Personal Support Programme evaluation

Interim report

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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
FaCS	Department of Family and Community Services
HILDA	Household, Income and Labour Dynamics in Australia [survey]
JSSP	Job Seeker Support Panels
MIFS	More Intensive and Flexible Services
PSP	Personal Support Programme

Summary

This report presents the interim findings of an evaluation of the Personal Support Programme (PSP) being carried out by the Brotherhood of St Laurence, Melbourne Citymission and Hanover Welfare Services. The PSP provides intensive case management 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. It is estimated that in 2005–06 50,000 people will receive assistance through the program.

The aim of this study is to evaluate the extent to which the Personal Support Programme (PSP) enables people with multiple non-vocational barriers to achieve economic and/or social outcomes. Results will be used to advocate 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 the first wave of surveys carried out with 134 PSP clients across metropolitan and non-metropolitan providers in Victoria, in-depth interviews with case managers across 15 PSP providers and interviews with Centrelink workers and PSP staff working at the Department of Family and Community Services and the Department of Employment and Workplace Relations. A second wave of participant surveys will take place by late 2005 and a further limited follow-up in the first half of 2006. A final report will be completed in the second half of 2006.

Research and good practice

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 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 result in a significantly increased likelihood of staying on welfare —or cycling on and off it—resulting in substantial and ongoing social and economic costs. Facing multiple personal barriers presents an even greater risk and numerous studies have demonstrated that the more barriers an individual faces the lower the likelihood they will exit welfare-to-work and then stay in work.

Of further concern is research indicating that welfare recipients facing personal barriers are less able to meet more onerous welfare-to-work requirements and are significantly more likely to be sanctioned, resulting in increased hardship and poverty.

Many elements of the Personal Support Programme model are in line with best practice identified in research in the European Union and the United States. 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

- a recognition that some clients are unable to work or meet regular welfare-to-work requirements before addressing personal barriers
- a strengths-based approach
- greater flexibility to meet clients' varied and complex needs
- 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, in terms 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
- ongoing barrier-specific post-employment personal support.

Results

Data from participant surveys illustrates the high level of disadvantage experienced by PSP participants. Around 50% of the sample have been homeless in the past five years, 70% have year 11 or less as their highest level of education and 78% suffer from a mental health problem such as anxiety, depression or a personality disorder. They also have an average length of unemployment before entering PSP of around two and a half years.

All clients surveyed face at least two barriers and the average number of barriers faced by participants in the sample is nine (from a list of 42 barriers). Common barriers include:

- family breakdown (66%)
- lack of self-confidence/self-esteem (65%)
- social isolation / alienation (56%)
- drug problems (40%)
- homelessness (35%)
- alcohol problems (31%)
- anger / conflict / behavioural difficulties (26%)
- physical disability (23%).

In addition clients also appear to be at considerable risk of social isolation. They are significantly more likely than the general population to live alone and 75% experience physical health or emotional problems that interfere with their normal social activities, compared with only 17% of the general population.

Despite these barriers, the vast majority of clients reported a desire to participate in either employment or further education and training and a large proportion (58%) have engaged in some form of employment over the past two years; however, the majority of this is casual work.

Around 40% of respondents indicated that they want to be working now and a further third would like to undertake further study or training now. However, intensive support to enter and stay in the workforce appears to be crucial: 84% of clients state that they would like to stay on PSP after gaining work or starting some other activity. In line with overseas research, case managers indicate that a very common pattern was for clients to move into work but be unable to sustain this due to the other issues they were dealing with.

Despite a desire to work being expressed by a significant proportion of PSP participants and around a quarter considering themselves very ready or close to very ready to work, it appears that the program model is not well designed (or funded) to deliver employment assistance at the same time as providing assistance with non-vocational barriers. This seems to overlook the potential of work to assist in overcoming personal barriers, as well as the range of abilities and goals across the client group.

The PSP approach is significantly different from that used with similar client groups in the US and EU, where there has been a greater focus on delivering intensive personal support in tandem with employment assistance developed specifically for clients facing non-vocational barriers.

This type of integrated approach has also been used locally with long-term unemployed residents on the Atherton Gardens public housing estate and in the YP^4 project working with young homeless job seekers. The Atherton Gardens model incorporates a number of dimensions: community engagement, work experience, personal support, pre-vocational training, job placement and post-placement support, and accredited training qualifications through traineeships. The YP^4 model is an integrated approach across the domains of housing, employment assistance and personal support, aiming to achieve durable outcomes for young homeless job seekers.

