with gender, level of education, time since most recently worked, or interference from physical health or emotional problems.

8 Social participation

Overview

Levels of social participation among PSP participants were very low for primary (living arrangements), secondary (informal sociability with friends and neighbours) and tertiary sociability (participation in associative life) measures. Participants were more than five times more likely than the general population to live alone, and reported much less frequent social contact than the general population or other unemployed people, and very high interference in normal social activities from physical health or emotional problems.

As expected given the high prevalence of family breakdown, participants' satisfaction with relationships with their partner, children, family and friends was substantially lower than among the broader population or other unemployed people. Findings were similar for measures of social support, including having no-one to confide in and not having someone to help out with food, money or accommodation if needed.

Many participants reported that due to emotional, physical health or financial issues they were unable to do many basic social activities including going to the cinema, eating out in a restaurant, going shopping, having a drink in a bar, or going to sporting events. Levels of membership of sporting or community groups and political parties and regular worship attendance were also all far below levels in the broader community.

There was some evidence of network exclusion: most participants stated that the people they knew were not a good source of contacts when looking for work and around one-third reported half or more of their friends were not in paid work.

Many participants reported low self-perceived abilities in areas likely to impact on social participation (coping with stressful events, managing money, managing day-to-day living, achieving goals, and coping with emotional issues).

There was also strong evidence of social participation being negatively affected by extreme financial deprivation. Events such as going without meals, being unable to heat the home, asking family or friends for financial help or being unable to pay utilities bills, the rent or mortgage were four to 12 times more common among the PSP sample than the population generally.

Change between survey one and survey two

Most social participation indicators revealed improvements between survey one and two, but many were not statistically significant (see Table 8.1) and among those that were the level of change was generally modest or small.

Frequency of social contact increased for 44% of participants and decreased for 30% but there was a substantial drop in the number of people reporting very low social contact (less than once a month) from 31% to 18%. The proportion of people reporting physical health or emotional problems interfering moderately or more with normal social activities fell from 76% to 62%, but most participants experienced no change in levels of interference.

Change in satisfaction with relationships was minimal: satisfaction with family and friends improved marginally, while satisfaction with partner recorded a larger but negative change. Similarly social support indicators changed little, but having someone to confide in and someone to help out with food, money or accommodation increased slightly.

No significant changes were found in the proportion of people unable to do activities because of emotional, physical health or financial issues, but the average number of activities people were unable to do decreased slightly. Change in civic participation measures was also not significant, but the average total number of civic activities showed a slight increase.

Participants' self ratings of ability to cope with stressful situations and ability to organise their life increased slightly at survey two. Case manager ratings, interestingly showed improvements in participants' ability to manage day-to-day living and to cope with emotional issues
. Only one of the seven income/resource deprivation measures (going without meals) showed improvement.

Links between unemployment and social participation

While unemployment can lead to poverty and social exclusion and reduced participation, this is not necessarily the case and is mediated by a range of individual and community factors (Saunders 2002a). However, those unemployed that appear most at risk are disadvantaged subgroups, who tend to be at the end of the jobs queue (Green 1997), and the long-term unemployed (Adelman, Middleton & Ashworth 1999). Duration of unemployment appears to be a crucial factor in increasing the likelihood of unemployed individuals suffering from other issues that reduce their ability to participate in society (Saraceno 2002). As Saunders (2002a) notes, the negative effects of unemployment, such as reduced contentment, poorer health, and increased isolation and alienation, feed off each other and make it progressively harder to reverse the damage caused to individuals. Thus, longer spells of unemployment increase the risk of reduced social participation and exclusion.

Unemployment can also result in income and resource exclusion and an increased risk of poverty (Saunders 2002b), which can then result in exclusion from the customary consumption activities of society (Atkinson et al. 1998). However, the risk varies considerably depending on individual and family support mechanisms and the level and type of social support available (Atkinson et al. 1998). Again, the length of unemployment appears to be a crucial factor (Gallie 1999).

An additional dimension of exclusion that may impact on unemployed people is exclusion from social relations. However, this appears to come about not primarily through a reduced number of social networks or contacts, but through a reduced quality of social networks. For example, unemployed people are more likely to associate predominantly with other unemployed people (leading to significant network exclusion) and report that they are less able to rely on friends and family in times of need (Gallie 1999).

Unemployment has been found to have a clear negative impact on participation in associative life, particularly for the long-term unemployed. This is seen as a reduction in 'the range of social activities in which individuals are involved, particularly those activities which help people to preserve their integration into socially acknowledged roles and citizenship norms' (Saraceno 2002, p.11). In terms of social isolation, cross-national comparisons show significant differences in the effect of unemployment (Gallie 1999), but negative impacts appear greatest where the social protection system is low, uneven or stigmatising (Saraceno 2002).

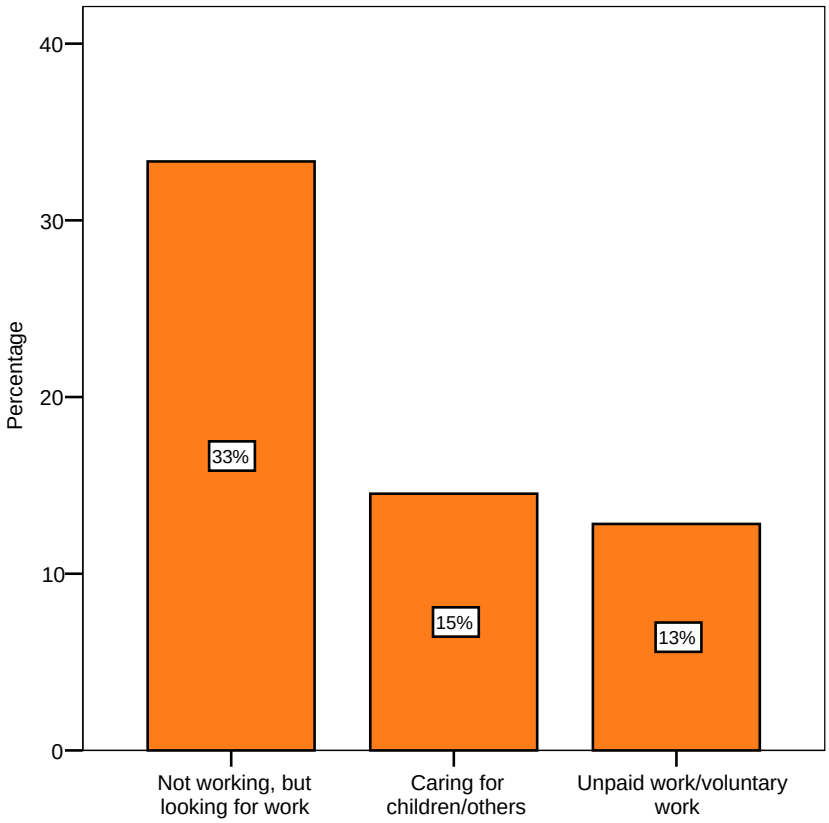
Other effects of unemployment are also likely to reduce participation in social relations. Unemployment has been shown to result in reduced levels of happiness and well-being (Clark & Oswald 1994), increased psychological distress (Gallie 1999) and higher rates of divorce and family breakdown (Stiglitz 2002). Moreover, compared with the rest of the population, the unemployed are likely to exhibit lower physical and mental health and greater disillusionment with economic and social prospects (Saunders 2002a).

Survey findings: social participation measures

Activities at survey two other than work or study

Other than the 38% of people that were working or studying at survey two, 33% reported their current activity to be looking for work but not working, 15% were caring for children or others and 13% were undertaking voluntary work (see Figure 8.1).

Figure 8.1 Activities at survey two other than work or study (n=117)



Asked what activities they would most like to be doing (see Table 8.1), 6% of people selected caring for children as their preferred activity, 5% other activities, 3% voluntary work and 2% (1% at survey one) supported employment. A substantial proportion of people said they did not know what their preferred activity was at both survey one (15%) and survey two (18%). This increase was not significant using McNemar's chi-squared test.

Table 8.1 Preferred activity survey one and survey two, percentage

Activity (n=110)	Survey 1 percentage	Survey 1 percentage
Paid work/studying/training	70	66
Caring for children or others	6	6
Other activities	5	5
Voluntary work	3	3
Supported employment program	1	2
Don't know	15	18

Social relations

Living alone is one indicator of social participation and is described by Gallie (2003) as the 'primary sociability' measure. Comparison with HILDA data (wave 3, 2002–03) indicates that at survey one the incidence of people living alone was around five times that in the general population, and almost four times that among the unemployed people generally. At survey two the proportion of people living alone had increased marginally from 54% to 56%.

Table 8.2 Percentage of participants living alone at survey one and two

Living arrangement (n=82)	Percentage of participants
Living alone survey 1	54
Living alone survey 2	56

'Secondary sociability' refers to informal sociability with friends or in the local community (Gallie & Paugam 2002). It is captured here through frequency of social contact. In Table 8.3, the frequency of PSP participants' social contact with friends or family not co-residing is compared, using HILDA (Household Income and Labour Dynamics in Australia) wave 3 survey data, with contact among unemployed people aged 15–60 (excluding full-time students), those marginally attached to the labour market (aged 16–60 excluding full-time students) and the broader population in Australia.

The literature suggests there is little difference in the frequency of social contact of unemployed people and the broader population. However, among the PSP sample frequency of contact is much lower: 20% of the PSP sample had social contact less than every three months, compared with 5–8% in the other groups, and 42% had social contact once a month or less, compared with 17% of unemployed, 25% of marginally attached and 20% of the broader population. The difference is less extreme but still substantial at the other end of the scale, where 49% of the PSP sample had social contact at least once a week compared with 72% of the unemployed, 63% of the marginally attached and 64% of the broader population.

Table 8.3 Frequency of contact with friends/family not co-residing

	PSP Survey 1 (n=134)	Unemployed (16–60 excluding f/t students)	Marginally attached (16–60 excluding f/t students)	Whole population (16–60 yrs)
	%	%	%	%
Every day	5	8	7	5
Several times a week	18	29	24	26
About once a week	26	34	32	33
2 or 3 times a month	10	12	11	16
About once a month	11	8	10	10
Once or twice every 3 months	11	4	7	5
Less than every 3 months	20	5	8	5

Source for columns 3,4,5: HILDA wave 3 survey data (2002–03)

As Table 8.4 shows, the proportion of people reporting infrequent social contact (once a month or less) decreased significantly from 41% at survey one to 28% at survey two. However, the proportion reporting social contact at least once a week was relatively stable, 52% at survey one and 53% at survey two. Overall, 44% of participants reported more contact, compared with 30% reporting less contact and 26% the same level of contact.

Table 8.4 Frequency of contact with friends/family not co-residing (n=111)

Frequency of contact*	Survey 1 percentage	Survey 2 percentage
Every day	5	7
Several times a week	19	20
About once a week	28	26
2 or 3 times a month	8	18
About once a month	10	10
Once or twice every 3 months	13	9
Less than every 3 months	18	9

*Change significant using Wilcoxon signed-rank test (Z=-2.113, p=.035).

The lower frequency of social contact reported by PSP participants may be partly attributable to the reported interference of physical health and emotional problems. Table 8.5 shows the extent to which clients reported that such problems had interfered with their normal social activities during the past four weeks. Again, data for the PSP sample is compared with HILDA data for those unemployed, marginally attached to the labour market and the general population.

PSP participants reported much higher levels of interference, with 18% reporting that physical health or emotional problems interfere extremely with normal social activities, compared with only 3% of the unemployed and marginally attached and 2% of the general population. Further, 62% of those in PSP had problems that interfered at least moderately, compared with 29% of the unemployed, 30% of the marginally attached and 18% of the general population. On the other hand, only 17% of PSP participants reported no interference, compared with 40% of the unemployed, 47% of the marginally attached and 61% of the general population.

This underscores the significant impact of the personal barriers on PSP participants' everyday lives.

Table 8.5 Interference of physical health or emotional problems with normal social activities

Degree of interference	PSP Survey 1 (n=134)	Unemployed (16–60 years excluding f/t students)*	Marginally attached (16–60 years excluding f/t students)*	Whole population (16–60 yrs)*
	%	%	%	%
Not at all	14	40	47	61
Slightly	10	30	21	21
Moderately	22	18	17	10
Quite a bit	38	8	12	6
Extremely	15	3	3	2

*Source: HILDA wave 3 survey data (2002–03)

Between survey one and two, the proportion of people that said physical or emotional problems were interfering extremely increased slightly from 16% to 18% (see Table 8.6). However, fewer people were impacted moderately or quite a bit and more reported slight or no interference These changes were only significant at the p<.10 level.

Table 8.6 Interference of physical health or emotional problems with normal social activities, change between survey one and survey two (n=114)

Degree of interference	Survey 1 percentage	Survey 2 percentage
Not at all	14	17
Slightly	10	21
Moderately	22	18
Quite a bit	39	26
Extremely	16	18

(Z=-1.655, p=.098)

Combining the categories into two groups—physical or emotional problems interfering not at all or slightly, and moderately/quite a bit/extremely—the proportion with minimal interference increased from 24% at survey one to 38% at survey two (see Table 8.7). This change is statistically significant using the Wilcoxon signed-rank test (Z= -2.828, p=.005). However, a relatively small proportion of participants (21%) reported a decrease in interference from physical or personal problems, while 72% reported no change and 7% reported an increase in interference.

Table 8.7 Interference of physical health or emotional problems in normal social activities (grouped) (n=114)

	Survey 1 percentage	Survey 2 percentage
Not at all/slightly	24	38
Moderately/quite a bit/extremely	76	62

Relationship changes

The quality of social participation is affected by both the quantity of social interaction and the quality of relationships. Given that family breakdown is the most common barrier among the PSP

sample, affecting almost two-thirds of participants, this is an important area to achieve positive outcomes. Several questions were used to gauge improvements in family relationships.

As Table 8.8 and Table 8.9 show, the high levels of family breakdown in the PSP sample are reflected in low levels of satisfaction with relationships with partners and children compared with other groups of Australians. Just under a quarter of participants were highly dissatisfied (1–3 on the 10-point scale) with the relationship with their partner, compared with between 6% and 9% in other groups. High levels of satisfaction (8 or above on the scale) were also less common (48%) than among the other three groups (each close to 72%).

Table 8.8 Satisfaction with relationship with partner

	PSP Survey 1 (n=47)	Unemployed (16–60 years excluding f/t students)*	Marginally attached (16–60 years excluding f/t students)*	Whole population (16–60 years)*
	%	%	%	%
1 (Completely dissatisfied)	13	4	5	3
2	6	2	1	1
3	4	3	1	2
4	2	4	2	2
5	9	6	6	5
6	4	4	9	4
7	13	9	8	11
8	9	22	15	18
9	9	19	19	23
10 (Completely satisfied)	32	29	34	32
Average	*6.68*	*7.71*	*7.83*	*8.09*

Percentages do not quite tally due to rounding

A similar pattern was seen in PSP participants' satisfaction with their relationship with their children. Some 23% rated their satisfaction as very low (1–3), compared with around 4% of the other groups. The proportion of people rating their satisfaction at 8 to 10 was highest among those marginally attached to the labour market (78%) and the unemployed (73%) respectively, but much lower among the broader population (54%) and the PSP sample (49%).

Table 8.9 Satisfaction with relationship with children

	PSP Survey 1 (n=67)	Unemployed (16–60 years excluding f/t students)*	Marginally attached (16–60 years excluding f/t students)*	Whole population (16–60 years)*
	%	%	%	%
1 (Completely dissatisfied)	15	3	2	1
2	3	1	0	1
3	5	0	2	1
4	8	1	2	1
5	9	5	3	1
6	3	5	5	3
7	9	12	9	5
8	8	21	16	10
9	13	21	24	20
10 (Completely satisfied)	28	32	38	25
Average	*6.54*	*8.10*	*8.41*	*8.28*

Minimal improvement in participants' average relationship satisfaction was evident from the survey questions (see Table 8.10). The only relationship to show a change significant at the $p<.05$ level or below was relationship with a partner, which decreased from 6.69 to 5.28 (Wilcoxon signed-rank test, $Z= -1.965$, $p=.049$).

Table 8.10 Change in satisfaction with relationships

	Survey 1	Survey 2	Proportion of people experiencing change		
	Average	Average	(+)	(-)	no change
Relationship with partner (n=39)	6.69	5.28*	23	49	28
Relationship with children (n=60)	6.45	6.25	28	35	37
Relationship with family (n=111)	5.19	5.65#	44	29	27
Relationship with friends (n=111)	6.03	6.52#	45	30	25

*p<.05, # p<.10 (Wilcoxon signed-rank test)

The level of social support perceived to be available from family and friends provides another measure of the quality of social relations. As Table 8.11 and Table 8.12 show, PSP participants surveyed were significantly more likely to feel they had no-one to confide in and could not easily find people to help them out when needed. PSP participants were more than three times more likely than the general population, 14% compared with 4%, to 'strongly agree' that they did not have anyone they could confide in. This was also substantially higher than the unemployed (8.2%) or the marginally attached. The percentage who disagreed (rating 1 or 2) that they had no-one to confide in was also lower than other groups (38%, compared with 60% of the unemployed, 63% of those marginally attached and 68% of the general population).

Table 8.11 Agreement with statement: I don't have anyone I can confide in

Rating	PSP Survey 1 (n=133)	Unemployed (16–60 years excluding f/t students)*	Marginally attached (16–60 years excluding f/t students)*	Whole population (16–60 years)*
	%	%	%	%
1 (strongly disagree)	25	38	43	43
2	14	22	20	26
3	9	12	9	9
4	20	8	11	8
5	8	6	6	6
6	11	7	6	5
7 (strongly agree)	14	8	6	4
Average	*3.59*	*2.74*	*2.57*	*2.38*

The proportion of PSP participants who strongly agreed that they could usually find someone to help them out when needed (16%) was about half that reported by the other three groups (around 30%). On the other hand, 42% of the PSP sample disagreed that they could usually find someone to help them out when needed (rating only 1–3). This was four times higher than the proportion in general population (12%), and more than twice that among those marginally attached to the labour market (17%) or unemployed (19%).

Table 8.12 Agreement with statement: 'When I need someone to help me out I can usually find someone' (n=111)

Rating	PSP Survey 1 (n=67)	Unemployed (16–60 years excluding f/t students)*	Marginally attached (16–60 years excluding f/t students)*	Whole population (16–60 years)*
	%	%	%	%
1 (strongly disagree)	8	5	4	3
2	9	8	6	4
3	14	6	7	5
4	17	15	12	10
5	17	18	15	16
6	20	19	27	31
7 (strongly agree)	16	29	31	31
Average	*4.46*	*5.05*	*5.32*	*5.53*

All four social support ratings displayed improvement between survey one and survey two, but the change in average scores was relatively small and only the reduction in people who had no-one to confide in was significant at the p<.05 level (see Table 8.13). Forty-six per cent of people disagreed more strongly that they did not have anyone to confide in, while 29% agreed more strongly that they did not have anyone to confide in (Z=-2.315, p=.021). The change in people agreeing that someone would help them out with food, money or accommodation was significant at the p<.10 level (Z=-1.733, p=.083) and 41% recorded a higher rating at survey two while 29% reported a lower rating. The average level of social support, based on the average of these four questions, increased for 57% of participants between survey one and two and this was significant at the p<.10 level (Z=-1.835, p=.067).

Table 8.13 Change in social support

Statement (Scale 1=strongly disagree to 7= strongly agree)	Survey 1	Survey 2	Proportion of people experiencing change in rating		
	Average rating	Average rating	(+)	(-)	no change
I don't have anyone I can confide in (n=112)	3.59	3.12	29**	46	26
When I need someone to help me out I can usually find someone (n=112)	4.60	4.83	42	29	29
There is a special person in my life who cares about my feelings (n=111)	4.79	4.86	32	27	37
Someone would help me out if I needed food, money or accommodation (n=112)	4.35	4.68	41#	29	29
Social support: average of 4 above (n=111)	*4.34*	*4.60*	*36#*	*57*	*7*

*p<.05, # p<.10 (Wilcoxon signed-rank test)
Note: To calculate an average, the first question responses were inverted

Participation in associative life

Associative life, also describe by Gallie (2003)as 'tertiary sociability', includes customary consumption activities as well as activities that preserve socially acknowledged roles and citizenship norms (Saraceno 2002). The low frequency of social contact and high proportion of PSP participants reporting physical or emotional interference in normal social activities suggests that they would be particularly at risk of reduced participation or exclusion.

As Table 8.14 shows, many PSP participants had experienced difficulty participating in basic social activities in the past 12 months due to emotional, physical health or financial issues. The activities most frequently missed were going to a cinema, theatre or concert, eating out in a restaurant and going shopping, each of which around two-thirds of participants had missed in the last 12 months. Only about 13% reported no difficulty doing any of the activities listed.

In addition to the listed activities, 30% of participants ticked 'other' and named a wide range of activities that they were unable to do. The most commonly mentioned things were related to spending time with family. A number of people mentioned not being able to provide properly for their children, take them on holidays or do activities during school holidays. Several other people reported being unable to visit family and friends in other parts of Victoria. For example one said: '[I] would love to visit my two nephews (have never met them) in Melbourne but cannot afford to'. Another person had missed two funerals and another could not afford a weekend away with her daughter and mother.

Many people also reported missing out on social activities generally including friends' parties, bingo and nights out, keeping in touch with friends, or going out on a date to meet someone. A few people mentioned being unable to buy clothes, food, electrical equipment, books or CDs and others reported missing out on health activities such as attending the dentist, 'eating properly', swimming or exercise, and getting massage therapy for RSI.

Fewer people had missed out on each of the activities at survey two than at survey one (see Table 8.14), but none of the changes was statistically significant using McNemar's chi-squared test. Moreover, the data does not show whether those people that did not report difficulty actually did the activities without difficulty or did not want to do them.