The lack of better integrated and specifically developed employment initiatives is currently a significant impediment to the effectiveness of PSP. However, it is also important to note that PSP's focus on goals that are broader than employment and its recognition that some participants are unable to engage in employment or related activities before addressing personal barriers are critical elements of the program. Moreover, around a quarter of participants consider themselves completely 'not ready' for work and 93% identify one or more barriers that are holding them back from work.

Program delivery

In terms of program delivery, the most significant concern is the inadequate program funding to assist a client group facing such significant disadvantage (recently announced small funding increases may improve this situation but are insufficient). This is evident in case managers reporting difficulties in almost 90% of cases in delivering the required assistance due to cost and their numerous comments about the resulting frustration of being unable to provide the assistance required because of cost. Due to low program funding, agencies reported being able to allocate (from general program revenue) a maximum of $120 brokerage per client per year, and a number of agencies reported having no brokerage funds available. In the Job Network, by comparison, providers receive $1350 brokerage per disadvantaged job seeker through the Job Seeker Account to work with a client group facing less severe barriers to participation.

Lack of funding is a key issue given the program's case management model and the scarcity of free or low-cost services. It impacts on the provision of services from counselling and mental health to education and training.

Adequate funding to facilitate access to education and training is 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 labour market outcomes and this is already identified by case managers as a required assistance type for around 50% of clients.

Lack of appropriate services and transport are both considerable difficulties in providing required assistance outside Melbourne. Lack of transport was reported as an obstacle with 28% of clients at non-metropolitan providers, compared with 14% of clients at outer-suburban and only 4% at inner-suburban providers. A similar pattern existed for services being unavailable in the area, which was reported as a difficulty for 51% of clients of non-metropolitan providers, compared with 28% and 14% of clients of outer and inner-metropolitan providers respectively.

Waiting lists for services were a problem for all providers, and reported as a difficulty in providing required assistance in almost 50% of cases. Of particular concern, given the high level of mental health problems, was the lack of access to counselling (beyond what could be delivered internally), which was listed as a required assistance type for two-thirds of participants. This combination of low program funding, scarcity of low-cost services and long waiting lists place a considerable constraint on PSP's operation.

Referral and engagement

The referral process and relationship with Centrelink seemed to operate reasonably well except for the long waiting times between a participant's referral and their first appointment with Centrelink: some 15% of participants reported waiting over 10 weeks. Also of some concern was the fact the one-third of clients reported not being given a choice of provider.

The significant positive relationship identified between the level of client engagement reported by case managers and the number of barriers faced suggests that PSP is successfully engaging those with the most severe barriers (of those who commence and stay on the program). However, quantitative and qualitative data indicate that clients with some barriers are more difficult to engage. Homelessness, very long term unemployment (over two years), periods in custody and/or a criminal record, drug problems, family relationship breakdown, anger/conflict/behavioural difficulties and intellectual disability all showed a statistically significant negative relationship to the level of engagement reported by the case manager.

Providers generally felt that referrals to the program were appropriate, although there was some concern about clients with serious mental health issues, particularly personality disorders, who were perceived to have support needs beyond what could be provided for through PSP. There were also health and safety concerns raised about working with clients with violent backgrounds and lack of disclosure of this by Centrelink in some cases.

Payments and funding

The payment structure appears to cause a significant administrative burden and also results in some distortion in provider behaviour. This was particularly visible 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 move 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, outreach, staff development and the overall effectiveness of the program. While small recent increases in payments have occurred, they are unlikely to make a significant difference to clients, given the operating deficit that most providers reported facing.

Transition and exit

Transition and exit arrangements are an area where there is significant scope for improvement, as present arrangements do not appear to provide an integrated pathway of assistance to a significant proportion of clients. Only a handful of clients (estimated by providers at 5–10%) were successfully making the transition to Job Network; and providers reported very mixed experiences of the co-case managing arrangements and working with Job Network providers generally (although recent policy changes have improved this situation somewhat). More effective working relationships with Job Network were associated with co-locating, case managers having previously worked in Job Network, having good personal relationships, and Job Network providers being community based or not-for-profit.

International evidence suggests that, for a large proportion of clients facing significant personal barriers, mainstream employment services such as the Job Network are not appropriate. This is due to the lack of integrated personal support, the absence of links to necessary support services in the community; a lack of expertise in supporting clients with severe personal issues; and the inability to provide the intensive and flexible case management required.

Many case managers spoke highly of other employment programs such as CRS (formerly Commonwealth Rehabilitation Service) and Disability Open Employment; however, in general these programs do not provide a continuation of support with the non-vocational barriers faced by PSP clients. There is also some concern expressed by case managers and Centrelink psychologists about those clients who move out of PSP and after providing medical certificates are given exemptions from participation requirements, but also no further assistance.