Table 8.14 Participants unable to undertake activities because of emotional, physical health or financial issues, in 12 months before survey 1 and survey 2(n=112)

Activity	Survey 1 percentage	Survey 2 percentage
Go to the cinema/theatre/concerts	65	56
Eat out in a restaurant	66	57
Go shopping	64	53
Have a drink in a pub/bar	46	43
Go to a football match/sporting event	44	34
Go to the library/art gallery/museum	25	20
Other	30	24

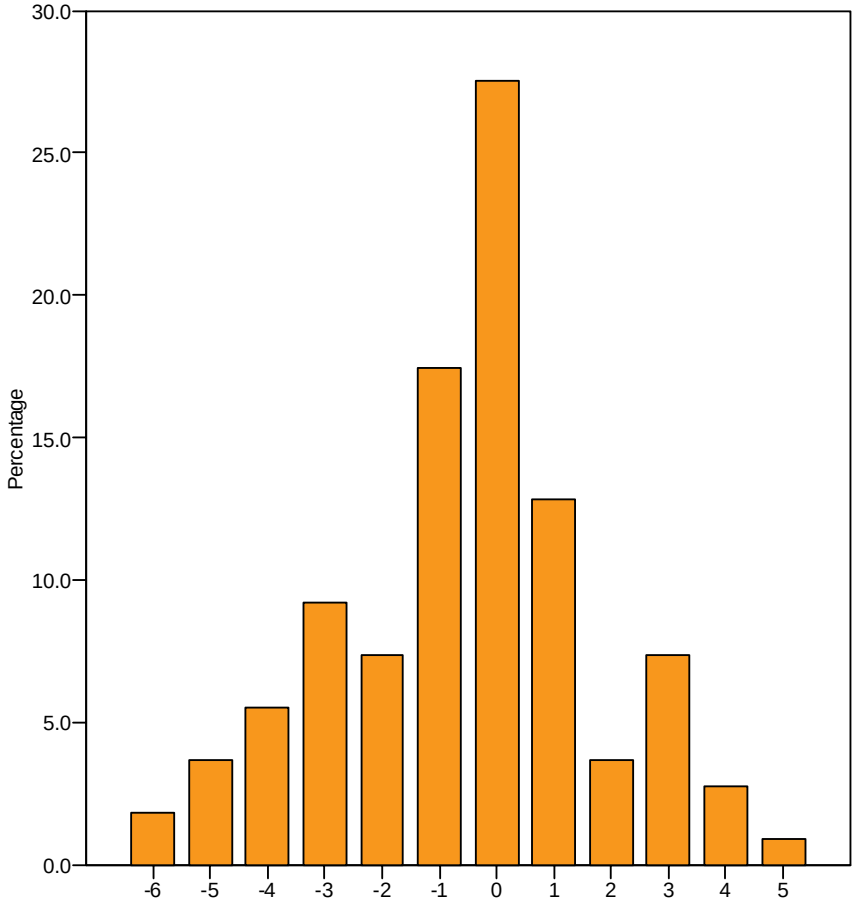
Table 8.15 shows how many activities participants reported being unable to do at survey one and survey two. The average was 3.4 at survey one, but had decreased to 2.9 at survey two. This change was statistically significant using a paired t-test ($t[109] = 2.455$, $p < .05$). Only 8% of people reported that there was nothing they had wanted to do but been unable to at survey one, but 21% did at survey two.

Table 8.15 Number of activities missed because of emotional, physical health or financial issues (n=109)

Number of activities missed	Survey 1 percentage	Survey 2 percentage
0	**8**	**21**
1	10	15
2	12	10
3	19	9
4	25	17
5	9	19
6	12	8
7	5	2

Around 45% of people were able to do more things that they wanted at survey two, but 29% were able to do fewer (see Figure 8.2).

Figure 8.2 Change in number of activities people wanted to do but could not, between survey one and survey two (n=109)



Associative life also includes participation in community groups, sport and hobby clubs and political parties. As Table 8.16 shows, surveyed PSP participants reported significantly lower levels of participation in these activities than other population groups.

Involvement in sporting, hobby or community clubs or associations by surveyed PSP participants (13%) was roughly one-third of involvement by the general population (38%), and also much lower than by people marginally attached to the labour market (28%) and the unemployed (23%). PSP participants' regular attendance at a place of worship was also around one-third of that among the general population, and none of the PSP sample reported being a member of a political party.

Table 8.16 Civic participation of PSP participants and other groups

	PSP Survey 1 (n=133)	Unemployed (16–60 years excluding f/t students) [a]	Marginally attached (16–60 years excluding f/t students)[a]	Whole population
	%	%	%	%
Active member of a sporting/hobby/community-based club/association	13	23	28	38[a]
Regular attendance at a place of worship	7	-	-	18[b]
Member of a political party	0	-	-	1.5[c]

[a] HILDA Wave 3 data (2002–03) 16–60 year olds
[b] Source: Levine & Morgan 2004
[c] Source: Tiffen & Gittins 2004

At survey two, more people in the sample were members of a sporting, hobby or community group, of other civic groups, and of political parties (see Table 8.17). Fewer people had regular contact with a welfare or support agency (other than through PSP): this may be a positive change reflecting reduced support needs. However these changes were not statistically significant using McNemar's chi-squared test.

Table 8.17 Civic participation at survey one and two

	Survey 1 percentage	Survey 2 percentage
Regular contact with welfare/support association (n=111)	39	34
Active member of a sporting, hobby or community-based club or association (n=112)	12	17
Member of any other community or civic group (e.g. school association or neighbourhood group) (n=111)	9	12
Regularly go to a place of worship (n=110)	7	6
Member of a political group/party (n=111)	0	2

The civic participation measure in Table 8.18 is the average of the number of activity types (in Table 8.17, other than regular contact with a welfare or support agency) that participants reported. This increased from 0.28 in survey one to 0.38 in survey two. Eighteen per cent of people reported an increase in the number of activities they were involved in, 10% reported a decrease in number of activities and 72% reported no change. This increase was statistically significant at the $p<.10$ level (Z-1.813, $p=.070$) using a Wilcoxon signed-rank test.

Table 8.18 Average number of civic participation types at survey one and two (n=112)

Measure	Survey 1	Survey 2
Average number of civic participation activity types	0.28	0.38#

# $p<.10$

Participants' perception of their influence in their local community is another measure of participation in associative life. This increased slightly between survey one and survey two, but the change was not significant using a Wilcoxon signed-rank test (see Table 8.19).

Table 8.19 Influence in local community (n=110)

Agreement with statement	Survey 1 average	Survey 2 average
I can influence things happening in my community	2.71	2.80

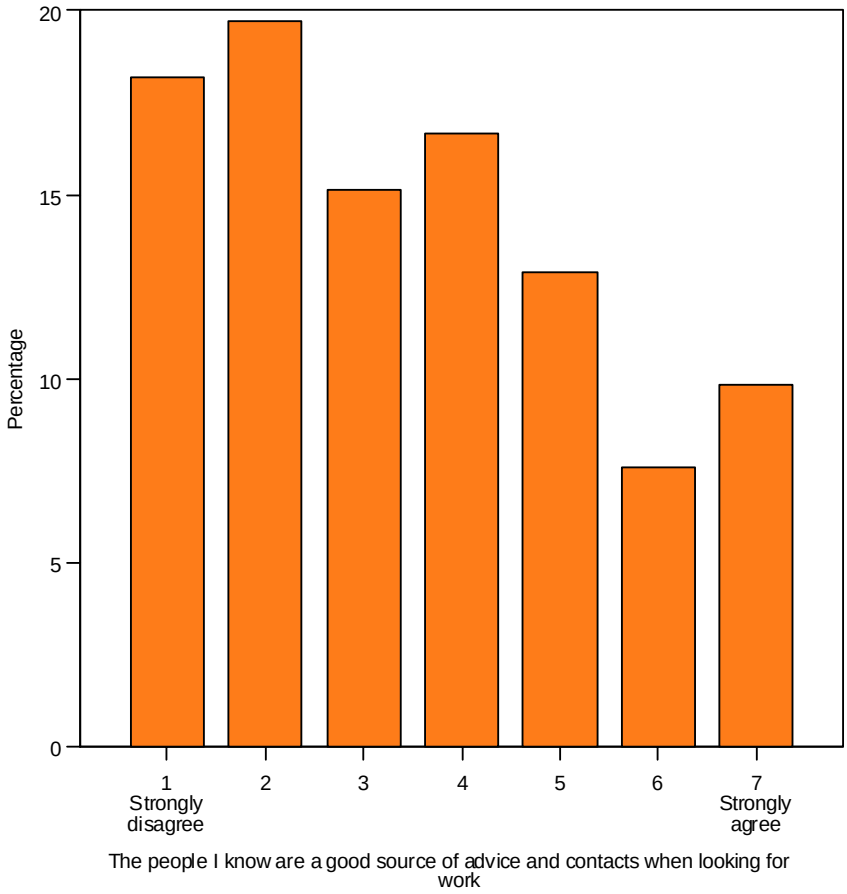
Scale: (1=strongly disagree to 7= strongly agree)

Network exclusion

Two questions were used to capture the quality of, and changes in, social networks of PSP participants: whether people they knew were a good source of advice and contacts when looking

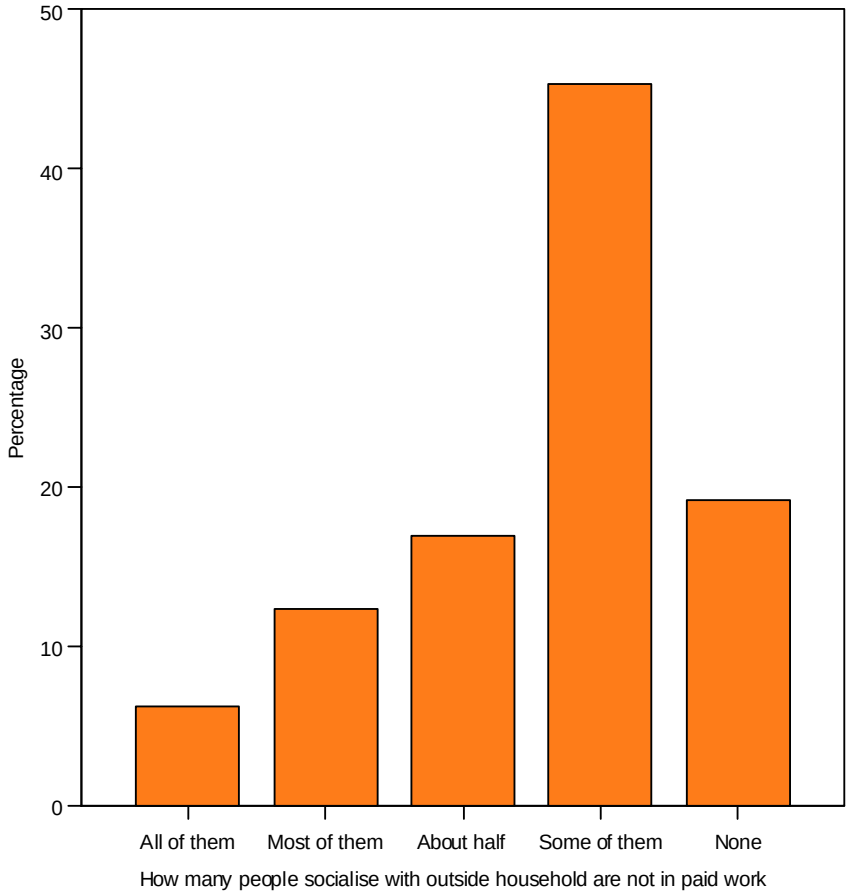
for jobs, and how many people they usually socialised with were not in paid work. As Figure 8.3 shows, most participants did not agree that the people they knew were a good source of advice or contacts when looking for work. The average score at survey one was 3.49 and this increased slightly to 3.79 at survey two, but the change was not significant using a paired samples t-test.

Figure 8.3 Perception of friends or associates as good source of employment advice (n=132)



The results in Figure 8.4 also suggest some degree of network exclusion among PSP participants. Almost 20% of participants reported that all or most of their friends were not in paid work, with an additional 17% reporting that about half were not in paid work. On the other hand, 20% reported that none of their friends was not in paid work and 45% that some were in paid work.

Figure 8.4 Proportion of friends not in paid work (n=130)



Between survey one and survey two there was only a small change in the proportion of the sample who reported their friends were not in paid work (see Table 8.20). This change was not significant using a Wilcoxon signed-rank test.

Table 8.20 Friends (outside household) not in paid work (n=107)

Associates not in paid work	Survey 1 percentage	Survey 2 percentage
All of them	6	4
Most of them	12	12
About half	17	30
Some of them	45	42
None	19	13

Participant abilities

Participants' capacity for social and economic participation is affected by abilities such as:

- achieving goals
- coping with stressful events
- managing money
- organising life as they want it
- managing day-to-day living
- coping with emotional issues.

Ideally a program like PSP will improving participants' capabilities in these areas. To gauge any such benefits, participants were asked to rate their own abilities on a scale of 1 to 7 scale (where

1=not able and 7=very able) at survey one and two. Case managers were similarly asked to rate participant abilities. The average scores indicate that although case managers generally give higher ratings than participants, the ordering of abilities was fairly similar.

Table 8.21 Average participant ability ratings (1=not able and 7=very able) at survey one (n=132)

Abilities	Case manager rating	Client rating
To achieve goals	4.99	3.70
To cope with stressful events/situations	4.05	3.37
To manage money/budget	4.83	4.19
To organise life as they want it	4.47	3.52
To manage day-to-day living	5.17	4.45
To cope with emotional issues	3.73	3.39

Both case managers and clients rated lowest the ability to deal with emotional issues and stressful situations. Around 50% of participants rated their abilities below the mid-point (1–3), compared with around 30% above (5–7). Participants and case managers rated highest the abilities to manage day-to-day living and money or budget. Both of these had more participants that were positive about their abilities (5–7), 48% and 46%, than negative (1–3), 31% and 38%. Overall, however, participant self-ratings in all areas were low, with between 52% and 72% rating their abilities at the mid-point or below (see Table 8.22).

Table 8.22 Participant abilities self-rated (1 to 7 scale; 1=not able, 7=very able) (n=109)

	Achieve goals	Cope with stressful events/situations	Manage money budget	Organise life as you want it	Manage day-to-day living	Cope with emotional issues
1–3	43	53	38	50	31	53
4	21	17	16	20	21	19
5–7	36	30	46	30	48	28

There were small but statistically significant increases in average ability scores between survey one and survey two (see Table 8.23 and Table 8.24). Clients' own ratings showed a significant improvement in the ability to cope with stressful situations (the lowest rated ability at survey one), and in the ability to organise their life. On the other hand, when rated by case managers, the ability to manage day-to-day living and the ability to cope with emotional issues increased significantly.

Table 8.23 Participant abilities (self-rated)

Abilities	n	Survey 1 average	Survey 2 average
To achieve goals	112	3.72	3.95
To cope with stressful situations	111	3.33	3.77*
To manage money/budget	111	4.17	4.32
To organise your life as you want it	111	3.53	3.86#
To manage day-to-day living	109	4.52	4.78
To cope with emotional issues	110	3.51	3.74
Total satisfaction with abilities	**109**	**22.78**	**24.27#**

* $p < .05$, # $p < .1$

The increase in participants' self-rated total ability scores (summed for the six questions) was significant at the p<.10 level, but the case manager total ability rating showed almost no change between surveys one and two (see Table 8.24).

Table 8.24 Client abilities (case manager rated)

Ability	n	Survey 1 average	Survey 2 average
To achieve goals	121	5.02	4.99
To cope with stressful situations/events	121	4.06	4.13
To manage money/budget	121	4.80	4.68

To organise life as they want it	121	4.44	4.60
To manage day-to-day living	119	5.13	5.48**
To cope with emotional issues	118	3.77	3.99#
Total abilities	**118**	**27.17**	**27.89**

* *p < .01, # p < .1

Income exclusion

Compared with other groups in Australia, PSP participants surveyed were also found to experience extreme levels of material deprivation (see Table 8.25) that will further impede social participation. They were between 4 and 13 times more likely to have experienced difficulties in the last 12 months due to a shortage of money. Sixty-five per cent had had to ask for financial help from family and friends, compared with 17% of the general population and around 35% of the unemployed and those marginally attached to the labour market. Fifty-nine per cent had asked for help from a welfare or community organisation, compared with 5% of the general population and around 15% of the other two groups. Fifty-six per cent of people could not pay electricity or gas bills on time and 54% had gone without meals, compared with only 5% of the general population. Even among the unemployed, the proportion going without meals due to a shortage of money was around four times lower than among the PSP sample.

Table 8.25 Difficulties in the last 12 months because of a shortage of money

Difficulty	PSP survey 1 (n=133)	Unemployed (16–60 excluding f/t students)*	Marginally attached (16–60 excluding f/t students)*	Whole population (16–60 yrs)
	%	%	%	%
Asked for financial help from friends/family	66	36	34	17
Asked for help from a welfare/community organisation	60	16	14	5
Could not pay electricity, gas or telephone phone bills on time	56	34	31	17
Went without meals	54	14	10	5
Could not pay the mortgage or rent on time	37	16	13	8
Was unable to heat home	25	8	8	3
Pawned or sold something	43	19	13	6

PSP participants also faced much higher risk of experiencing multiple difficult events. The average number of difficulties in the last 12 months due to a shortage of money was 3.4, almost six times higher than in the general population (0.6) and more than twice as high as among the unemployed (1.4) and those marginally attached to the labour market (1.2) (see Table 8.26).

Table 8.26 Number of difficulties in the last 12 months due to a shortage of money

Number	PSP Survey 1 (n=133)	Unemployed (16–60 excluding f/t students)*	Marginally attached (16–60 excluding f/t students)*	Whole population (16–60 yrs)
	%	%	%	%
0	16	45	50	72
1	10	21	17	12
2	8	12	15	7
3	12	10	10	4
4	17	5	3	2
5	21	5	2	1
6	9	2	1	0
7	7	1	1	0
Average	*3.3*	*1.4*	*1.2*	*0.6*

All of the measures of deprivation (except inability to pay utility bills) fell slightly between survey one and survey two, but only the proportion of people that went without meals (which fell from 56% to 47%) was statistically significant at the p<.10 level (see Table 8.27).

Table 8.27 Difficulties in last 12 months because of a shortage of money

	Survey 1 percentage	Survey 2 percentage
Asked for financial help from friends/family (n=111)	66	62
Asked for help from a welfare/community organisation (n=111)	60	53
Could not pay electricity, gas or telephone bills on time (112)	55	60
Went without meals (n=111)	56	47#
Could not pay the mortgage or rent on time (n=110)	36	27
Was unable to heat home (n=108)	25	24
Pawned or sold something (n=110)	42	41

# p<.10, using McNemar's chi-squared test

As Table 8.28 shows, the average number of difficulties experienced by individuals declined slightly from 3.4 to 3.1; but this was still very high compared with other groups, and the change was not statistically significant.

Table 8.28 Total number of difficulties in the last 12 months due to a shortage of money (n=112)

Number of events	Survey 1	Survey 2
0	15.3	10.9
1	10.8	15.5
2	9.0	16.4
3	9.9	13.6
4	17.1	13.6
5	24.3	10.9
6	7.2	13.6
7	6.3	5.5
Average	*3.4*	*3.1*

Housing

Inadequate or unstable accommodation is a common problem for PSP participants (see Chapter 5). At survey two, the proportion of people in the least stable category of housing ('moving frequently between temporary accommodation') had reduced from 6% to 1%, though this was not significant due to low numbers (see Table 8.29). However, the proportions of people living in a rooming or boarding house or caravan or in supported accommodation showed little change, as did all other categories. McNemar's chi-squared tests showed no statistically significant change.

These limited changes of housing situation are interesting, because on other indicators, housing appeared to be a barrier with substantial positive change. Significantly fewer participants were reported to face housing instability at survey two than at survey one; case managers assessed the impact of housing instability on individuals as markedly lower at survey two; and participants reported a greater improvement in the goal of improving their housing situation than any other goal listed. It seems likely that some change in the accommodation quality or security may have occurred but not be captured in by this question.

Table 8.29 Change in current housing situation (n=103)

Housing situation	Survey 1 percentage	Survey 2 percentage
Owner or purchasing private home	21	19
Renting privately	34	36
Renting public housing	26	29
Supported accommodation	4	3
Living in a rooming/boarding house or caravan	13	14
Moving frequently between temporary accommodation	6	1
Living on the street	0	0

Access to services

Connecting participants with local services is an aim of PSP, and should assist in overcoming barriers, as well as developing local networks. The services most frequently identified as difficult or very difficult to access at survey one were dental services (51%) and housing services (37%) (see Table 8.30). Around one in five people found access to education or employment services, family support services and counselling services difficult. A doctor or GP was least commonly identified as difficult or very difficult to access (11%). Around 70% of people indicated that at least one service would be difficult or very difficult to access and 40% identified two or more. The average number of services that were difficult or very difficult to access was 1.45.

There was little change between results at survey one and survey two, other than the percentage of participants perceiving difficulties accessing counselling, which increased from 17% to 31%. This change was statistically significant using McNemar's test (chi-square = 4.65, $p < .05$).

Table 8.30 Services difficult or very difficult to access , by percentage of PSP participants

Service	Survey 1 percentage	Survey 2 percentage
Doctor/GP (n=109)	11	12
Dental services (n=104)	51	46
Family support services (n=82)	19	23
Counselling services (n=102)	17	31*
Housing/accommodation services (n=98)	37	35
Education or employment services (n=102)	21	20

*p <.05, using McNemar's chi-squared test

9 Program delivery

Referral, commencement and engagement

Overview

The new referral system using Job Capacity Assessors (JCAs) (operating since July 2006) was generally thought to be working well, apart from some 'teething' problems. The two significant issues identified through interviews with case managers were the lack of continuity through a single contact person responsible for PSP clients, as had previously been the case, and the lack of integration of JCAs and the JCA systems with broader Centrelink systems. This was seen as problematic, hindering the flow of information and causing problems in a division of knowledge.

There was strong endorsement of the new report format used by JCAs by almost all case managers interviewed, with some reservations about repetition and readability. Providers were also positive about the quality of referrals and felt most people referred were likely to benefit.

The long wait times between referral and commencement were of concern. Some 58% of survey participants had had to wait three weeks or more in 2004; and administrative data for referrals between mid-2005 and late 2006 pointed to a sizeable 42% of people waiting just as long.

Engaging participants in the program was not seen as a substantial problem, but some groups were reported to be more difficult to engage. Bivariate analysis found eight barriers to be negatively related to clients' reported level of engagement. Factors most commonly seen as *improving* engagement were participants' attitude and developing a positive and open relationship. Common factors reported to impede engagement were transport problems, mental health issues, and the client's attitude or lack of motivation.

PSP referral process

Initial assessment of the level of disadvantage of all job seekers is done when clients complete the Looking for Work Questionnaire. This questionnaire produces the Job Seeker Classification Instrument (JSCI) score, which takes into account a range of factors to arrive at an overall measure of disadvantage. Clients that the JSCI flags as highly disadvantaged are referred for additional assessment.

Until July 2006, this assessment could done by Centrelink Psychologists, disability officers or social workers, but almost all referrals to PSP were done by Centrelink Psychologists. From July 2006, participants have been referred to a Job Capacity Assessor (JCA) who completes a report and refers each person to PSP or an alternative program. While Centrelink Psychologists worked mainly with PSP referrals, JCAs have a broader assessment role, including eligibility for the Disability Support Pension, and only 24% of referrals are to PSP (DHS 2007).

The effectiveness of the system relies on clients disclosing issues in their initial Centrelink interview to gain the additional assessment. This appears to sometimes be problematic. One Centrelink staff member reported that clients are often reluctant to disclose issues as they just want to get payments started and that Centrelink staff are under pressure to process people as quickly as possible and may find it difficult to spend enough time on the Looking for Work Questionnaire.

Individuals may also be directly referred for a JCA assessment if a Centrelink staff member believes there has been a change in circumstances or the client is facing difficulties; if a person is requesting an exemption from activity test requirements after being provided with a medical certificate; if external providers such as Job Network believe a client is facing personal issues; or if an individual has approached a PSP provider directly and then been referred to Centrelink to organise a Job Capacity Assessment.

Unlike the previous system where the Centrelink Psychologist made the decision about the referral, the Job Capacity Assessor only makes a recommendation to the Centrelink Senior Customer Service Officer who then makes the decision[3]. In practice, however, JCAs reported that it is very unusual for their recommendation not to be followed, and one case manager suggested that this seemed like more of an administrative exercise. An additional difference is the lack of contact with PSP providers after the assessment has been made. While Centrelink Psychologists formerly remained the point of contact for PSP providers regarding clients, under the new system both JCAs and PSP case managers reported having little or no contact, with some providers reporting they had been told they were not allowed to contact the JCAs at all. Instead, the contact point for case managers is now the Senior Customer Service Officer. Part of the reason for this change is that, with 20% of JCA positions contracted to outside agencies, JCAs in Centrelink no longer have access to the Centrelink system as this was seen as providing an unfair advantage over other organisations competing for contracts.

Once referred, participation in PSP satisfies the mutual obligation requirement for activity-tested participants and consequently penalties apply for failing to meet requirements. The much smaller group of non-activity-tested participants such as those on the Disability Support Pension or Parenting Payment do not face penalties for non-compliance.

Case manager views about the new referral system

Providers were mostly positive about the new referral system overall and considered it to be as good as or better than the previous system, although many case managers commented on teething problems. These included receiving many referrals from outside their geographic Employment Services Area (ESA); lack of knowledge about the PSP program among JCAs and Senior Customer Service Officers; conflicting information about whether clients still have a choice of provider or can view their JCA report; an increase in inappropriate referrals; and caseloads not being filled due to Centrelink staff or JCAs not knowing about PSP.

The most significant complaint was lack of continuity through a single contact person responsible for PSP clients, with most case managers feeling such a single contact had been a strength of the old system. A number of providers preferred having an ongoing relationship with the Centrelink Psychologist, both to assist referral to the most appropriate provider and for ongoing communication about the participant. The lack of integration of JCAs and the JCA systems with broader Centrelink systems was seen as problematic, hindering the flow of information and causing problems in a ‘division of knowledge’.

Views about the Senior Customer Service Officers were mixed: some providers reported having a good relationship but others had encountered difficulties such as being unable to contact them, not having phone calls or emails returned, or lengthy delays in making small changes on the Centrelink system that ‘would have taken two minutes on the phone with the psychologist’. Some also felt that the role was too broad to allow individual staff to build up knowledge of issues specific to clients in PSP. Interestingly, in the UK’s Progress to Work program, Department of Work and Pensions program managers reported that having a dedicated contact person within Job Centre Plus (the equivalent of Centrelink) was a vital factor in the program’s success.

In relation to non-referring Centrelink staff, there was a feeling that they were not always as well informed about PSP, and that the few referrals from disability workers and social workers were also less informed; however that was to be expected given their small role in the referral process.

[3] As of 1 July 2007, referral of clients to PSP can be done directly by the JCA and no longer requires the involvement of Centrelink officers.

JCA reports

There was strong endorsement of the new report format used by JCAs by almost all case managers interviewed. Most felt that it was more thorough, more informative and more current, but others did find it somewhat repetitive, not very readable and too focused on work. Reports discuss work in terms of temporary, current and future capacity to work, with and without interventions, the type of work people may be able to undertake (e.g. semi-skilled), and number of hours capacity. As with the Centrelink Psychologists' reports, there were some complaints of missing or unclear information, such as barriers just being listed as 'personal issues' or 'other' with no additional information. A more worrying problem reported by some case managers was a significant proportion of referrals having no JCA report attached at all, leading to case managers having to sit down with the person when they came in and ask them why they had been referred.

Referral criteria

The criteria that JCAs and/or Centrelink Psychologists reported using to decide whether to refer a person to PSP include:

- the type, severity and number of personal barriers faced
- capacity to benefit from PSP
- level of work readiness and ability to go into a work-focused program
- problems retaining a job because of personal issues such as anger management or depression
- ability to cope with the pressure of the Job Network
- capacity to benefit from Job Network.

In practice, however, for many clients there appear to be few other options, regardless of their capacity to benefit from PSP. JCAs reported that if a client does not have a medical reason for an activity test exemption and is not ready for Job Network or other employment program, there is little choice but to refer them to PSP. Although PSP is set up to work with those facing personal barriers, the limited resources in the program mean that it is unlikely to be appropriate for those facing the most extreme barriers such as psychotic illnesses.

Time between referral and commencement

After a decision is made to refer an individual to PSP, the time to commencement depends on places available in their area, or with their provider of choice, as well as the priority assigned to them. In the survey sample, the most common waiting time, reported by 32% of participants, was 3 to 5 weeks (see Table 9.1). Almost 20% commenced the program within a week, while 11% waited 6 to 10 weeks and 15% reported waiting over 10 weeks. Providers reported similar waiting times, with one stating that they currently had 16 people on their waiting list, which would result in roughly a 6-month delay.

Table 9.1 Time between Centrelink referral and commencement reported by participants (n=124)

Length of time	Number	Percentage
Less than a week	23	19
1–2 weeks	28	23
3–5 weeks	39	32
6–10 weeks	14	11
Over 10 weeks	19	15

Administrative data for individuals referred to PSP between mid 2005 and mid 2006 (whereas individuals in the survey sample were referred mid 2002 to mid 2004) shows shorter but still substantial waiting periods between referral and induction. Just under half of participants commenced within 1–2 weeks, but over 40% waited 3–5 weeks (see Table 9.2).

Table 9.2 Time between Centrelink referral and induction being signed (administrative data) (n=238)

Length of time	Number	Percentage
Less than a week	25	11
1–2 weeks	111	47
3–5 weeks	98	41
6–10 weeks	3	1
Over 10 weeks	1	0

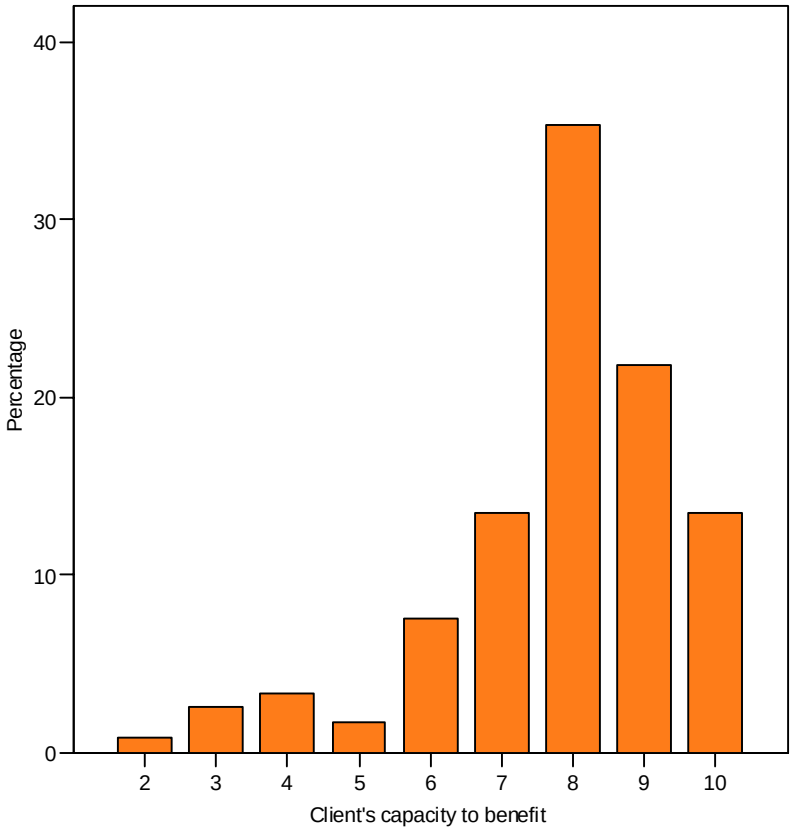
Quality of referrals

Providers were generally positive about the appropriateness of referrals, with many commenting that they had only received one or two that were inappropriate, although such complaints were more common after the introduction of the JCA system. However, some case managers felt that they sometimes received clients because there was nowhere else for them to go and that PSP was becoming 'a dumping ground'. JCAs also pointed to this issue, as did a Centrelink Psychologist who commented that they faced an increasing problem of clients not being suitable for Job Network, PSP or other employment-related programs such as CRS or Disability Open Employment. This was suggested to be a result of fewer people being granted exemptions from activity test requirements.

Case managers' reasons for believing that referrals were inappropriate included clients needing more intensive counselling than PSP could provide, requiring considerable support due to personality disorders or other psychiatric illnesses, and having violent backgrounds. One case manager also observed that it was difficult for providers to work with clients from non-English speaking backgrounds due to the costs of interpreters.

Despite these comments, provider ratings of the capacity of survey participants to benefit from PSP suggest that inappropriate referrals are a relatively small proportion of the total (see Figure 9.1). On a scale of 1 to 10 (where 1=no capacity to benefit, 10=high capacity to benefit), 70% were rated 8 or higher and 91% were rated above 5.

Figure 9.1 Participant capacity to benefit from PSP (n=119)



It was also noted that some clients who first appeared unsuited responded surprisingly well to the program. At the other end of the scale, a couple of providers commented on clients who they felt did not need PSP and had found jobs quickly on their own.

New participant groups

From July 2006 additional PSP places were created to cater for groups targeted under Welfare to Work changes: sole parents, people with a disability and the very long term unemployed. Case managers differed about whether they were seeing more entrants from these groups in late 2006.

However, several case managers felt that the PSP client group was changing and had more complex barriers. One case manager gave an example of a newly referred client with seven barriers including Acquired Brain Injury, social anxiety, confidence or self-esteem problems, social isolation or alienation, financial management problems, and bipolar. This person had not worked for 15 years, had previously been on DSP for 24 years and was one and a half hours' drive away the PSP office. It seems unlikely that a program such as PSP would have the capacity to provide effective support in such a case.

The referral process for clients

Participants were generally positive about their experience of the referral process to PSP, with most comments being about the Centrelink Psychologist:

> I found that the psychologist was the one person at Centrelink that did sort of treat you as an individual.

> Fair enough, I've been in a bit of trouble and stuff and the psychologist, he was the only person who understood, you know what I mean.

On the other hand, a few people did report less positive experiences:

> I had to see the psychologist there who was dreadful, I can say that. I think she was really demeaning and unpleasant. She didn't make me feel safe and be helpful. Sort of like nasty, like I was a loser.

> The psychologist is a very poor listener. I'd tell her something and she would get it all backwards, and that was it. A bit of arrogance there, you know.

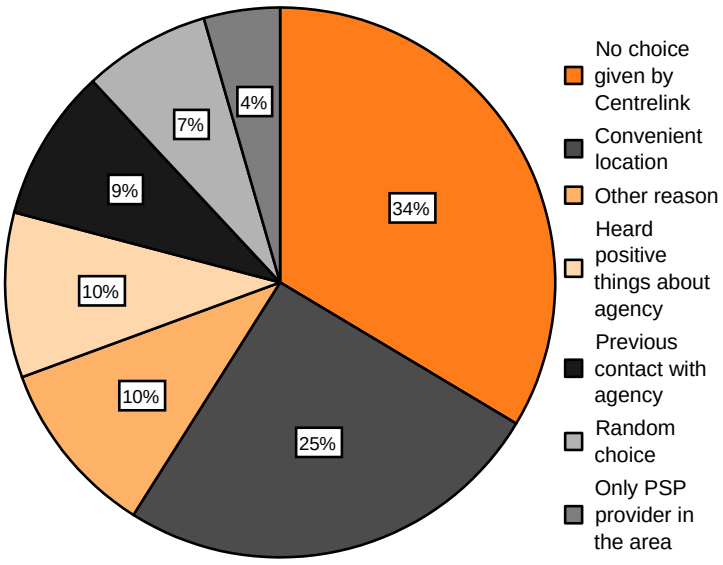
Almost all participants (86%) first heard about PSP through one of the Centrelink staff able to make referrals prior to the JCA system, predominantly the Centrelink Psychologist (67%) (see Table 9.3).

Table 9.3 How clients first heard about PSP

Source	Number	Percentage
Centrelink psychologist	89	67
Centrelink social worker	16	12
Centrelink disability officer	9	7
Centrelink personal adviser	5	4
Other Centrelink staff	4	3
Job Network provider	1	1
Word of mouth	1	1
Don't remember	3	2
Other	5	4

Although all participants are supposed to be given a choice of PSP provider, around one-third of the survey sample reported that they were not given such a choice when referred by Centrelink (see Figure 9.2). The most common reason given for choosing a provider, reported by 25% of participants, was because it was convenient or close to home. Positive reports from others or previous contact with an agency were each selected by around 10% of participants.

Figure 9.2 Participants' reason for choosing PSP provider (n=134)



Commencement

After referral to PSP, providers are required to contact the participant to arrange within 10 business days a meeting where they explain the program and have a commencement form signed by the participant (DEWR 2006a).

Case managers differed in the methods used to get clients to commence, but many reported that this could often take a considerable amount of time and effort. Common strategies included phone calls, letters, and outreach including home visits, which were seen as particularly useful for clients with mental health issues such as agoraphobia or social anxiety.

There was some dissatisfaction at the absence of any financial payment if case managers were not able to get the client to commence after putting in lots of time. Many case managers also commented on the added pressure resulting from the referral-to-commencement ratio being one of the PSP High Performance Indicators. A number did not feel this was appropriate, due to their limited control over whether a person commenced or not.

Action plans

Within 3 months of PSP commencement, providers are required to complete an action plan to:

- list the participant's non-vocational barriers
- list the participant's goals to overcome the barriers while on PSP
- list proposed strategies and interventions for the participant
- identify appropriate and available assistance
- include arrangements for monitoring progress (DEWR 2006a).

After this, the provider receives an action plan payment. However, a number of providers pointed out that if the participant leaves the program before the action plan is completed, the provider misses out on this payment for any work undertaken since receiving the commencement payment.

Apart from concerns about missing out on payments, case managers were generally positive about the action plan process. Participants on the other hand were ambivalent about the value of an action plan: some felt it was helpful as a starting point or way to see the steps to a goal, but many did not remember doing one at all or thought that it was an administrative requirement for Centrelink rather than of particular use to them:

> The action plan seems to be more for the government. Because I think most of us around here have some idea, sort of, where we want to go and I think the action plan might be more helpful for Centrelink and the government. Just so they have some idea …

Some people also felt that PSP was about counselling and helping people address difficulties as they came up, rather than a goal setting approach used in the action plans:

> From my own personal point of view, we tend to go in there and treat them more as a counsellor rather than actually putting something down and saying, well we're going to do this, we're going to do this and we're going to that, goal setting and so forth.

Engagement

After participants had commenced and understood what the program was about, case managers generally felt that engaging clients was not a substantial problem, but that it sometimes took time to build a trusting relationship. This often required more intensive work in the first few months to help stabilise the client's circumstances before focusing on the 'official' barriers.

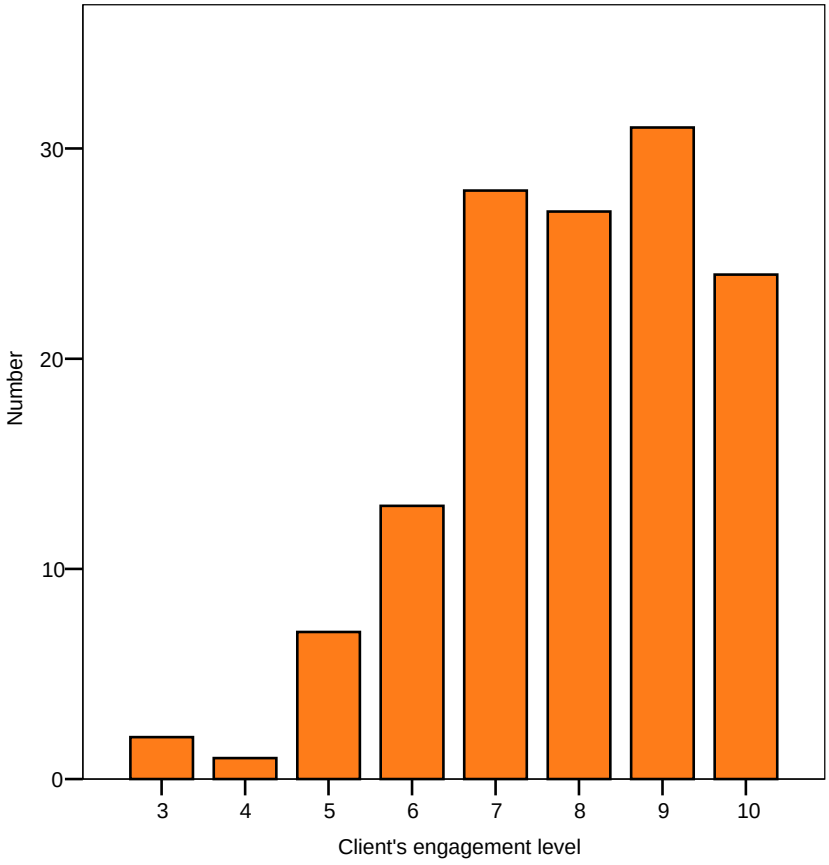
Client groups that were identified as more difficult to engage were homeless clients with mental health issues, drug-using clients deeply ensconced in their subculture, men who have been in jail, younger clients in general, people suffering from social isolation, males in their late 20s or 30s with a long history of marijuana use and individuals with personality disorders. One case manager also commented that those from what he described as 'an intergenerational poverty background' who have 'been through the mill of everything' were difficult to engage. There was also a suggestion

that some people were happy with their lifestyle even when it involved a drug or alcohol issue and that they would turn up for their appointment every month but see no reason to move on to anything else.

Overall, however, case managers reported the majority of participants to be showing high levels of engagement. On a scale of 1 to 10 (where 1=no engagement and 10=complete engagement), the average rating at survey one was 7.9. Over 60% of participants were rated at 8 or higher and only 8% rated at 5 or below (see Figure 9.3).

Female participants had a higher average engagement than males, 8.27 compared with 7.73, but this was only significant at the p<.10 level using an independent samples t-test (t[131] =1.90, p=.06). There was also a weak positive correlation (r=1.51, p=0.85) between age and level of engagement, again only significant at the p>.10 level. No statistically significant correlation was present between the level of engagement and number of months on PSP at survey one, and there was no significant change in average engagement at survey two.

Figure 9.3 Participant engagement at survey one, rated by case managers (n=133)



A Kruskal-Wallis test found no statistically significant differences in client engagement based on the participants' description of what was holding them back from work ($X^2 = 14.96$, p =.244). However, bivariate analysis of survey data found that eight Centrelink or provider-identified barriers were negatively related to level of engagement (see Table 9.4). The strongest negative relationships with engagement were for anger/conflict/behavioural difficulties, family relationship breakdown and periods in custody or a criminal record.

Table 9.4 Correlation between selected client barriers and level of engagement

Barrier	Spearman's rank correlation
Anger conflict behavioural difficulties (n=133)	-.290***
Family relationship breakdown (n=132)	-.267**
Periods in custody and/or a criminal record (n=132)	-.239**
Very long term unemployment (n=132)	-.216*
Drug problems (n=133)	-.212*
Homelessness (n=133)	-.206*
Intellectual disability (n=128)	-.198*
Literacy/numeracy problems (n=133)	-.190*

*** p < .001, ** p < .01, * p < .05, # p < .10 (Spearman's rank correlation)

Interestingly, significant positive relationships were found between the case manager's assessment of a client's level of engagement and the number of barriers they were facing and between the level of engagement and the client's total barrier score (sum of 1–10 ratings for all barriers faced) (see Table 9.5). This suggests that PSP is effective at working with the most disadvantaged clients but does not engage as well with less disadvantaged clients.

Table 9.5 Correlations between participants' total barriers and barriers score and level of engagement (n=133)

Indicator	Correlation	Significance
Total number of barriers	.302	.00
Total barriers score	.259	.00

Strong positive relationships were also found between a client's level of engagement and both their level of insight into their barriers (r=441 p<0.000) and the desire or motivation to bring about change (r=472, p<.000), suggesting that interventions which assist clients to understand the barriers they face may lead to a greater desire to bring about change and a higher level of engagement.

Factor affecting engagement

A number of factors were reported by case managers as helping and hindering client engagement in PSP. Table 9.6 and Table 9.7 show the coded responses. The leading factor helping engagement, mentioned in 41 cases, was the participant's attitude, motivation or commitment, which was expressed in comments such as 'Client very ready to engage and seeking help' and 'Participant is eager to have someone to talk to about the issues of his relationships within his family and others'. Developing a positive or open relationship was the next, mentioned by 34 case managers, often expressed as being honest or straight with clients, showing interest and having a non-judgmental attitude. Other common factors, each mentioned by 13 case managers, included outreach or home visits, linking with required services and providing personal or emotional support.

Table 9.6 Factors helping client engagement (case manager reported)

Factor	Number
Participant's attitude/motivation/commitment	41
Developing a positive/open relationship	34
Outreach/home visits	13
Linking with required services	13
Providing personal/emotional support	13
Frequent contact/intensive support	9
Financial assistance	9
Family support	8
Good transport/access to provider	4
Reminder calls	4
Flexibility in meeting times	4
Other	6

Fewer case managers reported things that were hindering engagement, but transport or access problems were the most common (reported by 15 case managers). One manager commented on a participant who had no car and lived 92km from the PSP office. Mental health problems and client's attitude or lack of motivation were also impediments, mentioned by 14 and 12 case managers respectively, while substance abuse, financial problems and unstable accommodation were each mentioned by 7 or 8 case managers.

Table 9.7 Factors hindering client engagement

Factor	Number
Transport problems/difficulty accessing PSP provider	15
Mental health issues	14
Client's attitude/lack of motivation	12
Substance abuse	8
Client's poverty/financial condition	7
Unstable accommodation/transient lifestyle	7
Change of case worker/agency	6
Family problems	6
Client's trust issues	4
Lack of attendance	4
Other	9

Provision of assistance

Overview

Agencies varied widely in the model used to deliver support to clients, but all reported considerable difficulties. The average number of difficulties faced in providing assistance was 2.2, and 95% of case managers reported at least one difficulty. Cost was the most common problem, reported by case managers in 90% of cases and also reflected in numerous comments in interviews about the frustration of being unable to provide the assistance required because of lack of funds. This not surprising given that low funding means agencies can only afford (from general program revenue) a maximum of $150 brokerage per client per year, and some have no brokerage funds at all. Other common difficulties included waiting lists, services not being available, available services not being appropriate and lack of transport.

Providers reported the greatest shortfall in meeting the needs of clients on PSP for counselling, but all services were difficult to access. Some participants had positive views about the ability of PSP to connect them with local services and activities but many others were frustrated or felt that there had been insufficient referrals, usually due to costs.

Many case managers indicated the minimum four-weekly contact was insufficient for many clients and the high case loads (ranging from 40 to 75 per full-time worker) necessitated by low program funding made it difficult to spend sufficient time with clients. Many participants also felt that meeting once a month was not enough, or sometimes not enough. Others reported higher levels of contact and were positive about this. Most spoke highly of the relationship with their case manager and felt there was a genuine level of care and support, although a few people felt the balance was tipped too much towards basic welfare support. Outreach was particularly appreciated by participants that had received this assistance.

Services model

PSP providers are required to provide 'counselling and personal support', 'practical support' and 'referral, coordination and advocacy support'(DEWR 2006a). However, agencies varied considerably in the model of delivering these types of support to clients. Approaches included accessing other in-house services, employing psychologists or counsellors as PSP workers

(although this was uncommon), developing partnerships with other organisations and accessing almost all services through external agencies.