Overall effectiveness

Overall PSP appears to be a crucial and well-designed program for assisting some of the most disadvantaged job seekers, but there are also a number of elements which reduce its effectiveness. Adequate resourcing is essential to helping these people back into the workforce. Indeed, this also represents an investment likely to provide substantial returns to the society as a whole, for without it there is a high likelihood of individuals remaining on some form of government benefit for the long term.

1 Introduction

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2 Disadvantage in the labour market

There is a growing recognition amongst 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; 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 Orol (2004) suggest that the combination of personal barriers and human capital characteristics are more important in predicting medium and high levels of welfare accumulation than demographic factors.

In their early work looking at the impact of personal barriers, Olsen and Pavetti 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 (Olson & Pavetti 1996).

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. A number of other studies have found personal barriers to be associated with increased time on welfare and faster returns to welfare (Derr, Hill & Pavetti 2000; Nam 2005; Pollack et al. 2002; Seefeldt & Orzol 2004; Social Research Institute 1999).

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 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; Danziger et al. 2000).

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; Waghorn & Lloyd 2005). Butterworth (2003b) found that 57% of long-term welfare recipients reported depression and that around 15% suffered from post-traumatic stress disorder, and that amongst 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, p.154) 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 (Waghorn & Lloyd 2005). 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; Waghorn & Lloyd 2005). Mental health problems have also been shown to increase the risk of sanctioning and be associated with more rapid returns to welfare (Jayakody & Stauffer 2000; Nam 2005). Reviewing the literature, Derr et al. found that post-traumatic stress disorder, major depression and generalised anxiety all significantly increased the likelihood of long-term welfare receipt (2000).

A range of 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 significant 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 compared with those without (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% (Waghorn & Lloyd 2005).

Multiple barriers

While the presence of a mental health problem or other single barriers 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 (Chandler, Meisel & Jordan 2002) 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 (Nam 2005).
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 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

Australia

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 1988a). 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 (1988b) 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 Centrelink psychologist, disability officer or social worker 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 clients 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’.