Services that agencies accessed in-house included:

- English language classes
- financial counselling
- family mediation
- youth housing
- supported accommodation
- living skills programs
- music lessons
- employment services (such as Job Network, Disability Open Employment Services and the Correctional Services Employment Pilot Program)
- theatre projects for young people
- computer training
- marriage education counselling
- group activities.

Being able to access services required by participants was seen as crucial to the program's overall effectiveness by many case managers. One commented that the level of 'effectiveness is only as good as the linkages and that's where it can really fall down'. Others suggested that it was often difficult to link clients to desperately needed services in an appropriate time and within the budget.

However, even when services were available in house, they were not always used. For example, some agencies that also had Job Network contracts reported that there was little interaction between the two programs. In other cases there was still an internal charge for services, which was beyond the reach of PSP. One provider had considered setting up some internal services but decided it was not the role of PSP to plug local service gaps and did not proceed.

A couple of providers had also set up groups specifically for PSP clients and noted that they had been successful in getting the very socially isolated clients to attend, although another provider felt that most PSP clients were not ready for group activities. Groups included a fishing group, art group, gym group, men's group and a music group. However not all of these were still running due to the resources required.

Accessing external services

Due to varying client needs, PSP providers need to access a broad range of support services. Several case managers commented on the importance of strong knowledge of local services, while another provider did a lot of research and belonged to networks in order to keep up to date. Given that the PSP operates with a brokerage model but that funding levels allow providers to put aside only $50 to $150 per client per year (and some agencies have no discretionary funds), free or low-cost services are crucial for the effectiveness of the program.

Providers reported the greatest shortfall in meeting the need for counselling, which was required by two-thirds of all PSP clients. Although the PSP guidelines require all agencies to undertake some client counselling, many case managers do not have the skills or qualifications to provide specialist counselling.

Some case managers were able to arrange six counselling sessions through a community psychiatry scheme which provides counselling through participating GPs for the cost of normal visit

(sometimes bulk-billed), but others reported that the service was not available through their local GPs or was difficult to access.

Generalist counselling through community health centres was often reported to have waiting lists of up to five months, and then often still had a small charge ($10–$40) which was problematic. Some providers had paid for a couple of sessions, or matched half payment with clients, but one case manager commented that because there was no free counselling in their area 'mostly clients miss out'. Another commented that clients who do receive low-cost counselling, often see a trainee psychologist, 'but for lots of people that's not adequate'.

Due to the lack of counselling options, some case managers were careful 'not to go too deeply into client issues' they might not be able to deal with. As one case manager commented:

> You allow them to ventilate, allow them to acknowledge that this is an issue, but you can't take it too far. It is an issue knowing how far you can open that lid, or if you should not open it at all.

Specialist counselling through CASA (Centre Against Sexual Abuse) was reported as having waiting lists in different areas ranging from a couple of weeks to three months. Other mental health services were also widely seen to be difficult to access and 'proper cognitive behavioural therapy or a proper course of psychotherapy' was described as 'pie in the sky'. One case manager commented that 'those things we don't even *think* about because they're just so far off the radar'.

Availability of other services varied by locality, but in general case managers reported that it was rare for clients to get into any service immediately and that they were 'stretched across the board'. Accessing bulk-billing GPs was difficult in some areas, with clients sometimes having to go to a hospital casualty department for medical treatment. Dental services were reported as highly inadequate, particularly in rural areas where waiting lists were two to four years: one case manager reported that some clients had resorted to pulling out their own teeth.

Drug and alcohol services were described as good, accessible and affordable in some areas and stretched with waiting lists of one to two months in others. However, overall they seemed more accessible than mental health services.

A number of case managers mentioned inadequate access to housing and suggested it was a particular area of vulnerability for PSP clients. The problem was often insecure accommodation rather than homelessness as such. One case manager suggested that crisis accommodation could be difficult to access due to a high level of bureaucracy and the eligibility criteria. In one rural location, the housing shortfall was being addressed by the Department of Housing by putting people in caravans. Transport and a 'decent' education or TAFE facility were also identified by a rural provider as a significant gap.

Given the low level of program funding and minimal discretionary funds, providers reported being very restricted as to when and how they could assist clients financially. One agency within a national welfare organisation reported they had access to a direct relief fund. Some providers matched (modest) clients' contributions dollar for dollar, to help clients to retain a sense of ownership and pride. Another agency had implemented successful interest-free loans that participants would pay back through Centrepay (a direct deduction from their income support payment): of $5000 in loans taken the previous year, 90% had been repaid.

Financial assistance was used for expenses including medicines, dental work, food, petrol (to visit family members), education or recreational courses and getting a driving licence. Financial aid from other organisations was reported to be hard to access: one case manager reported food vouchers were only available four times a year and assistance with rent arrears was not available unless an eviction notice had been issued.

Community houses were nominated by a case manager in inner Melbourne as an excellent resource that offered short courses ranging from cooking to crafts to self-defence.

> You can just send them away with this (flier), and they will find something. Ninety-nine per cent will find something that takes their fancy. And it's affordable and gives them some participation in their local community. It's brilliant … And once they've been into the community houses, they're really friendly places and they have community lunches … Once you've got them integrated, that's a ready-made community for them to access.

However, the down side was that these courses still often had fees of $40 to $70, which clients found difficult even if some financial assistance could be provided. One case manager commented that sending participants on short courses 'would sometimes just make the difference' but was beyond the reach of their agency.

Adequate funds to access education and training are particularly important for this group, given their low average levels of education compounded by poor labour market history. Education and training can have a powerful effect in reducing social exclusion and improving employment outcomes; and this is already identified by case managers as required assistance for around 50% of clients.

Participant views

Some participants had very positive views about the ability of PSP staff to connect them with local services and activities:

> I could have a full day, every day of the week. She's [the case manager] really opened up a lot. At the same time she said, you know, 'Don't go in over your head, so you come out pulling your hair out, and then you go back to your little den or your hole and go back to your room and lock yourself away again', sort of thing. But no, I've found it excellent. Because it's up to me whether I take on these options or not, and … just for someone to make you aware of them is great.

However, many others felt that there had been insufficient referrals or that due to a lack of brokerage money case managers were not able to refer to the most appropriate services:

> One can't help but feel that they like to keep trying to stick us in courses because they don't have anything else to offer us.

Another person commented:

> The only actual piece of assistance that I've received is my worker finding me a doctor—which didn't actually have anything to do with normal channels because one of her other clients actually recommended it. That's the only thing in a year that has happened. [I've] just sort of been sitting around, periodically pulling my hair out and trying to ignore it.

The frustration at lack of referrals was clearly evident in many participants:

> Basically I just feel like I've been put on hold … There's three stages of Centrelink existence: beating you to death, putting you on hold and ignoring you; and PSP is on hold, yeah, for the most part I think.

Survey data provides further evidence of participants' strong awareness of the severe shortage of funds and its impact on referrals. When asked to describe how PSP could be improved, more brokerage funds or financial assistance was by far the most common suggestion, by 43% of respondents.

The difficulties facing case managers in finding free or low-cost services were also evident in participants' comments about inappropriate referrals, such as one woman saying that her case

manager had tried to put her into group courses despite her repeatedly telling him that she could not cope with groups.

A number of other people felt that there was not enough support to actually connect them with services. One person had been given many places to call, but noted: 'They're all on the other side of the city and all fairly inaccessible to me … and there's no actual putting me in contact with them or anything like that'. This issue was repeated by other participants:

> And sometimes there is good stuff that comes out, contact numbers and things you can get on to, but then it's just solely left up to me. And that isn't always a good thing. [Often] I haven't been able to get on to anyone, I haven't been able to follow it through.

Another participant appreciated being given a phone number to find out about volunteering but commented:

> There's still the stress of having to get in it. And there's no go between me and the volunteer services. It's just 'There's the number, go to …' and it's just a vicious circle of 'Yeah I'll do it' and a month later we've forgotten all about it and we talk about the new batch of things.

Inadequate or non-existent transport was also raised by some participants, with one person living in outer Melbourne remarking that to get to a course that was half an hour away by car could involve up to 4 hours travelling due to buses only coming every 2 hours and additional travelling time at either end. Others had concerns about having to walk long distances to and from public transport at night when they believed most courses were run.

Another common issue was the need for more referrals to psychologists. One person had actually contacted Centrelink and asked them to request this of the case manager, but said it still did not happen. Another was unable to undergo the required psychological assessments because of the $200 fee. Others had received some assistance from a psychologist, only to have the funding run out:

> So I saw a psychologist for three weeks, and then the funding was gone, and that's it, there was no more money to pay for it and I couldn't afford a private one. I mean, I'm having enough trouble trying to live as it is without … And it was like now I have to get used to another one. But there's been no other one.

Some participants also reflected on the effects of the low level of funding for activities available through PSP, in contrast to the Job Network (for example through Intensive Assistance).

> When you get the Intensive Assistance… it's literally like 'Here, money. Just go and do whatever course you want to'. And I mean *this* [PSP] is supposedly for people that are having more troubles and should get more help, and I mean you can't do courses on this program. And there are probably a few courses that I wouldn't mind doing, but I just haven't had the opportunity.

> I mean they've got $120 to spend on a person a year and I think that sometimes they're quite frustrated by that. Because that's the thing, if they had a bigger budget, they could actually send you to programs and help you pay for them and stuff. But they can't, they've got no money. The money they have, they have to keep for emergencies to help the person when things go wrong.

Types of assistance required

Case managers were asked about the specific types of assistance that participants required, based on the list used by Centrelink. As already noted (see Table 6.20), the most common type of assistance required was counselling. The counselling mainly related to general mental health issues

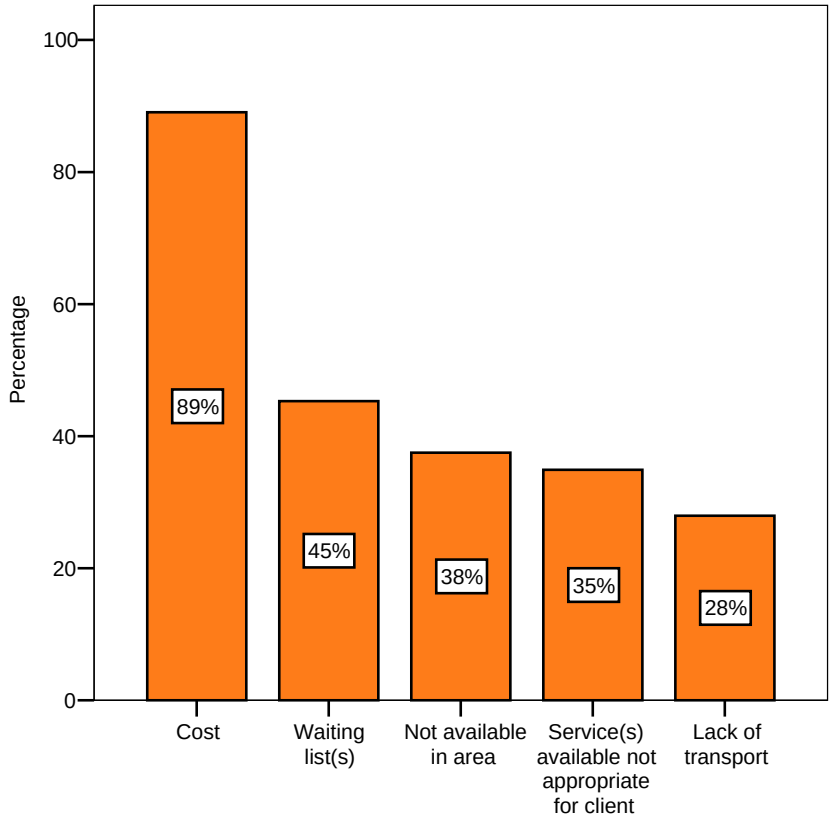
such as anxiety and depression, but also included areas such as sexual assault, anger management, drug and alcohol use, family support, trauma and grief and cognitive behavioural therapy.

Other major types of assistance included self-esteem or confidence training (required by 61% of participants), study or training opportunities (51%) and goal setting or decision making (41%).

Difficulties in providing assistance

As Figure 9.4 shows, for around 90% of clients case managers reported that cost was a barrier to providing required services. This confirms qualitative findings that a large proportion of clients are missing out on required services due to cost.

Figure 9.4 Difficulties in providing assistance at survey one*



* Cost n=128; waiting list(s) n=117, not available in area n=112, not appropriate n=106, lack of transport n=118.

Waiting lists and services unavailable locally were both reported as difficulties in providing assistance for a significant proportion of clients (45% and 38% respectively). Inappropriate services and lack of transport were also reported as difficulties for 35% and 28% of clients.

The average number of difficulties faced in providing assistance was 2.2 and 95% of case managers reported at least one difficulty. Around 28% reported one difficulty, 31% two difficulties and 36% three or more difficulties (see Figure 9.5).

Figure 9.5 Number of difficulties faced in providing required assistance (n=129)

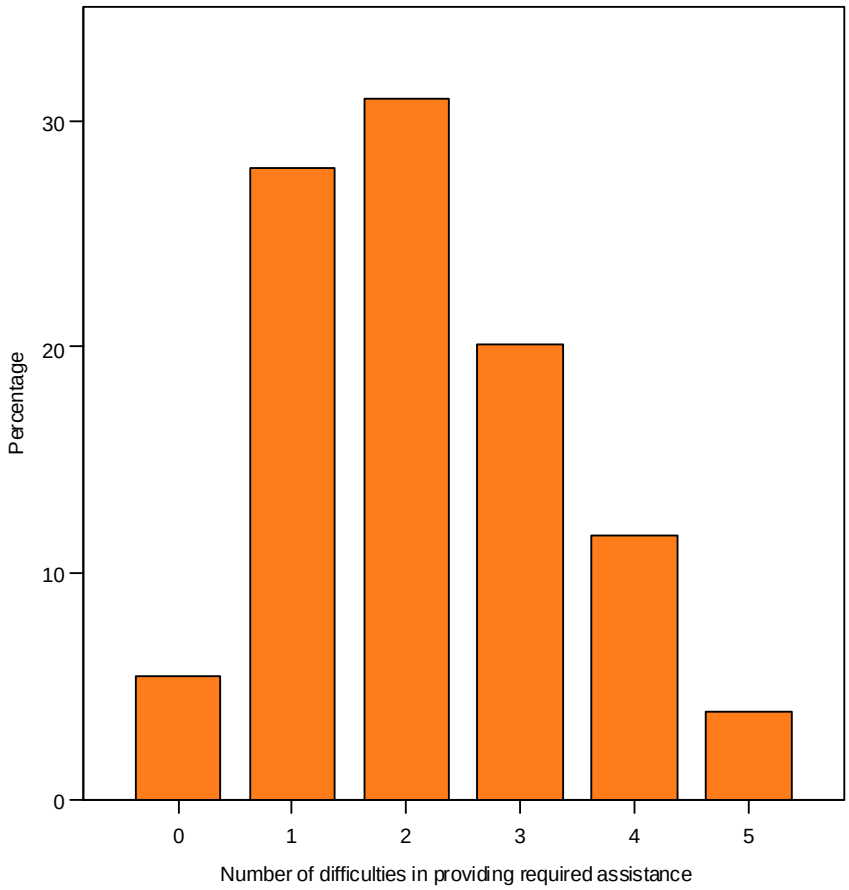


Table 9.8 shows difficulties in providing assistance by location. Problems of cost or waiting lists were somewhat worse at inner metropolitan providers than outer or non-metropolitan providers, but these differences were not statistically significant. No local services, lack of transport, and inappropriate services for the client were all significantly more common at non-metropolitan providers than inner or outer metropolitan providers. No local services and lack of transport were significantly less common at inner-metro providers than outer.

Table 9.8 Difficulty in providing required assistance by location

Difficulty survey 1	Inner metropolitan	Outer metropolitan	Non-metropolitan
	%	%	%
Cost (n=128)	96	90	86
Waiting list (n=117)	57	34	47
Service(s) available not appropriate for client (n=106)	23	22	46*
Not available in the area (n=112)	14	28	51**
Lack of transport (n=118)	4	9	46***

*** p<.001, ** p<.01, * p<.05 (using Pearson's chi-squared test)

Client case manager contact

Frequency of contact

The program guidelines stipulate a minimum of one contact with each participant every four weeks, face to face or over the phone, although face-to-face contact is now preferred (DEWR 2006). In practice, providers reported considerable variation in contact, depending on need.

Many case managers reported that the usual pattern was more frequent, intensive contact in the first two or three months, when they might spend a whole afternoon or day working through problems. This could include working on urgent issues such as finding accommodation and advocating for clients with existing services. However, crises requiring more intensive assistance could occur at any time, and in some cases clients would be in PSP for some time before they felt confident to reveal issues that required intensive support.

After the initial period, contact was reported as ranging from more often than weekly up to monthly, but many suggested that monthly was only sufficient for those clients who were 'on track'. One case manager reported that after a year if he felt things were going well, he used mainly phone contact, with face-to-face meetings every 3 months.

Many case managers reported that the high case loads (ranging from 40 to 75 per full-time worker) necessitated by the program funding made it difficult to spend the time they wanted with clients. Some case managers and a Centrelink Psychologist suggested that PSP providers varied markedly and that some might not go beyond the program's minimum contact requirements. However, an alternative view put forward by a couple of case managers was that case loads that were 'too low' might foster dependence and not be in the best interests of the participants.

Particularly for the many clients who were very isolated, the regular connection with a support person was seen as an important foundation for achieving substantial change and helping clients to become more focused. Having a case manager who could empathise and relate effectively to the clients was identified as crucial. A few case managers made the point that a lot depended on how much clients were willing to take up the assistance on offer, with some clients simply moving from one crisis to another or lacking the desire to change. However, it was also noted that some clients changed during the program and breakthroughs sometimes came about unexpectedly.

Participant views

Participants' views on the adequacy of contact with their case manager varied a lot. Some felt that their current level of contact was sufficient. Many of these reported meeting more frequently than the monthly minimum: 'I look forward going to PSP, every second week, because I think "Oh! I can get this off my chest. I can talk to someone … A real person!" '. Others were able to ring at any time if they had a problem; and some even had phone contact with case managers outside business hours. Being able to meet with their case manager at short notice if things came up was highly valued by participants:

> Sometimes I think 'No I don't want to see you this week', but then there's other times … I know I can drop in every couple of days if I need to, and that's good.

Many felt that meeting once a month was not (or not always) enough, with some saying it did not allow case managers to really know what was going on in people's lives:

> You go along and do your 'hour' thing and you say what's been happening and blah, blah, blah and then everything's all typed and for that time I believe that the worker really is there for you. But then you go out the door and then she has, or he has, you know, twenty other people to deal with before the end of the day. And it's just like … these people don't have any idea who we are, what kind of lives we live, what our homes are like—anything.

One person remarking that the program was 'too busy' and that it was not possible to talk about things properly having a meeting only every 4 weeks, while another stated that there was not enough contact to provide 'that extra bit of actual support that I need to push me on my way'. Some also reported having contact less than once per month: one person said he had only had one phone contact with his case manager in the last three months.

However, the need to spend time constructively was highlighted by one person who had increased the appointments to every three weeks and remarked that:

> It kind of feels even more pointless than ever. Because I'm seeing her more often, and it's just like I can't wait to get out of there at the end, because I'm just trying to think of things to say to pass the hour because nothing is going on.

Relationship with case manager

Most participants spoke highly of the relationship with their case manager and felt a genuine level of care and support. Comments such as the following were common:

> That's the big strength of the programme is the staff. They're very good and they seem to care and they listen to you properly.

> I mean they're fantastic, the staff here *are* fantastic.

> Person 1: I'll ring up and I won't even say my name and she'll say 'Hi [participant]. How are you going?
> Person 2: She knows my voice too!

A number of people also commented on the benefits of having time to develop a trusting relationship with one person and disliked having to repeat themselves to numerous people:

> You get familiar with the person. They know you and you can be more relaxed with them, and you can be more open with them. They can help you more. When you're in our situation, when you've been unemployed for some time … you don't want to stop and start and tell the whole story again.

Many participants appreciated the lack of pressure in PSP:

> Yeah, no, (case manager) has been too good to me. He's let me for a year try to sort out what I've been trying to sort out for a long time and he's been supportive whatever I've … I've started a course and then I've … no he's *too* good.

> I think PSP is good, it has been for me. It just gives you space to sort out your life and your self. There's all those pressures on you. [Case manager] has been fine, he just lets me go along at my own pace and doesn't pressure me.

However, others felt that the support was too focused on basic welfare rather than actually getting people to move on with their lives:

> That's a problem that I've noticed consistently is that they don't seem to have any idea of the middle ground of looking after you and making sure you're safe and actually pushing you out and making you get on with things. They don't have an idea of that middle ground and they tend to flip-flop backwards and forwards too much. Or sit in one court too much.

Some participants were less positive about the relationship with their case manager generally and felt that the support was impersonal or not focused enough on their needs:

> There doesn't seem to be that extra level of 'Hey I can actually be a part of making you feel better just by being here, and being actually nice and knowing who you are and knowing about you and properly interacting with you'.

> It sounds weird, but customer service would actually be a really good quality for the support workers to have. Because I know, like, three months into it, I messaged my worker saying 'Everything's shit, I need this'. And I got a message back saying 'Oh who is this exactly?' And I'd messaged her and talked to her on my mobile before, but she didn't have

> any idea who that number was, um and it's things like that … when you're feeling a bit insecure and things like that and you've just … and your personal support worker doesn't have any idea who the hell is calling them …

Outreach

Outreach is a required activity in the PSP contract and many case managers reported meeting clients in informal settings such as cafés. Some providers also frequently made home visits. The level of outreach, however, varied markedly between providers and was greatest in rural areas, where clients were commonly geographically isolated and without access to transport. One rural provider indicated that outreach was essential due to the lack of public transport and the clients who did not have their own vehicle. Other providers had a policy of trying not to visit clients in their home because of safety concerns, and one manager said that they were trying to build a sense of independence through a hands-off approach that did not intrude too much into people's lives.

Participants for their part seemed to appreciate case managers' home visits. One person who could not catch the bus due to knee surgery was delighted with the case manager saying they could meet at the person's house, while another commented that the case manager had 'even dropped me home and I made her a cup of tea'.

Duration of PSP

Almost all case managers strongly supported PSP's two-year time frame, given the complex barriers faced, the clients' experience of long-term cycling through the welfare system and the need to build a stable and trusting relationship. However, most case managers were not in favour of extending the program. The limit was seen as preventing long-term dependency and also prompting clients to think seriously about the changes they wanted to achieve as they drew near the end of their two years. One widely suggested improvement was the option to extend for six or twelve months for a small proportion (possibly 5% or 10%) of participants on a provider's case load.

Employment assistance

Overview

Other research suggests many unemployed people with severe personal barriers, such as those on PSP, have a strong desire to participate in the labour market and that appropriate employment can be both realistic and beneficial. Key elements of effective employment interventions include long-term support, rapid movement into work, seeing work as part of the recovery process, emphasis on encouraging and supporting work, and careful matching of individuals to jobs based on preferences and capabilities. Two particularly promising models of vocational support for individuals facing severe barriers are the Individual Placement and Support (IPS) model, used primarily in the mental health sector, and the Transitional Employment Program (TEP) model.

However, the current approach in PSP fails to provide such assistance. There is variable support available, depending on each case manager's background and attitude; but no case managers reported employment support to be a major component of their work.

While PSP does allow for participants to be transferred to the Job Network to receive employment assistance (with a six-month co-case managing period), this is inappropriate for most participants who require ongoing personal support, and does not provide the integrated approach found to be critical in other research. Other programs such as Disability Employment Assistance or vocational rehabilitation provided by CRS are likely to be more effective but do not have the focus of PSP in assisting people to overcome personal barriers.

Some participants were happy with the employment assistance they received. However, in line with some case managers, many felt that PSP was not really focused on this type of support. The reduced pressure to look for work in PSP was widely appreciated, but numerous people stated that after a time they wanted to move on with finding employment and that PSP did not provide sufficient opportunities.

Studies of programs for disadvantaged job seekers

Given the evidence from this study and others that many unemployed people with severe personal barriers such as those on PSP have a strong desire to participate in the labour market, and that appropriate employment can be both realistic and beneficial (see section 7), understanding the types of employment assistance that are most effective is critical for improved participation outcomes.

Traditional welfare-to-work approaches 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; Horn & Jordan 2006; Parkinson & Horn 2002). 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'.

Barrier-focused interventions such as substance abuse programs, mental health services or general case management programs, often fail to recognise the significance of work; tend to focus on impairments (Evans & Repper 2000; Marrone & Golowka 1999); overlook labour market opportunities (Richards & Morrison 2001); or provide vocational assistance that is absent, poorly defined or of variable quality (Blankertz & Magura 2004). Research looking at people with mental health problems suggests that case management without specific vocational efforts will have little impact on employment (Bond 2004).

A further problem of all program approaches can be attitudes of professional 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 a participant's mental health or well-being (Waghorn & Lloyd 2005).

Effective program elements

Research, mainly undertaken in the US, has identified elements associated with achieving employment outcomes for clients facing personal barriers. Examining US programs assisting homeless people with mental health problems, Shaheen, Williams and Dennis (2003) found two themes across all successful programs: a belief in the value of work at the earliest possible stage as an aid to the recovery process, and a recognition that a job can help people develop motivation to change, dignity and self-respect. Five factors were found to be related to program success, regardless of the model:

- an organisational climate and culture that supported work
- facilitation of employment
- emphasis on consumer preferences and strengths
- ongoing, flexible, individualised support
- re-placement assistance.

Brown (2001) also identified elements associated with successful programs, including 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 research has reported greater success when participants are able to gain a qualification in a training component (Philbin 2003).

Pavetti and Kauff (2006) suggest that some people need programs that provide 'developmental work opportunities' that build marketable skills, provide gradually increasing responsibility, identify flexible tasks matching their strengths and limitations, and provide ongoing supervision in a nurturing environment.

Other program elements found to be effective in assisting this client group include:

- utilising staff with specific vocational expertise (CalWORKs Project 2001)
- high expectations in goal achievement and lifestyle advancement, using a supportive rather than a coercive approach (Marrone & Golowka 1999; Richards & Morrison 2001)
- providing a variety of activities appropriate to individuals at different times (Brown 2001; Richards & Morrison 2001)
- employing staff with a good 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 processes with other participants (Philbin 2003)
- employment specialists spending more time out of the office assisting participants (Bond 2004)
- providing peer support and mentoring (CalWORKs Project 2001)
- small case loads of up to 25 (Shaheen, Williams & Dennis 2003)
- utilising a flexible measure of outcomes (Brown 2001)
- providing long-term support (Brown 2001).

Integration of employment and support services is also important (Shaheen, Williams & Dennis 2003). 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).

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

Models of vocational assistance

A number of employment models show potential in helping job seekers facing severe personal barriers. Two particularly promising examples are the Supported Work and Transitional Employment models. A model-based approach allows consistency in service delivery and the ability to replicate, develop and evaluate individual components (Blankertz & Magura 2004).

Supported work

The Supported Work model has been developed in the US, primarily with clients suffering from mental health problems, but is now being extended to others such as substance abuse clients. The model is a 'place–train' approach based on variations of the following principles:

- eligibility based on consumer choice (no-one in the target population is excluded)
- integration of vocational rehabilitation with mental health care
- a goal of competitive employment
- rapid commencement of job search activities and employment
- 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, it is also recognised that clients have changing needs and ideally programs aim for time-unlimited and flexible support (Bond 2004).

US research has consistently found the supported work approach to be 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 US sites, 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 than those who had done pre-vocational training.

Supported employment programs have also been successful with people with substance abuse problems (Dillon et al. 2004) and those with concurrent substance abuse and mental health problems. Becker et al. (2005) reported the following principles to be important in supported employment programs working with dual diagnosis clients: encouraging employment; understanding substance abuse as part of the vocational profile; finding a job that supports recovery; helping with money management; and using a team approach to integrate mental health, substance abuse, and vocational services.

Comparing 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 be less work-focused. Low-performing providers were more likely 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
- provide less ongoing support once clients were placed in employment.

Individual placement and support

The Individual Placement and Support (IPS) model is a variation of the 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 in the case management or mental health team, emphasises integration of vocational and clinical services, contains [a model can't conduct anything] minimal preliminary assessments, and considers work part of the participant's ongoing treatment regimen.

In a review of 12 randomised control studies, Drake et al. (2006) reported that 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. Similar results have been obtained in many other studies, where IPS clients gained competitive employment faster, stayed longer 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). Employment rates do vary between IPS programs, but this is often explained by lack of fidelity to the base model. Employment rates can also vary significantly between case managers, from 75% to 25%.

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

Transitional employment program (TEP)

Transitional employment programs place participants in temporary jobs, often in non-government organisations or the public sector, where they 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 staff-to-client ratios of around 1:25 and strong links with support services in the community. Transitional jobs are designed to act as stepping stones to unsubsidised employment and are often targeted to unemployed people who face barriers to employment and have been unable to find work through regular welfare-to-work programs (Waller 2002).

A review of six 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 to address more severe personal and family issues. Consistent participation led to permanent unsubsidised employment for 81% to 94% of participants who completed the program, but around half of those referred did not complete. Participants reported that the program resulted in personal, professional and financial benefits. Another evaluation of a transitional jobs program in Washington targeted to hard-to-place participants reported a net impact 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, 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 English as a Second Language (ESL), GED (General Educational Development qualification) and professional development classes; and allowed participants to progress through three levels (EnSearch Inc. 2004). At the end of the study, 43% to 47% of participants had gained competitive unsubsidised employment across the five sites, with the following rates for participant sub-groups:

- homeless people 34% to 48%
- victims of domestic violence 18% to 53%
- people with drug problems 18% to 47%
- ex-offenders 27% to 43%
- people with learning disabilities 35% to 47% (EnSearch Inc. 2004).

Comparisons of transitional jobs programs with the IPS model for welfare recipients have shown superior performance of the latter (Evans & Repper 2000), and its higher employment rates (see above). However, these differences may be due to differences in the populations served.

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

Employment assistance in PSP

There is no coherent model of employment assistance within PSP. This study found that the level and type of assistance offered varied and seemed to depend largely on the background of the individual case manager. Those that had worked in other employment programs generally reported a greater focus on employment, but none reported such activities to be a major component of their PSP work.

Employment assistance was usually limited to doing a bit of job search, helping with a resume or providing some vocational counselling, although a couple of case managers had also tried to assist clients in starting their own businesses—producing a promotional pamphlet or investigating the New Enterprise Incentive Scheme.

Some case managers commented directly that employment outcomes should not be a priority of PSP and that there was a need to deal with people's social problems first. Several also suggested that finding work for people facing such barriers as many PSP participants do can be very difficult and is unrealistic for most participants even if they have the desire to work. However, this seems a somewhat unhelpful position given that participants' own perception of their readiness for work and their desire to work were both significant predictors of being in work at survey two.

Several case managers thought that the emphasis on employment might increase after the addition in July 2006 of a fourth PSP High Performance Indicator, the 'outcome rate'. This includes social and economic outcomes but weights economic outcomes (final) at a rate of 1.2 times social outcomes. Some were concerned that this could lead to participants being pushed into jobs before

they were ready, but one case manager with several participants already in work thought it could be a good thing, encouraging some providers that might otherwise 'coast along' to be more proactive in approaching work.

Some case managers remarked that the clients entering the program after the July 2006 changes to income support were facing more barriers and less likely to be able to move into employment. One person commented that 'PSP is becoming a parking lot for people Centrelink does not know what to do with'. To give an extreme example, this case manager told of the recent referral of a 59-year-old woman with throat cancer, no English and no formal schooling, who had previously been on DSP: the Job Capacity Assessors report said she had the capacity for 30 hours' work per week.

Although some PSP clients clearly do not have the capacity to work, many others do have some capacity and desire, and the lack of a more active employment component is of concern. Work was the activity that 40% per cent of participants stated that they would most like to be doing now, it was the most common goal people wanted to achieve while on PSP and it was the most common activity that people envisaged after PSP. In addition, as Blankertz and Robinson (1996) identified, staff attitudes that clients lack the capacity to work have been shown to be a common barrier preventing people from moving towards employment.

However, it should also be noted that clients' average self-assessed readiness to work on a scale of 1 to 10 (where 1=not ready and 10=ready) was 4.3 and that only 11% of clients rated themselves as ready (10). This suggests that significant support will be required to achieve employment in practice.

Participants' views

Some participants were happy with the employment assistance they received on PSP, with a couple of people mentioning that their case managers provided good support, having previously worked as an employment consultant. However, like many case managers, numerous participants felt that PSP was not really focused on this type of support:

> It's more of a counselling thing than anything else. We haven't had the help-me-find-a-job type of thing.

The reduced pressure to look for work in PSP was widely appreciated, but a number of people stated that after a time they wanted to move on with finding employment and that PSP did not proved sufficient opportunities to do that:

> But after being on it (PSP) nine months, nine months is long enough, I would like more opportunities.

One participant felt PSP needed to find a better way to 'balance your ability to look for work with your ability to *not* look for work', while another remarked:

> You shouldn't feel limited by being on the program. For what you're trying to do, you should have more scope … without being pushed.

Some participants also made comments about the need for more integrated employment support within PSP:

> PSP should be linked to some organisations that could work with corporates to basically take people out of the PSP program, like an apprenticeship … more training. To put them back in the workplace and integrate with people again.

> I don't think it's integrated enough with employment specialists, or employment services. Get them [participants] set up in the workforce, and combine with employment agencies, which I don't think is happening.

Exit and transition

Overview

At survey two, 37% of participants had exited or been suspended from PSP. Among this group the most common activity was working, reported by 32%, followed by study or training and looking for work. They were significantly more likely to be working than those remaining on PSP.

However, even among those exiting PSP, evidence of the need for ongoing personal support was compelling: around half did not feel ready to leave. Some 74% of all survey two participants wanted to stay on PSP while undertaking their preferred activity (mostly work or study); and over 80% reported that it would be helpful to continue to receive some assistance after leaving PSP, most commonly counselling, personal support or having someone to talk to. High ongoing support needs were also highlighted by case managers' assessments of assistance required in the 12 months after survey two.

These data, combined with strong evidence of the persistence of personal barriers over time, point to a strong need to provide ongoing support in critical areas including counselling, housing support, and mental health. The current assumption that many people will be able to exit PSP into mainstream employment programs such as Job Network does not seem realistic. Moreover, case managers in Job Network are likely to struggle to meet the needs of PSP due to their lack of experience and skills in addressing personal issues, lack of connections with local support services and inability to provide intensive support due to higher case loads.

Providers reported very mixed experiences of the co-case managing arrangements and working with Job Network providers to support transitions from PSP to Job Network. More effective working relationships with Job Network were associated with co-locating, case managers having previously worked in Job Network, good personal relationships, and Job Network providers being community-based or not-for-profit.

Many case managers spoke highly of other employment programs such as CRS (formerly Commonwealth Rehabilitation Service) and Disability Open Employment Services; however, in general these programs do not provide a continuation of support with the non-vocational barriers faced by PSP clients. The recent change to include transition support as one of the PSP core services was seen, in practice, as making little difference to the work already done.

Exiting PSP

Participants generally exit PSP after two years, or earlier if they achieve an economic outcome or leave for other reasons. Recognised economic outcomes (detailed in Appendix 2) include:

- transition to employment assistance (Intensive Support Customised Assistance, Disability Open Employment Services, or vocational rehabilitation)
- employment, unsubsidised self-employment, or an apprenticeship or traineeship for a minimum number of hours
- participation in an approved education or training course.

Participants that complete two years in PSP are deemed to have achieved a social outcome:

> During this period it is expected that the participant has benefited from PSP and their circumstances have improved. (DEWR 2006c, p.53)

However, in practice this amounts to a two-year completion payment, since there is no attempt to quantify the actual change in social participation. In addition, the present research data indicates that two years on PSP does not necessarily result in improved circumstances or levels of social participation.

On the other hand, the recognition of outcomes broader than just employment is important, and legitimises working towards other goals such as building social networks or encouraging participation in hobbies or clubs. Such activities are crucial given the very low levels of social participation and high levels of social isolation among PSP participants. This broader focus has been also been recognised as an important element of programs such as PSP in other research (O'Donnell et al. 2003).

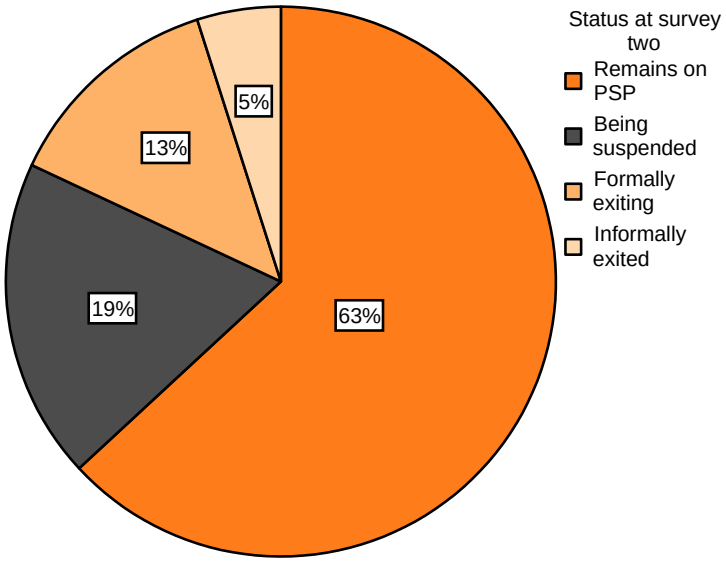
Suspension

Participants can also be suspended (described as an 'allowable break') from PSP under some circumstances. An individual can be suspended for up to 26 weeks while undertaking an economic outcome, or up to 52 weeks to accommodate a change such as illness, imprisonment, or a crisis (DEWR 2006c). Suspension allows for individuals to return to the program if appropriate, and continue their two years from the point at which they left.

PSP status and activities at survey two

At survey two, almost two-thirds of survey participants (63%) were still on PSP, 19% had been suspended from PSP, 13% exited formally and 5% exited informally (see Figure 9.6). Data was not available on the number of economic or social outcomes achieved.

Figure 9.6 Participant status at survey two (n=122)



The most common activity of those that had exited or been suspended from PSP was working, reported by 35%. This was followed by study or training and not working but looking for work, each reported by 23% (see Table 9.9). Pearson chi-squared tests showed that participants who had been exited or suspended were significantly more likely to be working (35% compared with 17%), taking part in an employment program (8% compared with 1%, only significant at the $p < .10$ level), and less likely to be undertaking unpaid or voluntary work (3% compared with 18%) or looking for work (23% compared with 39%). Those suspended or exited were also more likely to be studying or training (23% compared with 13%) or caring for children (8% compared with 18%) but these differences were not statistically significant.

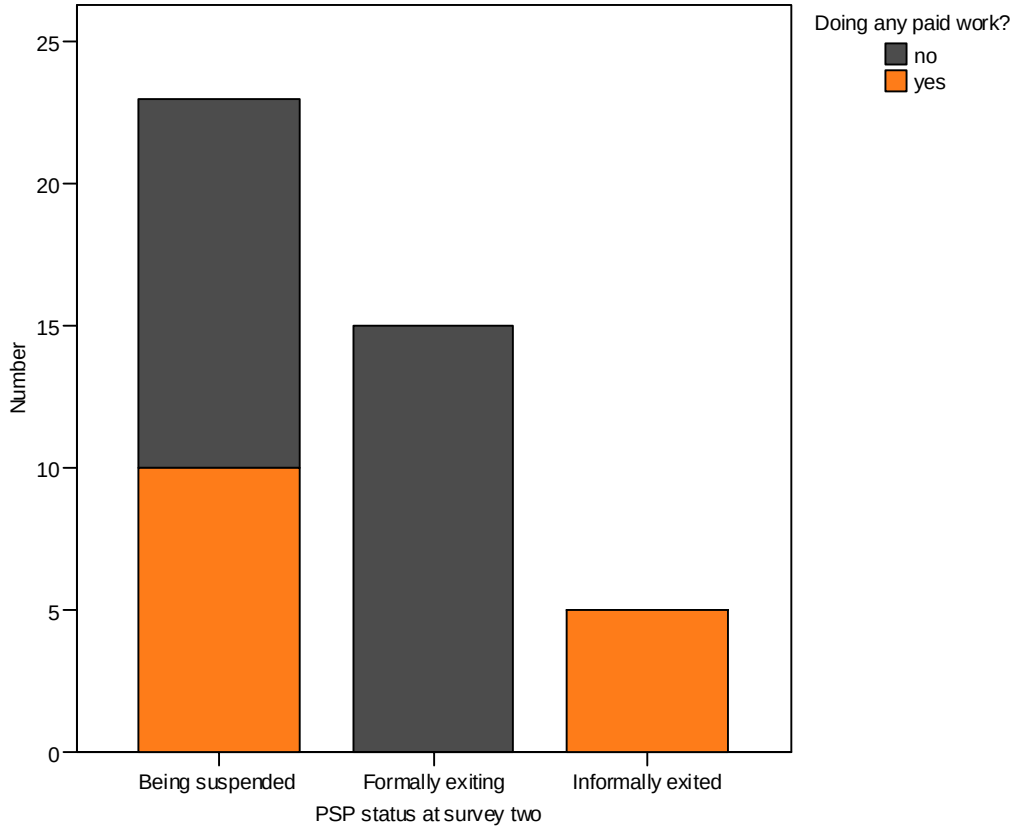
Table 9.9 Activities participants are currently doing or leaving PSP to do

Activity	Exited or suspended		Remains on PSP	
	Percentage	**Number**	**Percentage**	**Number**
Paid work – any type (n=119)	35*	15	17	13
(Working full-time)	*19***	*8*	*0*	*0*
(Working part-time/casual/seasonal)	*16*	*7*	*17*	*13*
Study/training (n=117)	23	9	13	10
Not working, but looking for work (n=117)	23#	9	39	30
Employment program (n=118)	8#	3	1	1
Caring for children or others (n=117)	8	3	18	14
Unpaid work/voluntary work (n=117)	3*	1	18	14
Prison/institution (n=117)	0	0	0	0

# p< .10, * p < .05, *** p < .001 using Pearson chi-squared test

Employment status varied somewhat between participants who were suspended, had formally exited or informally exited PSP (see Figure 9.7). While 10 of the 23 people suspended, and all five people informally exiting were doing some type of work, none of the 15 people formally exiting reported doing any work at survey two.

Figure 9.7 Employment status of participants not in PSP at survey two (n=43)



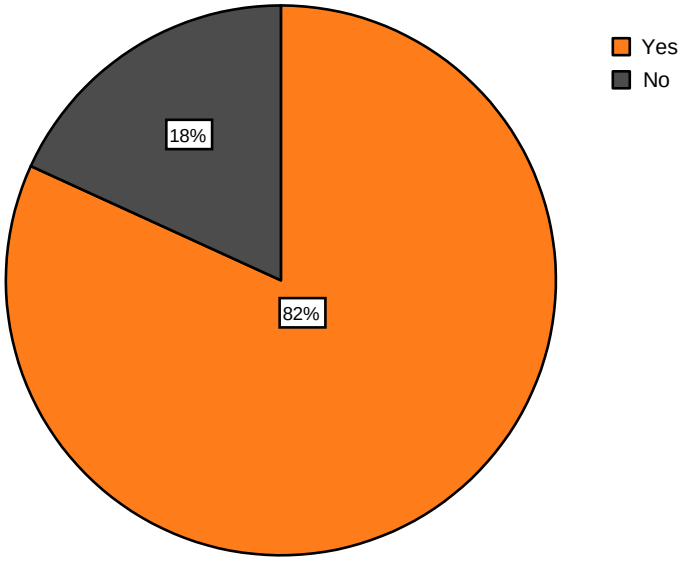
Readiness to leave and ongoing support needs

Of the 23 participants leaving PSP that answered this question, 12 (52%) felt that they were ready to leave. Most reasons for feeling ready to leave were based on achieving their goals or having appropriate support in place, for example ‘Gained employment and stable accommodation’ and ‘I feel I have support in place to help me through’. However a couple of participants reported that they were ready to leave because the program was not providing the support they needed: ‘Every hour spent here [is] not constructive: just double checking by Centrelink’ and ‘I don't think PSP has any more to offer me but I still don’t feel ready for the workforce’. Among the 11 participants not

feeling ready to leave, common reasons included feeling they still required the emotional support or had not adequately addressed their barriers. One person commented that he did not have a choice about leaving after enrolling in a Certificate III course.

A parallel finding was that a large percentage of people stated they wanted to remain on PSP while undertaking their preferred activity. At survey two almost three-quarters of people (74%) wanted to stay on PSP while undertaking their selected activity. This was down from 83% at survey one, but this change was not statistically significant using McNemar's chi-squared test (n=105, p=.122). Similarly, 82% of survey two participants reported that it would be helpful to continue some of the assistance they had been receiving through PSP (see Figure 9.8)

Figure 9.8 Would any of the assistance you have received through PSP be helpful to receive after you cease being a participant (n=110)



Of those wanting assistance after leaving the program, 36% mentioned counselling, 25% ongoing personal support or advice, 20% referrals or information about services, and 14% someone to talk to. The combined total (75%) highlighted the strong need for ongoing personal support.

Table 9.10 Types of assistance participants would like to continue to receive after PSP (n=91) (multiple responses possible)

Assistance type	Number	Percentage (of those wanting assistance after leaving)
Counselling	33	36
Ongoing personal support/advice	23	25
Referrals/information about services	18	20
Someone to talk to	13	14
Study/training advice	6	7
Housing	5	5
Not specified	5	5
Support when needed	4	4
Employment assistance	2	2

Responses coded from participants' descriptions

Case managers' assessments of the assistance that would be required by participants in the 12 months after survey two confirms the continuing high support needs among those leaving the program. The need for the two most common assistance types, counselling and self-esteem or confidence training, was virtually the same among those leaving as among those remaining on PSP

(see Table 9.11). This was also true for study or training, job search skills or support, accommodation support and mental health support services. Those exiting were reported to have a lower requirement for goal setting or decision making assistance (28% compared with 38%), drug and alcohol programs (16% compared with 27%) and work experience or voluntary work (23% compared with 36%). However, the only statistically significant differences were for legal assistance and independent living skills assistance, both of which were required by a greater proportion of people exiting or being suspended from PSP.