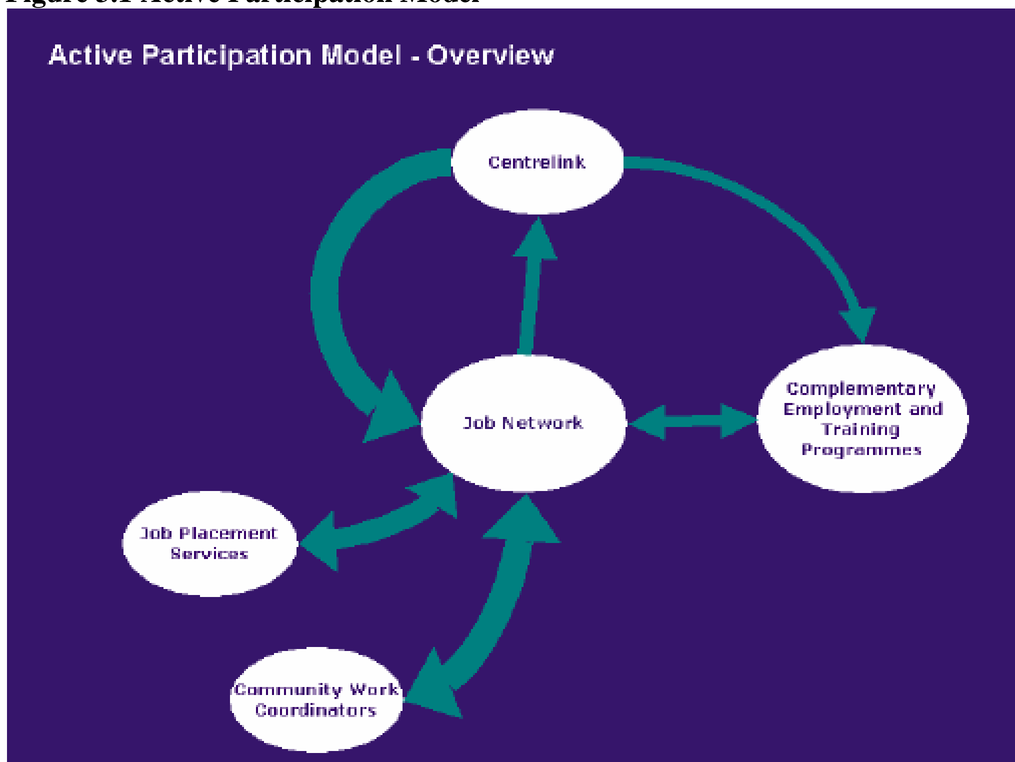
PSP in a broader employment context

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

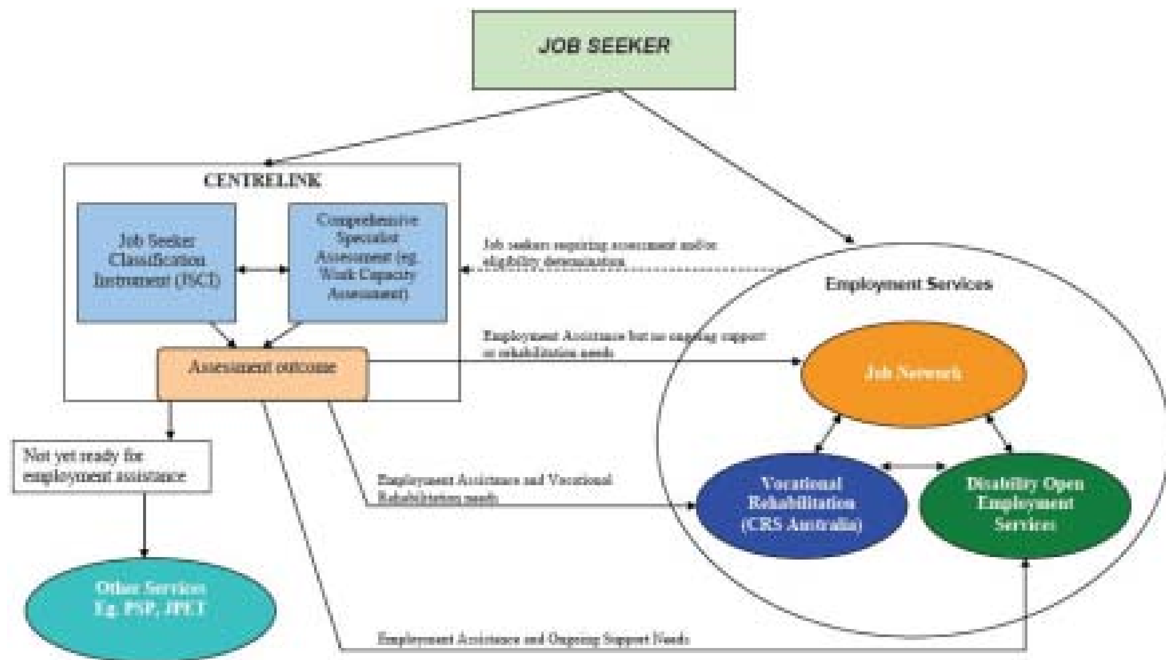
The delivery of Job Network services is contracted to private and non-government organisations, which are funded primarily on outcomes achieved. They provide varying levels of assistance depending on a job seeker's assessed disadvantage and length of time unemployed.

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 (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. While Job Network, CRS and Disability Open Employment are all seen as employment-focused services, JPET and PSP are classified as programs for those not ready for employment assistance.

Figure 3.2 Operating environment for disability employment assistance



Source: DEWR 2005b, p.6

JPET

The JPET program is 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 leaving or in 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 significantly greater focus on education and employment (Butlin et al. 2002).

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 et al.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 the 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 et al. 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 are likely to require ongoing support to gain and maintain employment. However, under recently announced changes, 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 Disability Open Employment Services, 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 Disability Open Employment. 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 (resume writing, interview skills etc.), 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 at Centrelink results in some clients facing significant barriers staying in the Job Network.

The Job Network's effectiveness of the for disadvantaged clients 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 is actually intensive and personalised (ANAO 2005).

International approaches

US and EU 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) 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). 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 with which member states must align their policies. 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 the achievement of 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 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 a legitimate step 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 (Bliss 2001; Brown 2001; Centre for Law and Social Policy 2003).

In contrast to Australia's PSP, all of these approaches have a primary focus on the gaining of employment, rather than a broader goal including increased social participation.

Of particular interest, but no surprise, is the strong connection to the labour market maintained by almost all US programs working with clients with multiple barriers. Thirty-six states report that they strive to keep the program's primary focus 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 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 review of state strategies for working with hard-to-place clients carried out by the US Office for the Inspector General in all 50 states 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 2002).