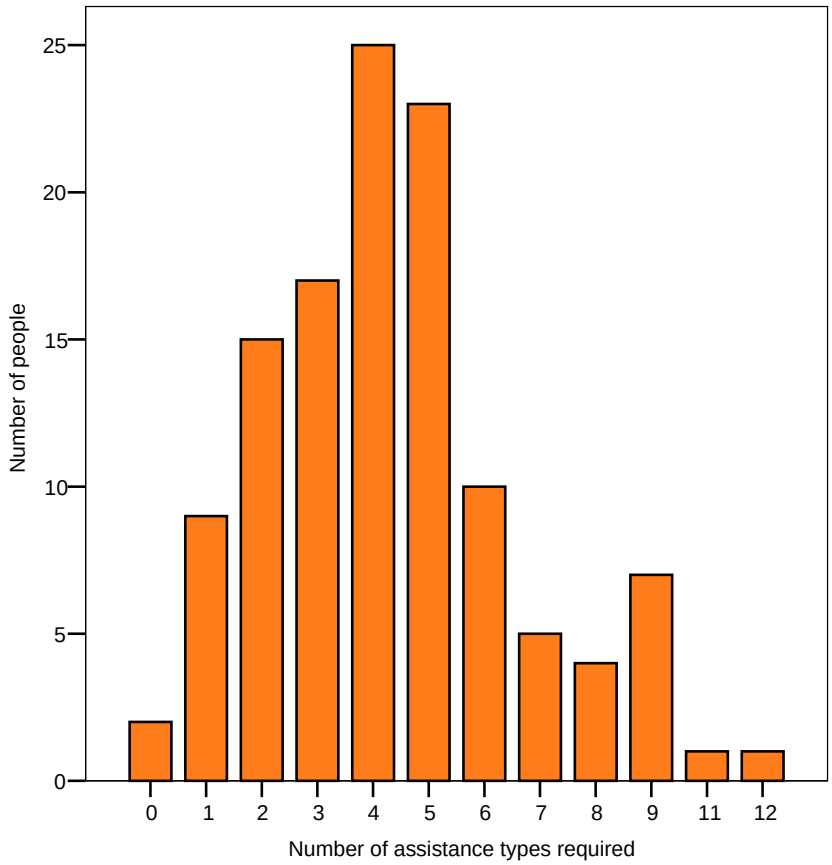
Table 9.11 Assistance required in the 12 months after survey two, case manager assessment

Type of assistance	Percentage of participants being suspended or exiting PSP (n=43)	Percentage of participants remaining on PSP (n=77)
	%	%
Counselling	56	56
Self-esteem/confidence training	33	35
Goal setting/decision making	28	38
Study/training opportunities	40	46
Drug and alcohol program	16	27
Job search skills/support	44	43
Language/literacy/numeracy	30	25
Accommodation/housing	23	21
Work experience/voluntary work	23	36
Financial/budgeting skills	21	23
Health/fitness	28	30
Mental health support services	26	20
Assessments	14	10
Anger management/behaviour management	12	9
Legal assistance	19	7*
Independent living skills	7	0*

* $p < .05$ using Pearson chi-squared test

In addition to the high need for individual assistance types, almost all participants required multiple types of assistance (see Figure 9.9). The average number of assistance types required was 4.37 among those remaining on PSP and 4.33 among those exiting or being suspended from the program. This difference was not significant using an independent samples t-test.

Figure 9.9 Number of assistance types required in the 12 months from survey two, case manager assessment (n=119)



These data, combined with strong evidence of the persistence of personal barriers over time, indicate a strong need to provide ongoing support in critical areas including counselling, drug and alcohol support and mental health). The current assumption that many people will be able to exit PSP into mainstream employment programs such as Job Network does not seem realistic and is likely to be jeopardising long-term participation outcomes, as participants are unlikely to make the transition into employment without additional support. Moreover, case managers in Job Network are likely to struggle to meet the needs of PSP participants due to their lack of experience and skills in addressing personal issues, lack of connections with local support services, and high case loads.

Transition support

Currently PSP guidelines state that transition support must be provided to participants who are ready to move on from PSP to an economic outcome to assist people in sustaining this outcome. Such support is to be provided for a minimum of 4 weeks and up to 6 months. For participants moving to a DEWR-funded employment program, providers are required to negotiate with the new provider to:

- arrange the frequency of contact with the participant
- arrange joint interviews between PSP provider, employment program provider and the participant
- establish a contact schedule between themselves and the relevant provider (at a minimum this must include contact at 13 weeks and 26 weeks) (DEWR 2006c).

For those people moving on to education or training, PSP providers are required to negotiate transition support arrangements with the participant and relevant education or training provider,

while for those moving to employment, self-employment or an apprenticeship/traineeship, transition support must be negotiated with the participant (DEWR 2006c). The lack of a more developed strategy for assisting people moving into work appears to be a significant gap, given research indicating that people facing severe or multiple barriers face a far greater risk of falling out of employment and returning to welfare.

When a person is ready to move from PSP to a DEWR-funded employment program, the PSP case manager can refer them either directly or to a JCA who will then conduct an assessment and make a referral. If referring directly to Job Network, PSP case managers are expected to choose a provider that can best meet the individual's needs, make contact to discuss those needs and goals and arrange or attend the initial appointment. Parallel servicing is then expected to take place over the six-month transition phase.

Case manager views

There was a range of views among providers about the effectiveness of the PSP transition and exit arrangements. Some reported that once clients left PSP, staff had very little contact and were unsure of what happened to them, while others had ongoing contact with many clients that had officially finished the program. One case manager commented that, after two years on the program, 'suddenly other people, other systems have got to come into their lives and sometimes I think it works, but some don't come back, you don't really find out much after that'. Inability to access client details on the system during the transition phase was one factor making this more difficult.

One Centrelink Psychologist reported some difficulty linking high-need clients with appropriate programs and noted that in some cases these individuals are given exemptions from activities after providing a medical certificate. However, this also results in these clients receiving no further assistance. This psychologist remarked that they had seen clients come out of PSP having made significant steps forward but then quickly regress after becoming 'inactive' (they are not able to take part in PSP again until 12 months after finishing the program). The psychologist, along with a number of providers, suggested the need for a bridging program between PSP and employment-oriented programs such as the Job Network. Parkinson and Horn (2002) identified cycling between Job Network Intensive Assistance, the Community Support Program (the forerunner to PSP) and medical certificate exemptions as a common experience for many disadvantaged job seekers.

From July 2006, transition support became one of the PSP core services, along with assessment and regular review; counselling and personal support; referral, coordination and advocacy; and practical support (DEWR 2006b). Most providers felt this would make little difference to the work they already did in this situation, although some felt that it might make case managers take it more seriously. A few people voiced concern about transition support being added as a core function of PSP without any corresponding increase in provider funding and one person also commented on the need for flexibility since some clients do not want contact with their case manager after leaving the program.

Working with other programs

Providers generally reported that only a handful of clients had moved to Job Network. Case managers had very mixed experiences of the six months co-case managing: some felt that the process worked well and that providers were helpful and cooperative, while others had had little contact or perceived that Job Network case managers had little interest in working with PSP clients. One case manager commented that 'there was a bit of "He's mine now, you can go away" sort of stuff', while another remarked 'We don't really work very closely with Job Network … and I know the manual sort of talks about the conferences together and managing the client, but it just hasn't worked that way'.

Factors that seemed to be linked with a more effective working relationship included co-locating with a Job Network provider (although this was not always the case), case managers having

previously worked in the Job Network, and having personal relationships with Job Network staff. Some providers also reported more success working with community-based or not-for-profit Job Network agencies, as they 'tended to be more interested in the client'.

There was also some concern about the assistance supplied by Job Network providers and their lack of expertise in dealing with the issues many PSP clients are facing. One case manager reported that clients were apprehensive about transferring to Job Network because 'they fear being forced into a job or something they don't want' and another remarked on 'an absence of latitude if they [clients] need to step back'. The inappropriate support provided by some Job Network agencies was also recognised by a Centrelink Psychologist who would only refer clients to particular agencies, and noted that many agencies that had been better suited to working with PSP clients had lost their contracts in the third Job Network contract.

Several case managers had had success transferring participants to Disability Employment Assistance and CRS vocational rehabilitation. These were reported to be easier to work with than Job Network, but only clients with a disability or requiring vocational rehabilitation were eligible.

Most providers also had a small number of clients that had moved directly into employment, either by their own initiative or with assistance from their PSP case manager, but often this was reported to be short term. There was a view among case managers that many PSP clients still wanted to work and that the program was better suited to this goal because it allowed them to alter the intensity of their job search depending on circumstances (e.g. depression) and to think more carefully about their employment choice.

A major focus of PSP is to develop an action plan for clients to address and overcome personal barriers. However, there appear to be few progression options that allow a coherent continuation of the barrier-related work of PSP together with employment assistance. This appears problematic for the large proportion of clients requiring ongoing support with non-vocational barriers.

Compliance

Overview

From July 2006, providers have been required to advise Centrelink if a participant fails to meet a participation requirement without a 'reasonable excuse'. Such participants risk losing their payments until they comply, and face an 8-week payment suspension if they have three participation failures in any 12-month period. Individuals defined as 'exceptionally vulnerable' are entitled to financial case management; however this definition is so narrow that it excludes a large proportion of PSP clients.

Research reviewed indicates that individuals with severe personal issues such as those on PSP have a greater risk of being sanctioned because of their difficulties with participation requirements. In addition, such disadvantaged jobseekers were found to encounter greater difficulties than other job seekers when sanctions were applied.

Case managers had mixed views about whether such compliance measures should apply in PSP, but there was very strong agreement from all about the imposition of an 8-week payment penalty, which was seen as excessive. The PSP guidelines and definition of a 'reasonable excuse' were seen as not offering sufficient scope not to lodge participation reports, with common barriers omitted from the definition.

Opinions were also mixed on whether participation reporting could achieve the stated goal of improving engagement. Some felt that it would not, but others felt that used in the 'right' way it might achieve this goal. Some suggested there might be other negative impacts on engagement by harming the case manager–client relationship. However few people felt reporting had made much difference to the way they worked with clients, other than now raising it in commencement interviews.

An extra change in some locations has been the move from three-monthly to fortnightly reporting to Centrelink. Again case managers differed about whether this was a constructive change, although most thought monthly reporting would be more appropriate. Some felt more frequent reporting could help keep people 'on track', while others thought it was simply an increased burden, particularly for clients with severe anxiety, physical health problems or transport difficulties.

Sanctions

From July 2006, a new compliance system replaced the previous 'breaching' system and was extended to a number of programs funded by DEWR. This placed an obligation on PSP case managers to report 'participation failures' (failures to undertake activities required by Centrelink) to Centrelink. The rationale behind this change is described as follows:

> The new arrangements will considerably reduce the chance of PSP participants disengaging and improve their chances of overcoming barriers, and participating in employment assistance (DEWR 2006b, p.3).

Under the new system, individuals that have a 'participation report' lodged with Centrelink and accepted (around 65% were accepted by Centrelink in 2006 (Nagle 2007)), are warned about their non-compliance next time they meet with Centrelink and can avoid penalty by subsequent re-engagement and compliance. If they do not comply, their payment is suspended until they do. Individuals with three participation failures in any 12-month period have 100% of their payment suspended for 8 weeks.

Although participation in PSP previously satisfied the mutual obligation requirement for activity-tested clients, so participants could theoretically have been sanctioned for failing to meet the program requirements, providers were not obliged to report participation failures to Centrelink and in practice sanctioning rarely occurred. One Centrelink Psychologist commented that 'we would *never* breach PSP participants'.

From July 2006, providers must advise Centrelink if a participant fails to comply with the program without a reasonable excuse. The following types of non-compliance must be reported and can constitute a 'participation failure':

- failure to attend the initial interview or subsequent appointment
- failure to attend a JCA appointment initiated by the PSP provider
- refusal to participate or unsatisfactory participation in PSP due to poor attendance or attitude, or unacceptable behaviour (This does not include participants who struggle to meet their activity test or participation requirements due to their non-vocational barriers)
- failure to finish an agreed activity (such as requirement to participate in PSP) due to serious misconduct or violence (DEWR 2006b).

A 'reasonable excuse' for not complying includes 'homelessness or unstable accommodation, lack of literacy and language skills, psychiatric problems or mental illness and drug/alcohol dependency' (DEWR 2006b, p.4). However, this fails to include other common barriers such as physical disability or illness, family breakdown, domestic violence and lack of transport.

Providers are also permitted not to submit participation reports if the participant is defined by Centrelink as 'exceptionally vulnerable' and the non-participation is a reasonable consequence of the participant's non-vocational barriers (DEWR 2006b).

In addition to providers lodging participation reports, Centrelink may also initiate such reports when alerted by the system that a participant has not attended an appointment and a manual report has not been lodged by the case manager.

Financial case management

Those receiving an 8-week non-payment penalty who have dependent children or are defined as 'exceptionably vulnerable' are entitled to financial case management (Centrelink 2006). However, to be so defined, individuals need to meet all of the following criteria:

- have a recognised disability, medical condition, or physical or mental impairment
- require medication to manage that condition or impairment
- not have sufficient funds available to purchase essential medication (Centrelink 2006)

It should be noted that Centrelink does have some discretion in determining eligibility.

Research

Risk of sanctions

A number of studies have indicated that individuals with severe personal issues such as those on PSP have a greater risk of being sanctioned because of the difficulties these cause in complying with participation requirements.

Some Australian studies suggest that groups facing an increased risk of breaching include those with poor literacy and English comprehension, physical and mental disabilities or substance dependency, individuals that are homelessness or in unstable accommodation and those with a recent exposure to violence (Horn & Jordan 2006; Parkinson & Horn 2002; Pearce, Disney & Ridout 2002). However, Eardley et al. (2005) were unable to conclude from quantitative analysis whether breaches were concentrated among these disadvantaged groups.

Even when individuals facing severe barriers are eligible for activity test exemptions, it is suggested that often they are unable to negotiate these with Centrelink and are unlikely to appeal against sanctions (Eardley et al. 2005).

Personal issues that have been associated with an increased likelihood of sanctioning among welfare recipients in the US include having physical or mental health problems, experiencing substance abuse, being a recent victim of physical abuse, having more children, lacking childcare, having an ill or disabled child or other household member and not having a phone or car (Cherlin et al. 2002; Danziger & Seefeldt 2002; Goldberg 2002; Hasenfeld, Ghose & Larson 2004; Reichman, Teitler & Curtis 2005). People sanctioned have been found to be four times more likely to have a substance abuse problem, three times more likely to have a family health problem and twice as likely to have a mental health problem or be a recent victim of domestic violence (Goldberg 2002).

In the UK, sanctioned New Deal clients are reported to be more likely to have multiple barriers including drug and alcohol dependence, a criminal record, lack of social skills, lack of accommodation and health problems (Eardley et al. 2005).

Indeed, the research indicates that failure to comply with welfare rules often has more to do with difficulties associated with personal barriers rather than lack of motivation (Cherlin et al. 2002; Reichman, Teitler & Curtis 2005) and that sanctions can 'exacerbate recipients' already difficult life circumstances by further reducing their income and limiting access to needed services' (Hasenfeld, Ghose & Larson 2004).

Impact of sanctions on individuals

Welfare recipients that are sanctioned have been found to experience material hardships and psychological distress. In Australia, Eardley et al. (2005) reported that breaches resulted in health-related and psychological impacts, housing instability and reduced educational opportunities for young people.

People who had been breached reported effects such as relationship stress, household conflict and having to cut down on medications. Some also reported engaging in illegal activities—including robbery, property crime, drug dealing and street begging—to pay for food, utilities, medication or accommodation (Eardley et al. 2005). Another recent Australian study found numerous disadvantaged job seekers becoming homeless as a direct result of sanctions and around 13% resorting to illegal activities after losing payments (Horn & Jordan 2006).

The impact of sanctions was more severe where there was a lack of family support and after a full loss of payments. Moreover, disadvantaged job seekers encountered greater difficulties than other job seekers after being breached (Eardley et al. 2005). This is particularly relevant to PSP clients given their low levels of family support (see Chapter 8) and multiple types of disadvantage.

US studies have linked sanctions to increased food insecurity, homelessness, evictions, utility shutoffs, poorer health, having to rely on family and friends for financial support or housing and an increased child welfare risk (Cook et al. 2002; Lee, Slack & Lewis 2004; Reichman, Teitler & Curtis 2005). Activities associated with sanctions include selling personal possessions, begging, and stealing. Sanctions also sometimes appear to push people with severe personal barriers off welfare but not into employment (Danziger & Seefeldt 2002; Goldberg 2002; Reichman, Teitler & Curtis 2005), leaving them at risk of extreme deprivation and poverty. Indeed Cherlin et al. (2002) report that sanctions can ensnare families already experiencing hardship and impose further hardships on them.

Case manager views

Although case managers had mixed views about whether participation reporting should have a place in PSP, there was very strong opposition to the imposition of an 8-week payment penalty after three participation failures. This was seen as quite excessive for individuals who are already facing severe multiple disadvantages. As one case manager commented, this level of financial penalty would have a 'massive impact on clients that are already on the edge, and would undoubtedly push some over'. Although case managers were uncertain how many participants would be impacted by the recent changes, a number thought that many could end up getting 'three strikes' over their time in PSP.

At the time of interviews, most, but not all, organisations had lodged a small number of participation reports, but none had had a client lose payments for 8 weeks. Providers spoke of lodging reports when clients had not commenced and were uncontactable and for clients they believed were 'deliberately not coming in'. Some also stated that participation reports had been done automatically by Centrelink: in one case a participant was out of Melbourne for two weeks staying with family and a report was lodged by Centrelink after a letter was sent and they did not attend an interview. Even after an explanation, Centrelink refused to withdraw the report.

Although most agencies had lodged participation reports, almost all said they worked hard to avoid them: comments such as 'We try to do everything possible to avoid getting in the situation' and 'We do everything in our power not to have to do them' were common. This even extended to doing home visits. On occasion, agencies turned a blind eye, as long as there was not an 'underlying bad attitude'. One case manager also stated they would not lodge a report on highly vulnerable clients such as those with severe anxiety. A number of organisations had a policy of sending out a letter with the DEWR script as soon as participants started, to make them aware of the requirements. However, one recipient wrote back saying that he was already very depressed and having the language of 'failing' in a letter about a program he thought was there to help him was very demoralising.

One organisation had resolved not to lodge participation reports and to hand back their contract if pressured on this by DEWR. Another had devised a system to determine when lodging a report would be appropriate. Most agencies, however, had no formal policy on participation reporting and left the decision to case managers.

Some felt that the PSP guidelines provided sufficient scope not to lodge participation reports, but not everyone agreed. The issue of contact difficulties was raised by a number of people, with one person remarking that often PSP clients disappear when in crisis and the case manager, with no way of knowing whether there is a 'reasonable excuse', has to lodge the report with Centrelink or be in breach of contract. It was also commented that despite the severe multiple barriers faced most clients were not flagged as 'exceptionally vulnerable' by Centrelink, so that justification for not lodging a report was not available. The effect of this seemed to be to push providers towards making educated guesses about the reasons for things such as missing meetings and whether these would meet the criteria for a 'reasonable excuse'.

One of the Job Capacity Assessors interviewed felt that the threat of participation reports was the only way to get some participants to come to interviews:

> If there wasn't any threat of losing that (financial support), then what would be the motivation to come? Particularly for people who really struggle with commitments and appointments and things like that. It's harsh, but I'd say it's probably the only thing.

However another JCA highlighted the difficulty of using participation reports in a program such as PSP:

> Clients are referred to PSP because they have problems with attending because of what's going on. It can make it difficult really because that's the whole reason they're on the program.

It was also noted by a JCA that the Participation Solutions Team in Centrelink, which is responsible for participation reports, put a lot of effort into ringing clients and explaining their responsibilities and even reminding them about appointments in order to not have to cut payments.

Engagement

Case managers were split on the question of whether the participation reporting system was able to achieve the stated goal of improving engagement. Some felt that it would not have this effect at all. One person commented that it 'shows huge insensitivity to the level of vulnerability faced by these clients', while another remarked that 'change only comes about when it comes from the client, it cannot be forced externally'. However, several case managers felt that if used in the 'right' way it might be able to achieve this goal. They favoured clearly outlining the requirements, explaining that these were set by DEWR not the PSP provider and explaining that the case managers were there to support the participant and did not want to lodge participation reports but did have to work within these guidelines.

A few case managers said they were already seeing benefits to participants of the new system. One thought that it could 'help clients move up a notch with their attitudes', another said it could 'keep them on track and keep the momentum going', and another that 'it can make them take PSP more seriously'. Some other case managers also felt that with some people lodging participation reports was the only way to get them to come to their initial appointment.

Client relationships

On the other hand, a few case managers suggested that the participation reporting system worked against engagement by impacting on the case manager–client relationship. Few people reported that this changed the way they worked with clients, other than now raising this in the interview, but a number felt it might reduce trust. One person commented that PSP relies on a good relationship with clients and having to lodge participation reports would jeopardise this; another suggested that the threat might lead to anger and resentment with clients attending appointments but being less open to addressing barriers. This had occurred at one agency where a staff member had put through a lot of participation reports and caused many clients (including those she had been working successfully with) to become resentful, with some requesting a change of case manager.

Many others had not found a negative impact on their relationships with clients, or had found this in only a small number of cases. A few commented that the effect would depend on the way that participation reporting was raised with clients. Interestingly, one person remarked that it was much more difficult for clients already on the program then for people referred after July 2006, who had few problems with the new compliance system.

Fortnightly reporting

A separate change that has been made to the PSP compliance requirements in some areas is the frequency of reporting to Centrelink, which has altered from 3-monthly to fortnightly. Again, case managers differed about whether this was constructive. Some commented that many participants found dealing with Centrelink and forms a very stressful experience and that increased reporting would affect their well-being and harm their progress on PSP. Having a break from this pressure was seen as one of the benefits of PSP, particularly for clients that struggle to express themselves, even with a case manager whom they trust. The increased reporting requirement was also seen to be particularly burdensome for clients with barriers such as severe anxiety, physical health problems or transport difficulties.

The transport issue was raised by rural providers who commented that many participants with limited public transport options could have to spend many hours travelling, only to see Centrelink

for a couple of minutes to have their booklet signed. Where public transport operated, it was often infrequent and expensive and people might be forced to hitch or get lifts with family or friends.

The alternative view, put by around half the case managers, was that 3-monthly reporting was too infrequent and that increased frequency could help engagement and keep clients 'on track'. One case manager spoke of aligning the monthly appointment with the Centrelink reporting date and having much better attendance, while another where 3-monthly reporting was still operating commented on a participant who signed his form and 'went up the coast' and was now 'off the radar'. However, a number of people did think that fortnightly was too frequent and that monthly would be more appropriate. Many also felt that exemptions were necessary for participants such as those suffering extreme anxiety; one person reported being able to get these when necessary.

Program funding

Overview

The payment structure appears to cause a significant administrative burden and also results in some distortion in provider behaviour. This was particularly evident in relation to the completion of the Action Plan, which almost all case managers reported completing earlier than was optimal for the client to ensure they did not miss out on the payment. Other issues included difficulty getting verification, and hence payment, for clients that moved into work, and inability to claim the remote loading payment even when case managers at rural providers were doing outreach to isolated clients up to 180 kilometres away.

In terms of overall program funding, the majority of agencies reported that PSP was only viable through cross-subsidisation from other programs. This financial pressure appeared to impact significantly on the ability to work with clients, undertake outreach, provide staff development, and the overall effectiveness of the program. While payments have increased modestly in the last couple of years, this was reported to have had a minimal effect; probably due to the fact thate PSP was already being cross-subsidised from other programs.

Payment structure

PSP Providers receive three main types of payment: administration payments, milestone payments and outcomes payments, described in Table 9.12.

Table 9.12 Regular participant payments

Payment type	Description
Administration payments	• Commencement payment of $660 when the participant starts with the provider • Action plan payment of $660 on the production of an action plan with the client • Exit payment of $165 when a participant exits and an exit report is submitted
Milestone payments	• Two payments of $660 each when a participant completes 8 and 16 months on the program
Outcomes payments	• Social outcome payment of $825 after 2 years on the program and submission of an exit report detailing the social outcomes achieved • Interim economic outcome payment of $1100 after an economic outcome is sustained for 13 weeks • Final economic outcome payment of $440 after an economic outcome is sustained for 26 weeks • Post-outcome support payments $330 or $660 (can also claim 50 per cent of any missed Milestone payment(s) if a participant achieves a final economic outcome and exits PSP before two years) • Completion payment $220 (when a participant achieves an interim economic outcome, then returns to PSP and subsequently completes two years on PSP. No social outcome payment payable)

Other program payments, depending on location or clients' circumstances, include a remote loading payment, interpreter payment and payments for transient participants (see Table 9.13).

Table 9.13 Other payments

Remote loading payment	• $550 for providers to work with participants in remote areas ($275 at commencement and $275 with the 8-month milestone payment)
Remote loading special payment	• $550 for participants designated as 'eligible remote participants' but not living in a remote designated ESA
Interpreter assistance loading	• $660 (eligibility determined by Centrelink)
Transient participant payments	• Reconnection payment of $165 on referral to a new PSP provider **and** a recommencement payment of $660 for the new provider

While some providers found the structure of payments reasonably coherent, many found that it distorted client servicing and workload, with one case manager suggesting that 'Aspects of the payment structure encourage dishonesty in the provider and don't encourage good work for the client'. Another suggested that the funding in the Community Support Program (the forerunner to PSP) was much simpler and more client-focused:

> The CSP funding model was the number of clients you had in your service at that time and you got a payment per quarter. It had a high water mark, so that if you had 90% of your places filled, you'd get 100% of the money. It was great—there were no claims, no invoices. It was a really really simple model, and it was great. Currently we've got a whole lot of workers who feel like it's a better day's work when they do four claims, than when they see four clients. And I just think that's crazy.

A recurrent issue was the administrative burden of entering required information on the system and claiming all possible payments for a client. This was estimated on average to take over 20% of available time, which could otherwise have been spent with clients.

Not receiving a payment for chasing clients who did not commence was considered unjust by many providers. One PSP manager commented that they spent a lot of time, effort, money and petrol running after some clients with no return. Another who had worked in government and the community sector said:

> These clients are much more labour-intensive to administer than *any* other program I've seen … Chasing some people down, three or four addresses later, can take a long time. It would be good to have the recognition of that work.

A more widespread concern than commencement payments was the action plan payment and the incentive this created to do the action plan quickly even when it was not in the best interests of the client. This was commonly described as a tension between financial pressure to sign up clients and action plan quality. One manager had staff doing action plans after three months because she thought this was the 'ethical way', but after hearing at network meetings that other providers did it at the first meeting, they started doing that also, to ensure they received the payment. Many other case managers made similar comments:

> Because we're so reliant on the funding to keep going, you need to get your action plan done quickly, that's the way we see it here. And so, it would be better if the funding wasn't tied as much to the action plan.

> Action plans are done as soon as possible, they try to do them on the first visit, and on the second visit only if the client is very distressed—purely to get the payment through quickly, and because some clients don't come back after the second or third visit, and this is being very honest about it … at least we've got something out of it … It's realistic, we can be very idealistic about it, but that's how it is, isn't it?

A few case managers remained committed to not rushing the action plan and doing it only when the client was ready, sometimes waiting up to three months, while others reported doing the action plan on the system then doing the 'real' action plan, or adding to the initial one later. However the problems this could create were noted by one provider:

> If you want to be an economic rationalist, you'd do it in the first five minutes. The problem with the approach of doing the action plan immediately and then adjusting it later on, is that if the client is transferred, the next provider who still needs to do the work in a thorough way, won't get a payment.

Milestone payments were less of a problem but also created an incentive to keep clients in the program regardless of their best interests. This issue was raised by providers not receiving the payment if the client leaves just before reaching 8 or 16 months. It was also of concern because it can count against providers in the High Performance Indicator Framework (developed to determine whether providers will be offered further PSP contracts).

Claiming payments for clients who moved into employment was regarded as problematic by many case managers due to the difficulties of verification, including Centrelink's inability to disclose the client's employment status. Some case managers found that clients did not want to tell them or did not want to have contact once they had exited or been suspended from the program.

Issues with payments for transient participants were raised by some providers. These included when clients relocated close to the end of the two years and the final outcome payment was claimed by the second provider, and when clients were transferred early on and had already had the action plan claimed. Another case manager had found the reconnection payments 'impossible' and had never successfully claimed one. She gave an example of a client who relocated to northern NSW and was on the waiting list of a new provider for more than 28 days, which meant that they dropped off her system.

Rural and regional providers reported that due to the remote loading payment being postcode-based and excluding any Victorian locations (FaCS 2002), they did not receive it for any of their clients. This was despite having to visit isolated rural properties requiring up to three hours' travel.

Financial viability

Almost all providers reported that PSP was an extremely difficult program to run on the funding available and more than half reported cross-subsidising it from other programs. Such top-up funds were often used for things such as brokerage or running a car.

> PSP really struggled at the start, now we're only just scraping even. There've been times we can barely pay the wage of the case manager and so we've had to dip into other little buckets to pay for different things, particularly for clients and it has been difficult … We often have to do that.

Funding constraints led to significant frustration among many case managers:

> There are a lot of good people out there with good intentions, but they're just shackled by the lack of resources.

> I've been doing it on the cheap, which is the only way we could do it. If you really paid the right people to do these things, I'd have run the organisation broke long ago. Unless you do things like that, on the way it's funded, it's just not going to happen.

This lack of funding was also seen as impacting on the overall effectiveness of the program, the ability to refer clients to required services, to do outreach and to provide staff development. A few agencies reported having no money for staff training, while one reported having $150 per staff member every two years.

Most providers thought the doubling of the commencement payment in 2004 from $300 to $600 had made little improvement in overall financial viability (probably because most agencies were already having to cross-subsidise from other programs), but a couple of people felt it had made a difference.

Suggested changes to the payment structure included:

- introducing grades of payment depending on the level of barriers faced by the client, to allow more money to be spent on those most in need
- introducing an overall administrative fee, possibly incorporating the Action Plan payment
- block funding (possibly with outcome payments as well) to reduce the administrative burden and allow more time with clients
- a proportional outcome payment for clients who transfer to another provider almost at the end of their two years on the program.

Performance measurement

Performance measurement

The High Performance Indicator Framework (HPIF) and Key Performance Indicators (KPIs) in their current form did not appear to be a very effective measure of the quality of work done with clients, although there was evidence that they did encourage the desired behaviour in areas such as commencing referred clients.

There was also evidence of these measures increasing pressure on providers and diverting case managers from working with clients. Similarly, the performance audits seemed not to measure or facilitate improvements in the quality of work being undertaken with clients, instead focusing on basic administrative issues and encouraging a system-oriented rather than client-focused approach.

Suggestions for improving the performance measures included reporting that was designed to demonstrate how the work being done had contributed to client progress. The 8 and 16-month contracts were seen as already providing useful information to do this. Another person suggested linking the performance measure more closely to client satisfaction with the services delivered.

The performance of PSP providers is assessed against KPIs and measures derived from them known as the High Performance Indicator Framework. The three KPIs are:

- **efficiency**: the timeliness of participant reports and contacts
- **effectiveness**: the extent to which PSP providers engage and maintain participants in the program and the proportions of participants for whom social and/or economic outcomes are achieved
- **quality**: the extent to which PSP providers deliver quality services in line with the principles and commitments in the funding deed, the Employment and Related Services Code of Practice and the PSP Service Guarantee (DEWR 2006b). (See Appendix 3 for details.)

The High Performance Indicator Framework uses four specific measures to compare performance of individual providers against nationally derived benchmarks and is used by DEWR to allocate new business or reallocate existing business. The four HPIF measures are:

- referral to commencement ratio
- retention rate
- timeliness of exit reports (proportion submitted within 15 days)
- outcome rate (proportion of economic outcomes and/or social outcomes achieved) (DEWR 2006b).

The outcome rate is a new indicator added in 2006 and values economic outcomes at a slightly higher rate than social outcomes. Interim economic outcomes are valued at 1.08 times social outcomes, and final economic outcomes at 1.2 times social outcomes.

In addition, DEWR conducts occasional performance audits of providers to ensure they are adhering to the PSP contract.

Case manager views

Almost all case managers felt that the KPIs and HPIF were not a useful measure of the quality of work done with clients and several commented that these had a detrimental impact by increasing administrative work and pressure on providers and diverting attention from client needs. They also suggested that the performance measures were not fair as they measured things over which providers often had little control and could penalise case managers acting in the clients' best

interests. An example was given of a client with a drug problem who did not want to commence with a provider in a particular location due to drug relapse concerns, and the negative impact this would have on their statistics.

Others felt that the measures were too broad to capture the different ways in which case managers worked with clients. For example, a rural case manager reported that due to the lack of local services she took on a wider role that could include family mediation, financial counselling and even helping participants to get their learners' permit. Such additional work is not recognised by the administrative or outcome performance measures. One person suggested the increasing focus on performance measures was indicative of a new system-oriented and prescriptive approach being taken by DEWR and that this was resulting in the client focus being lost.

The new outcomes measure was seen by most as signalling an increased emphasis on moving people into employment, with a number of case managers expressing concerns that it could result in participants being 'pushed' into work before they were ready. There were also concerns about the addition of this new area of work without a corresponding increase in funding and about the lack of allowance for different labour market conditions.

Most providers reported performance audits to take place only occasionally. For example, one person reported having an audit in mid 2004 and another only one audit in September 2003. As with the performance indicators, case managers generally felt that the audits did not really evaluate the quality of work with clients. Audits were reported to have included asking people to quote the PSP guidelines, checking logos on paperwork, checking pamphlets and having the right stickers on the door. There seemed to be a strong emphasis on correct paperwork with almost no questions about the type of work that was undertaken with clients. One case manager reported that auditors just pulled out three files to check that they matched what was on the PSP system.

Suggestions for improving the performance measures included reporting that was designed to demonstrate how the work done had contributed to client progress. The 8 and 16-month contracts already provided useful information to do this. Another person suggested linking the performance measure more closely to client satisfaction with the services delivered.

Overall effectiveness

Overview

Both case managers and PSP participants were generally positive about PSP overall, but made a number of suggestions for improvements. Focus groups emphasised the need for more group and community-based activities and better connections to employment and training programs, while the biggest issue reported by survey participants was the need for more brokerage funds or financial assistance and more frequent or intensive assistance.

Case manager views

Case managers were almost unanimous that PSP was an effective and crucial program for assisting highly disadvantaged welfare recipients. Given this group's significant and entrenched disadvantage, they thought that a program that provided long-term support and allowed people time out from Centrelink requirements to address their underlying issues was very valuable. Several suggested that many clients had a history of being forced through a series of programs, some of them quite onerous but not helpful, so they desperately needed a program that focused on their goals.

Including social as well as economic outcomes was widely praised by case managers. As one case manager said, 'It reflects the complexity of their lives'. Others suggested that the social participation component allowed a genuine focus on individual needs. Encouraging participation in non-vocational activities and increased social contact was seen as important in developing

relationships and reducing the fear of social interaction, which could then lead to reduced social isolation and a re-engagement with society. Some case managers felt strongly that improved social participation led to better employment outcomes down the track.

The factor most often mentioned as reducing overall effectiveness was the chronic lack of funding, resulting in an inability to provide required assistance and case loads that were too large for the required intensity of support.

Participant views

Participants were also generally positive about the effectiveness of PSP overall, but suggested a number of improvements. Focus group suggestions were mainly about having more group and community-based activities, with a number of people commenting that being part of the focus group and hearing what other people were going through had been a very helpful experience. For example:

> I think this sort of atmosphere is good too, because then you know you're not alone, or that other people can be worse off than you.
>
> I'm thinking I'm the only person going through this, but hearing all these point of views and that … I understand a lot more you know … You realise you're not alone.
>
> I guess the one thing I thought PSP might have is more community group type stuff where people like us can talk and … because we can't do it in other situations. That's the only thing.
>
> Group sessions would be great, you know, for people like me who are really scared of them. I'm feeling a little bit more comfortable after listening to everybody sitting here.

Several people also suggested better connections to employment and training programs, in particular links with business and jobs that individuals could be supported to move into. This was seen as not only providing financial benefits but also 'integrating people back into the community' and improving self-esteem.

Participants were also asked in survey two about how PSP could be improved. The most popular improvement, mentioned by almost half of the 69 respondents, was more brokerage funds or financial assistance (see Table 9.14). Common expenses requiring this funding included short courses, groups and activities, external support services and public transport tickets. Other people mentioned financial help for those in a crisis and one person said simply 'Financial support to help achieve goals'. The strong awareness of low funding restricting participation in courses and other activities highlights the very real constraints on the program's ability to improve participation.

The other commonly mentioned improvement was more frequent or intensive assistance, which was mentioned by around a quarter of respondents. This included comments such as 'More frequent and longer appointments', 'More regular support and assistance' and 'More time spent on clients'. Several participants also suggested more time on PSP or the option to stay longer; and several suggested more group work and better service linkages or access (see Table 9.14).

Table 9.14 PSP improvements suggested by participants (coded survey responses) (n=69)

Improvement	Number	Percentage
More brokerage funds/financial assistance	30	43
More frequent/intensive support	18	26
Longer duration	6	9
More group work	5	7
Better service linkages/access	5	7
Greater employment/training focus	4	6
Continuity of case manager	4	6
Other	7	10

10 Conclusion and recommendations

The past decade has seen increasing international recognition that the most disadvantaged job seekers are not well served by mainstream welfare-to-work models based on rapid labour market attachment and minimum cost interventions. This has led to the development of targeted programs such as PSP that address personal barriers as well as providing vocational assistance.

Personal barriers affecting many disadvantaged job seekers are a major impediment to employment and to social inclusion more generally. If not adequately addressed, they increase the likelihood of staying on welfare—or cycling on and off it—with substantial ongoing social and economic costs. Multiple personal barriers present an even greater risk; and numerous studies have demonstrated that the more barriers an individual faces, the less likely they are to exit welfare-to-work and then stay in work. However, employment for these people is possible with appropriate support.

Nature and extent of barriers

Participants in the PSP were found to be facing extreme disadvantage. This included severe and multiple personal barriers, in addition to low levels of education (70% had attained year 11 or less) and long-term unemployment. At survey one, individuals faced an average of 8.5 barriers: the four most common were family relationship breakdown, confidence or self-esteem problems, mood disorders including depression, and social isolation or alienation, all affecting more than half the participants in the sample. Anxiety conditions, drug problems, financial management problems and homelessness each affected 30–50% of participants, while almost 80% faced some type of mental health problem (anxiety, depression or a personality disorder).

The acute disadvantage was further evident in low social participation, high social isolation and poor relationships with family and friends. Participants were more than five times more likely than the general population to live alone, and reported much less frequent social contact than the general population or other unemployed and very high interference in normal social activities from physical health or emotional problems. Satisfaction with relationships with their partner, children, family and friends was also substantially lower than among the broader population or other unemployed people. Findings were similar for broader measures of social support, including having anyone to confide in; having people to help out when needed; and having someone to help out with food, money or accommodation if needed.

High proportions of participants were unable to do basic social activities, including going to the cinema, eating out in a restaurant, going shopping, having a drink in a bar, or going to sporting events, due to emotional, physical health or financial issues. Other measures of social participation, such as membership of sporting, hobby, or community clubs and associations or of political parties, and regular attendance at a place of worship, were all also far below levels in the broader community.

Compounding these disadvantages was extreme financial deprivation. Events such as going without meals, being unable to heat the home, asking family or friends for financial help or being unable to pay utilities bills, the rent or mortgage were four to 12 times more common among the PSP sample than among the population generally.

However, an important finding was that, despite the range of barriers faced, participants expressed a strong desire for economic participation. At survey one, around 73% of participants identified paid work (40%) or study (33%) as the activity they would most like to be doing. Work or work readiness was the most common goal participants wanted to achieve on while on PSP; and working or looking for work was the most common activity people could see themselves doing after PSP.

Impact of PSP on economic and social participation

Multiple measures were used to explore the extent to which PSP enabled people to achieve increased economic and social participation between survey one and two. Overall, the results indicated that participants had higher levels of economic and social participation and less interference from barriers they were facing. While most measures showed change in the 'right' direction, this was not always statistically significant; and when it was, the scale of the change was often modest. There were also some concerning results, such as the increase in prevalence of a number of barriers between survey one and two, and the high ongoing support needs of participants even when exiting PSP or coming to the end of their time on the program.

Several factors need to be kept in mind when assessing the scale of changes achieved. These include the high level of entrenched disadvantage of this client group, the relatively small sample size, the fact that participants were followed up after only 12 months of a 24-month program and the extremely low funding levels for a program working with such a highly disadvantaged group, severely restricting ability to access required services and provide intensive support.

Measures of change in the impact and prevalence of barriers between survey one and two identified positive but limited change. Fifteen of the 26 barriers with at least 10 people with valid data at surveys one and two showed statistically significant reductions in their impact on economic and social participation. Greatest reductions in impact were found for homelessness, alcohol problems, legal issues, and grief issues. Although there were many barriers with reduced impact, only a small number of people experiencing each barrier at survey one were not experiencing the barrier at all at survey two. For example, for each of the five most common barriers (all affecting over 50 people) fewer than four people no longer experienced the barrier at all at survey two (based on case managers' ratings), pointing to a strong persistence of barriers over time. In addition, only one barrier (homelessness) showed a significantly reduced prevalence at survey two; and five barriers showed significant increases in prevalence.

Other barrier measures also showed mixed results and suggested that, while PSP seems to be making some gains, there is substantial room for improvement. There was little change in the prevalence of the 13 factors participants identified as holding them back from work, other than a reduction in family or personal problems. However, the percentage of people reporting that nothing was holding them back increased markedly from 1% to 14%. Achievements relating to participants' own goals showed greater positive change. Of the 12 goal types identified by participants at survey one, seven showed statistically significant improvements in average scores at survey two. These were generally larger than the improvements in barrier ratings reported by case managers. On the other hand, two of the most common goal types (addressing personal or emotional issues and improving skills or study) had no statistically significant change. More en encouraging results were the reduced proportions of participants requiring four assistance types, including self-esteem or confidence training, drug and alcohol services, and housing support, suggesting an improvement in the related barriers.

Four economic participation measures showed significant change, three of them positive. The percentage of people doing some type of paid work increased from 4% to 24%. However, no data was available about the sustainability of these outcomes. The percentage of people no longer receiving income support increased from 1% to 8%; and self-assessed readiness for work also showed a statistically significant improvement. However, while the proportion of people choosing work as their preferred activity at survey two remained constant, the proportion of people choosing study as their preferred activity actually decreased.

Most social participation indicators revealed improvements between survey one and two, but many were not statistically significant; and among those that were, the level of change was generally modest. Frequency of social contact showed a statistically significant increase, with a notable improvement among those with the least social contact. Interference in normal social activities from physical health or emotional problems improved slightly, but there was little improvement in

satisfaction with relationships with family and friends, participation in regular social activities, civic participation, or abilities to cope with everyday things such as 'stressful situations'. The very high levels of financial deprivation also showed little change at survey two.

Strengths and weaknesses of PSP

The PSP model

Many elements of the Personal Support Programme model were found to be in line with good practice approaches identified in research in the European Union and the United States. Particular strengths of the program include:

- a holistic model of assistance
- strong partnerships with local agencies to provide a wide range of support services
- a focus on addressing clients' underlying personal barriers
- smaller case loads than regular employment assistance, and more intensive case management, although case loads were still high compared with most effective models overseas
- a recognition that some clients are unable to work or meet regular welfare-to-work requirements
- a strengths-based approach, incorporating participants' goals and objectives
- greater flexibility to meet clients' varied and complex needs than in other programs such as Job Network
- a broad definition of outcomes extending beyond an employment focus.

However, some additional elements identified as critical to the success of programs with this client group are absent from the PSP model. These include:

- adequate resources of people, money and information
- ongoing staff training specific to this client group
- integrated employment or community participation activities for those clients who have the capacity to undertake them
- inclusion of group work
- ongoing barrier-specific post-employment personal support.

Lack of integrated employment assistance

The current approach to employment assistance for PSP participants is based on a sequential model, where individuals first address personal barriers in PSP, and then move on to other programs to receive employment assistance. Employment assistance provided within PSP is minimal and ad hoc. Such limited provision is not supported by research and fails to recognise the importance of work as part of the broader recovery process or the high support needs that many people will face after moving into work.

While the program does allow for participants to be transferred to the Job Network to receive employment assistance (with a 6-month co-case managing period), this is inappropriate for most participants who will require ongoing personal support to manage other barriers, and does not allow for the integrated approach found to be critical in other research. Other programs such as Disability Employment Assistance or vocational rehabilitation provided by CRS (formerly Commonwealth Rehabilitation Service) are likely to be more effective, but do not have the focus of PSP on assisting people to overcome personal barriers.

There is strong evidence that appropriate employment can be realistic and beneficial, and that programs integrating personal and vocational support can achieve positive outcomes with people such as those on PSP, who face personal barriers. Key elements of effective interventions include small case loads, long-term support, rapid movement into work, seeing 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. Two particularly promising models of vocational support for individuals facing severe barriers are the Individual Placement and Support (IPS) model, used primarily in the mental health sector, and the Transitional Employment Program (TEP) model.

The importance of providing improved employment support through such interventions is also highlighted by the strong desire of many PSP participants to participate in employment or education or training. It is even possible that the current approach, which in effect removes people from the labour market for two years, may contribute to further inactivity, as self-perceived readiness for work was strongly related to the time since last working, and other studies have found evidence of a causal negative relationship between unemployment and poorer mental health and well-being.

Lack of funding and access to services

The inadequate funding for PSP is a major weakness that is severely impeding the capacity of the program to achieve positive outcomes. The main consequence was inability to access services required by participants. Agencies delivering PSP reported being able to allocate (from general program revenue) a maximum of $150 brokerage per client per year, and a number of agencies had no brokerage funds available. By comparison, highly disadvantaged job seekers in the Job Network are automatically allocated $1350 brokerage funds through the Job Seeker Account.

Case managers reported difficulties in providing the required assistance due to cost in 90% of cases and made numerous comments in interviews about the frustration of being unable to provide the assistance required because of lack of funds. Frustration was also evident from participants; and increased brokerage was the improvement most commonly recommended, by over 40% of survey participants.

Lack of funding also had other impacts, creating higher than appropriate case loads and limiting intensive work with clients and provision of ongoing staff development.

Due to low funding levels, case managers were forced to rely primarily on free or low-cost services, but often had difficulty accessing these. Waiting lists were listed as a difficulty in 45% of cases, services not being available at all in 38% of cases, not being appropriate in 35% of cases and lack of transport in 28% of cases. However, lack of appropriate services and inadequate transport were both reported as obstacles by substantially more providers in non-metropolitan areas.

Providers reported the greatest shortfall in meeting the needs of PSP clients for counselling, which was required by two-thirds of all clients. Access to other services varied, but case managers reported that it was rare for clients to get into any service immediately and that they were ‘stretched across the board’. Some participants had positive views about the ability of PSP to connect them with local services and activities; however, many others were frustrated or felt that there had been insufficient referrals, usually due to costs involved. A number also suggested that the support to connect them with services was inadequate.

Other issues

Other weaknesses identified included:

- the payment structure causing a significant administrative burden and also resulting in some distortion in provider behaviour, such as prematurely completing action plans to ensure payment
- long waiting times between referral and commencement, with over 40% of people having to wait three weeks or more
- lack of group work and activities for participants
- assistance being inadequate in frequency or intensity. Many case managers and participants suggested that the minimum 4-weekly contact was insufficient; and more frequent contact was the second most common improvement mentioned by survey respondents.

Social outcomes

Although social outcomes are part of PSP language, the only appraisal is more like a two-year completion payment. There is no attempt to quantify the actual change in social participation: instead two years on PSP are simply deemed to be evidence of a social outcome:

> During this period it is expected that the participant has benefited from PSP and their circumstances have improved. (DEWR 2006c, p53).

Data collected as part of this research indicates that this assumption is incorrect and that not all participants improve their circumstances or levels of social participation. However, the recognition of outcomes broader than just employment is a crucial element of PSP, and provides legitimacy in working towards other goals such as building social networks or encouraging participation in hobbies or clubs. Such activities are vital given the very low social participation and high social isolation among PSP participants. This broader focus has been also been recognised as an important element of programs such as PSP in other research.

PSP's recognition of social as well as economic outcomes was also widely praised by case managers. As one case manager said, 'It reflects the complexity of their lives'. Others suggested that the social participation component allowed a genuine focus on addressing individual needs. Encouraging participation in non-vocational activities and increased social contact was seen as important in developing relationships and reducing the fear of social interaction, leading to reduced social isolation and re-engagement with society more broadly.

Recent changes in PSP

Job Capacity Assessment system

The new referral system using Job Capacity Assessors (JCAs) generally seemed to be working well. Almost all case managers felt that the JCA reports were an improvement on those under the previous system.

However, two significant issues were the lack of continuity through a single contact person responsible for PSP clients, as had been the case when Centrelink Psychologists were doing referrals, and the lack of integration of JCAs and the JCA systems with broader Centrelink systems. This hindered the flow of information and caused what one case manager called a 'division of knowledge'. Providers also had mixed reports about working with the Senior Customer Service Officers, with some reporting that they were not easy to contact and that due to their broad roles it was harder to get simple PSP-related things done.

Compliance

While some positive effects of the new compliance system were suggested by case managers, it seems likely that the severity of the current penalty system will cause severe harm to PSP clients. Other research has shown that individuals facing severe personal barriers are more likely to be unable to meet participation requirements. In addition, when sanctioning does take place, the negative effects have been demonstrated to be greater for more disadvantaged job seekers, those without good social support and those who lose 100% of payments. All of these factors apply to people on PSP, suggesting very large potential impacts.

Case managers also had mixed views about whether sanctioning should have a role in PSP, but were unanimous that the 100% payment loss was quite inappropriate for a group already facing such high levels of disadvantage and could have extremely detrimental impacts on individuals that are often already 'on the edge'. Other problems with the compliance system were the narrow ness of the definitions of 'extremely vulnerable' category (by which job seekers become eligible for financial case management) and of a 'reasonable excuse' in the PSP guidelines (this does not include some common barriers such as physical disability or illness, family breakdown, domestic violence and lack of transport).

However, comments of a number of case managers suggest that there may be scope for a less punitive compliance system to improve engagement by encouraging participants to take the program more seriously and helping to keep them on track.

Views were also mixed about the move in some areas from 3-monthly to fortnightly reporting to Centrelink. Although fortnightly reporting was seen as too frequent, some people thought monthly reporting could help to keep some participants engaged; however there was concern about the difficulties caused for those with anxiety, physical disabilities or inadequate transport.

Performance measurement system

The HPIF and KPIs in their current form do not seem to be very effective measures of the quality of work done with clients, although they seemed to foster the desired behaviour in areas such as encouraging case managers to put extra effort into commencing referred clients. There was also evidence of these measures increasing stress and pressure on providers and diverting case managers from working with clients. Similarly, performance audits seemed to have little capacity to measure or facilitate improvements in the quality of work with clients, instead focusing on basic administrative issues and encouraging a system-oriented rather than client-focused approach.

The addition to the HPIF of the outcomes measure weighted in favour of economic outcomes seems to be a blunt instrument for achieving increased economic participation, particularly when it is not accompanied by any additional resources or strategies to develop employment skills among PSP case managers.

Integration with other programs

The integration of PSP with other employment assistance programs and transition arrangements did not seem to operate smoothly. In general, post-PSP programs do not appear to provide continued support with PSP clients' non-vocational barriers, and to embrace the goals and strategies identified to overcome these. Providers reported mixed experiences of the co-case managing arrangements and working with Job Network providers, although more effective working relationships were associated with co-locating, case managers having previously worked in Job Network, having good personal relationships, and community-based or not-for-profit Job Network providers.

A number of PSP case managers expressed concern about the assistance supplied by Job Network providers and their lack of expertise in dealing with the issues many PSP clients face. The lack of adequate support provided by some Job Network agencies was also recognised by a Centrelink

Psychologist who would only refer clients to particular Job Network agencies, and noted that many that had been better suited to working with PSP clients had lost their contracts in the third Job Network contract. Many case managers spoke highly of other employment programs such as CRS and DOES.

The evidence of the need for ongoing personal support was compelling. Around half of those leaving did not feel ready to do so, and 74% of all survey two participants wanted to stay on PSP while undertaking their preferred activity (mostly work or study). Over 80% reported that it would be helpful to continue to receive some types of assistance after leaving PSP—most commonly counselling; personal support or advice, or having someone to talk to.

High ongoing support needs were also highlighted by case managers' assessments of assistance required in the 12 months after survey two. The proportion of individuals exiting or being suspended that required the two most common assistance types (counselling and self-esteem or confidence training) was virtually the same as among those remaining on PSP, as was the average number of assistance types required.

These data, combined with strong evidence of the persistence of personal barriers over time, point to a strong need to provide ongoing support in critical areas including counselling, accommodation and mental health. The current assumption that a large proportion of people will be able to exit PSP into mainstream employment programs such as Job Network does not seem realistic. Moreover, case managers in Job Network are likely to struggle to meet the needs of former PSP clients, due to their lack of experience and skills in addressing personal issues, lack of connections with local support services and inability to provide the intensive support required due to higher case loads.

Limitations and further research

Questions that require additional research include the sustainability of any increases in economic or social participation and the broader longer term outcomes. There are also some limitations of the current research, including the lack of a control group enabling changes to be ascribed directly to PSP; the small sample size; lack of independent interviewers conducting surveys; and the high variability in average barrier numbers and scores by case manager.

Recommendations

Overall, the PSP is a crucial program delivering essential support to some of the most marginalised unemployed people in Australia. It is achieving some positive outcomes by facilitating increased social and economic participation, but is severely constrained by the extremely low levels of funding, difficulties accessing required services and lack of specialist integrated employment assistance.

Project findings concur with other research in suggesting that individuals facing such severe disadvantage do have the capacity and desire for meaningful participation in society *if* appropriate support is provided. Low levels of investment and commitment to achieving outcomes will achieve low level results.

Many elements of the PSP are well designed and are in line with good practice identified in research internationally; however real investment is required to realise the potential of the program to achieve substantial change for large numbers of participants.

To improve the ability of PSP to achieve economic and social outcomes for participants, the Brotherhood of St Laurence, Melbourne Citymission and Hanover Welfare Services call on the Australian Government to consider the adoption of the following recommendations:

1. Improve employment assistance available to participants

1.1. Trial the use of the Individual Placement and Support model of employment assistance, which has been found highly effective in placing disadvantaged individuals with mental health problems in competitive employment.

1.2. Allow participants who move into employment or education to remain on PSP till the end of their two-year period so as to receive ongoing barrier-related support and facilitate sustained economic participation.

1.2.1. Ensure this support is provided to all participants for a minimum of six months, even if this runs over the two years.

1.3. Allow PSP participants access to Wage Assist wage subsidies with continued support from the PSP case manager.

1.4. Establish an integrated approach to employment assistance for highly disadvantaged job seekers that places participants in temporary jobs where they are able to gain meaningful employment experience and skills combined with intensive personal support. Examples that could be trialled include the Transitional Employment Program and the Intermediate Labour Market approach.

2. Increase funding

2.1. Introduce a Personal Support Account in PSP, similar to the Job Seeker Account in the Job Network, to ensure that case managers do not face difficulties in providing the required assistance due to cost, as currently occurs in 90% of cases.

2.2. Improve overall funding to the program to allow case loads to be reduced, more intensive client work to be undertaken and staff training to be increased.

3. Boost mental health support available through PSP

3.1. Provide funding to enable employment of workers with clinical mental health skills and/or access to specific mental health training for PSP workers (e.g. Certificate IV Mental Health), through the Individual Placement and Support model (1.1 above).

3.2. Explore the co-location of PSP providers with community mental health teams.

3.3. Ensure PSP participants have access to relevant specialist mental health programs (including those funded under COAG such as Personal Helpers and Mentors, Support for Day to Day Living).

4. Change compliance requirements for PSP participants

4.1. Abolish the eight-week non-payment penalty for PSP participants.

4.2. Change the definition of 'reasonable excuse' to cover any reasonable excuse related to the participant's personal barriers.

4.3. Remove the requirement to report participation failures when the provider is unable to contact the participant but believes the reason for the participation failure is due to the participant's personal barriers.

5. Increase the use of group and community participation activities in PSP

5.1. Identify and promote appropriate models of group work as a cost-effective means of increasing contact with participants, improving social networks and assisting in overcoming other barriers.

5.1.1. Provide training to PSP providers in running group sessions, or contract other agencies to provide this service.

6. Reform the PSP payment structure

6.1. Reduce reporting requirements to lessen case manager time taken up with administration.

6.2. Introduce an 'isolation payment' for remote clients (over 100 km from PSP providers) requiring outreach in rural and regional areas where providers are not eligible for the remote loading payment.

6.3. Match participant records to provide automatic verification of employment outcomes achieved.

7. Provide better connections with Centrelink

7.1. Integrate JCAs into Centrelink, including providing access to Centrelink systems to improve the flow of information.

7.2. Have a dedicated PSP worker in all Centrelink offices.

8. Improve the performance management system

8.1. Review the HPIF to enable a stronger focus on direct service delivery and sustainable outcomes for participants.

8.2. Implement annual performance audits to evaluate the effectiveness of work undertaken with clients and extent to which this has addressed individuals' personal barriers.

9. Other recommendations

9.1. Increase PSP places to ensure average wait times between referral and commencement do not exceed five days.

9.2. Allow providers to extend (by six months) the time on PSP of up to 10% of participants who have not moved into employment.

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Appendix 1 Correlations of barriers

Table 10.1 Survey sample co-occurring barriers

Barriers (overall sample proportion in brackets)	Kendall's tau-b	Percentage of those with barrier B also experiencing barrier A	Percentage of those with barrier B also experiencing barrier A	Percentage of sample experiencing both barriers
A Experienced/experiencing sexual abuse/assault (9%) B Experienced/experiencing physical abuse/assault (8%)	.53*	55	60	5
A Learning disorder (6%) B Literacy/numeracy problems (16%)	.46*	86	30	5
A Physical disability (23%) B Ongoing medical/dental condition (20%)	.44**	52	60	12
A Lack of access to transport (17%) B Lack of suitable jobs in the area (40%)	.35**	77	33	13
A Motivational problems (27%) B Lack of confidence/skills in seeking work (28%)	.34**	53	51	14
A Significant legal issues (17%) B Experienced/experiencing physical abuse/assault (8%)	.34*	29	60	5
A Very long term unemployment (29%) B Periods in custody (11%)	.33**	27	71	8
A Very long term unemployment (29%) B Motivational Problems (27%)	.32**	49	53	14
A Periods in custody and/or criminal record (11%) B Significant legal issues (17%)	.32*	50	33	6
A Significant legal issues (17%) B Torture or trauma experience, or other stress disorder (6%)	.32*	24	63	4
A Confidence/self-esteem problems (63%) B Lack of suitable jobs in the area (40%)	.30**	51	80	32
A Very long term unemployment (29%) B Age (9%)	.30*	22	73	6
A Significant legal issues (17%) B Facing significant grief/loss issues (21%)	.29*	48	37	8
A Significant legal issues (17%) B Anger/conflict/behavioural management problems (22%)	.28*	48	36	8
A Financial management problems (37%) B Significant legal issues (17%)	.27**	30	67	11
A Homelessness (33%) B Alcohol problems (28%)	.26**	45	53	15
A Very long term unemployment (29%) B Lack of confidence/skills in seeking work (28%)	.26**	46	49	13
A Very long term unemployment (29%) B Mood disorder (61%)	.26**	81	39	24
A Very long term unemployment (29%) B Ongoing medical/dental problem (20%)	.25*	35	52	10
A Lack of confidence/skills in seeking work (28%) B Lack of suitable jobs in the area (40%)	.25**	60	41	17
A Very long term unemployment (29%) B Alcohol problems (28%)	.25**	46	47	13
A Limited education, training or skills (21%) B Insufficient work experience (21%)	.25*	41	41	8
A Drug problems (39%) B Experienced/experiencing physical assault/abuse (8%)	.25*	16	80	6
A Significant legal issues (17%) B Lack of access to transport (17%)	.24*	38	36	6

A Very long term unemployment (29%) B Confidence/self esteem (63)	**.24****	**81**	**38**	**24**
A Ongoing medical/dental condition (20%) B Lack of access to transport (17%)	**.24***	**36**	**41**	**7**
A Periods in custody and/or criminal record (11%) B Drug problems (39%)	**.24***	**71**	**20**	**8**
A Periods in custody and/or criminal record (11%) B Anger/conflict/behavioural management problems (22%)	**.24***	**50**	**25**	**6**
A Drug problems (39%) B Anger/conflict/behavioural management problems (22%)	**.24****	**35**	**61**	**13**
A Alcohol problems (28%) B Significant legal issues (17%)	**.24***	**31**	**52**	**9**
A Confidence/self-esteem problems (63%) B Experienced/experiencing sexual abuse/assault (9%)	**.24****	**14**	**100**	**9**
A Confidence/self-esteem problems (63%) B Insufficient work experience (21%)	**.24****	**29**	**85**	**18**
A Motivational problems (27%) B Limited independent living skills (6%)	**.24***	**15**	**71**	**4**
A Periods in custody and/or criminal record (11%) B Alcohol problems (28%)	**.23***	**57**	**22**	**6**
A Financial management problems (37%) B Poor communication/language skills (7%)	**.23***	**15**	**79**	**6**
A Very long term unemployment (29%) B Legal issues (17%)	**.23***	**30**	**52**	**9**
A Alcohol problems (28%) B Lack of suitable jobs in the area (40%)	**.23***	**58**	**41**	**17**
A Motivational problems (27%) B Social alienation/isolation (54%)	**.23****	**74**	**36**	**20**
A Periods in custody and/or criminal record (11%) B Mood disorder (61%)	**.23****	**93**	**17**	**10**
A Age (9%) B Social alienation/isolation (54%)	**.23****	**91**	**15**	**8**
A Periods in custody and/or criminal record (11%) B Social alienation/isolation (54%)	**.22****	**86**	**17**	**9**
A Alcohol problems (28%) B Lack of access to transport (17%)	**.22***	**31**	**50**	**9**
A Motivational problems (27%) B Mood disorder (61%)	**.22****	**79**	**35**	**21**
A Family relationship breakdown/issues (65%) B Experienced/experiencing physical abuse/assault (8%)	**.22****	**12**	**100**	**8**
A Family relationship breakdown/issues (65%) B Facing significant grief/loss issues (21%)	**.22****	**28**	**85**	**18**
A Very long term unemployment (29%) B Family relationship breakdown/issues (65%)	**.22****	**81**	**37**	**24**
A Very long term unemployment (29%) B Insufficient work experience (21%)	**.22***	**35**	**48**	**10**
A Poor communication/language skills (7%) B Lack of suitable jobs in the area (40%)	**.21***	**78**	**14**	**6**
A Mood disorder (61%) B Facing significant grief/loss issues (21%)	**.21****	**28**	**82**	**17**
A Confidence/self-esteem problems (63%) B Motivational problems (27%)	**.21***	**34**	**79**	**21**
A Confidence/self-esteem problems (63%) B Social alienation/isolation (54%)	**.21***	**63**	**73**	**39**
A Insufficient work experience (21%) B Lack of confidence/skills in seeking work (28%)	**.20***	**44**	**34**	**9**

A Insufficient work experience (21%) B Lack of suitable jobs in the area (40%)	**.20***	**59**	**31**	**13**
A Very long term unemployment (29%) B Drug problems (39%)	**.20***	**54**	**41**	**16**
A Social alienation/isolation (54%) B Gambling problems (5%)	**.20***	**9**	**100**	**5**
A Family relationship breakdown/issues (65%) B Significant legal issues (17%)	**.20***	**22**	**86**	**14**
A Personality disorder (8%) B Anxiety condition (46%)	**.20***	**80**	**14**	**6**
A Motivational problems (27%) B Lack of suitable jobs in the area (40%)	**.19***	**56**	**37**	**15**
A Motivational problems (27%) B Family relationship breakdown/issues (65%)	**.19***	**79**	**33**	**21**
A Family relationship breakdown/issues (65%) B Torture or trauma experience, or other stress disorder (6%)	**.19****	**10**	**100**	**6**
A Confidence/self-esteem problems (63%) B Lack of confidence/skills in seeking work (28%)	**.18***	**34**	**77**	**21**
A Anxiety condition (46%) B Facing significant grief/loss issues (21%)	**.18***	**29**	**63**	**13**
A Very long term unemployment (29%) B Lack of suitable jobs in the area (40%)	**.18***	**54**	**39**	**16**
A Anxiety condition (46%) B Ongoing medical/dental problem (20%)	**.18***	**28**	**64**	**13**
A Family relationship breakdown/issues (65%) B Limited training, education, or skills (21%)	**.18***	**27**	**82**	**17**
A Drug problems (39%) B Family relationship breakdown/issues (65%)	**.18***	**76**	**45**	**29**
A Confidence/self-esteem problems (63%) B Family relationship breakdown/issues (65%)	**.18***	**71**	**70**	**45**
A Confidence/self-esteem problems (63%) B Anger/conflict/behavioural management problems (22%)	**.17***	**28**	**79**	**17**
A Confidence/self-esteem problems (63%) B Ongoing medical/dental problem (20%)	**.17***	**25**	**80**	**16**
A Family relationship breakdown/issues (65%) B Lack of suitable jobs in the area (40%)	**.17***	**46**	**75**	**30**
A Family relationship breakdown/issues (65%) B Experienced/experiencing sexual abuse/assault (9%)	**.17***	**12**	**91**	**8**
A Social alienation/isolation (54%) B Anxiety conditions (46%)	**.17***	**54**	**64**	**29**
A Social alienation/isolation (54%) B Torture or trauma experience, or other stress disorder (6%)	**.17***	**10**	**88**	**6**
A Confidence/self-esteem problems (63%) B Experienced/experiencing physical abuse/assault (8%)	**.16***	**11**	**90**	**7**
A Family relationship breakdown/issues (65%) B Acquired brain injury/other organic mental illness (4%)	**.15***	**6**	**100**	**4**

Appendix 2 Recognised economic outcomes of PSP

Economic outcomes recognised in PSP are:

- employment or unsubsidised self-employment or an apprenticeship or traineeship for an average of 15 hours per week or which generates enough income to reduce a person's basic rate of income support payment by an average of at least 60 per cent over the outcome period
- employment or unsubsidised self-employment or an apprenticeship or a traineeship that is on average at least 70 per cent of the minimum number of hours per week in the range as assessed by Centrelink, a JCA provider or another party identified by DEWR, but is not less than an average of 8 hours of work per week, for a participant who has been identified and recorded on DEWR IT systems as having a disability and a partial work capacity prior to commencing employment
- employment or unsubsidised self-employment or an apprenticeship or a traineeship of an average of 10 hours per week for a participant who is in receipt of Newstart Allowance or Youth Allowance (excluding individuals in full-time study or who are already New Apprentices) with part-time participation requirements, and who is identified and recorded on DEWR IT systems by Centrelink or another party identified by DEWR, as a parent or having a disability prior to commencing employment
- employment or unsubsidised self-employment or an apprenticeship or a traineeship of an average of 10 hours per weeks for a participant who is in receipt of Parenting Payment (Partnered or Single)
- participation in an education or training course of 13 weeks or more at a full-time study load (where 'a full-time study load' is defined by the institution)
- participation in a part-time education or training course (where 'part-time' is defined by the institution) and employment for an average of at least 15 hours per week
- participation in an ABSTUDY, Youth Allowance or Austudy eligible education or training course of one or more semesters
- participation in a Commonwealth-funded vocational rehabilitation programme (vocational rehabilitation)
- participation in Job Network–Intensive Support customised assistance (Job Network–ISca)
- participation in Disability Open Employment Services (DOES)
- participation in another activity that DEWR may notify the PSP provider, from time to time, as being an economic outcome (DEWR 2006c).

Appendix 3 Key performance indicators for PSP

KPI	Description	Measures
Efficiency	Timeliness of participant reports and contacts	• Length of time between referral and Commencement • Length of time between Commencement and submission of completed Action Plan • Length of time between 8 and 16-month Milestones and submission of completed Milestone Reports • Length of time between exit and submission of finalised exit report
Effectiveness	Extent to which PSP providers engage and maintain participants in the program. Proportions of participants for whom Social and/or Economic Outcomes are achieved.	• Ratio of referrals to commencements • Proportion of participants with completed Action Plans • Proportion of participants on Allowable Breaks and reason • Proportion of participants on Allowable Breaks for achieving economic outcomes • Ratio of interim economic outcomes/ final economic outcomes to Allowable Breaks for economic outcomes • Proportion of participants achieving interim (13 weeks) economic outcomes • Proportion of participants achieving final (26 weeks) economic outcomes • Ratio of final economic outcomes to interim economic outcomes • Proportion of participants achieving social outcomes • Duration of participation with the PSP provider and exit reason • Proportion and type of exits without an outcome • Ratio of finalised exit reports to exits
Quality	Extent to which PSP providers offer a service to participants that complies with the funding deed and is in accordance with the Code of Practice and PSP Service Guarantee.	DEWR satisfaction with the delivery of services, including but not limited to: • Evidence of delivery of personalised services to participants, through findings of site visits, quality audit projects or other qualitative information, and • The number or type of serious complaints, series of complaints, and active management of complaints, including assisting DEWR in negotiating complaint resolution.

Source: DEWR 2006c