Researchers reviewing a range of 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 it is now a core theme in the EQUAL initiative, with all projects 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 significantly 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 emphasises 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, there is an intention that it 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 in the UK found that a pathway approach was appropriate for disadvantaged clients, and that the development of 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; ESU 2000; European Foundation 2002; European Foundation 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 Evaluating the Personal Support Programme

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 for 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 is the nature and extent of non-vocational and employment barriers faced by PSP participants?
2. To what extent is the PSP enabling people with multiple barriers to achieve economic and/or social outcomes?
3. What are the PSP's strengths and weakness in terms of service delivery to participants?
4. To what extent have the changes from the CSP arrangements improved assistance and outcomes for the target group?
5. What are the values and meanings of 'social outcomes' and how are they assessed?
6. As a practical expression of the Government's AWT and welfare reform initiatives, to what extent is the program model resulting in better outcomes for participants?
7. How integrated is the PSP with the suite of employment assistance and support programs (including SAAP)?
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

Client surveys were carried out with 134 PSP participants who had been on the program between two and twelve months. Surveys contained three sections, one of which was 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. A follow-up survey will be completed by clients and case managers twelve months after the initial survey, or upon exit if the client leaves PSP before their two-year period is complete.

Clients also authorised a Freedom of Information request for the researchers to access a range of information from their Centrelink file six months after survey 2. This will give an indication for all clients, including those who are lost from the sample between surveys 1 and 2, about whether they are working, the type of benefit they are on and changes in their JSCI score.

Three client focus groups have also been conducted with PSP participants who have been on the program between two and twelve months.

In-depth interviews were carried out with case managers across 15 PSP providers, as well as with PSP staff in Centrelink and the Department of Family and Community Services.

5 Results

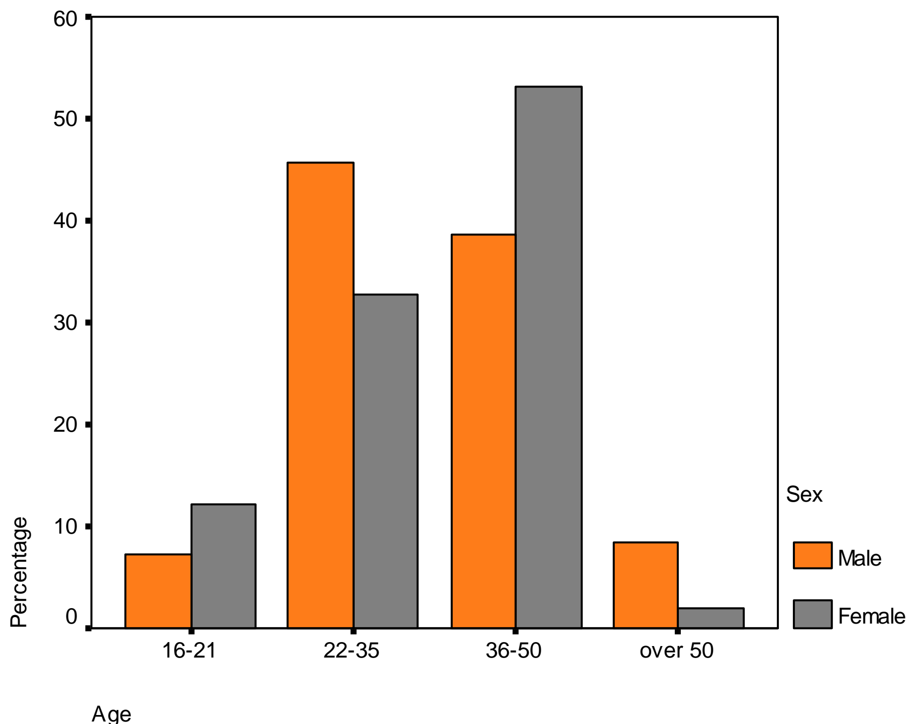
Client demographics

Data regarding the characteristics of PSP participants at an aggregate level has not been made available by the Department of Employment and Workplace Relations at this stage, but discussions are continuing to enable this to take place for the final report.

The participants in the present sample ranged from 16 to 60 years at the time of the first interview. The average age was 35 for females and 36 for males, but the sample was quite widely spread, with 25% aged over 45 and 25% aged under 27. Overall 63% were male and 37% female.

Figure 5.1 shows the gender distribution across age groups. The greatest proportion of males (46%) are in the 22–35 category, while the greatest proportion of females (53%) are in the 36–50 category. Females have a greater representation in the young (16–21) and middle age (36–50) while males are over represented in the 22–25 and over 50 age groups.

Figure 5.1 Participant gender by age group



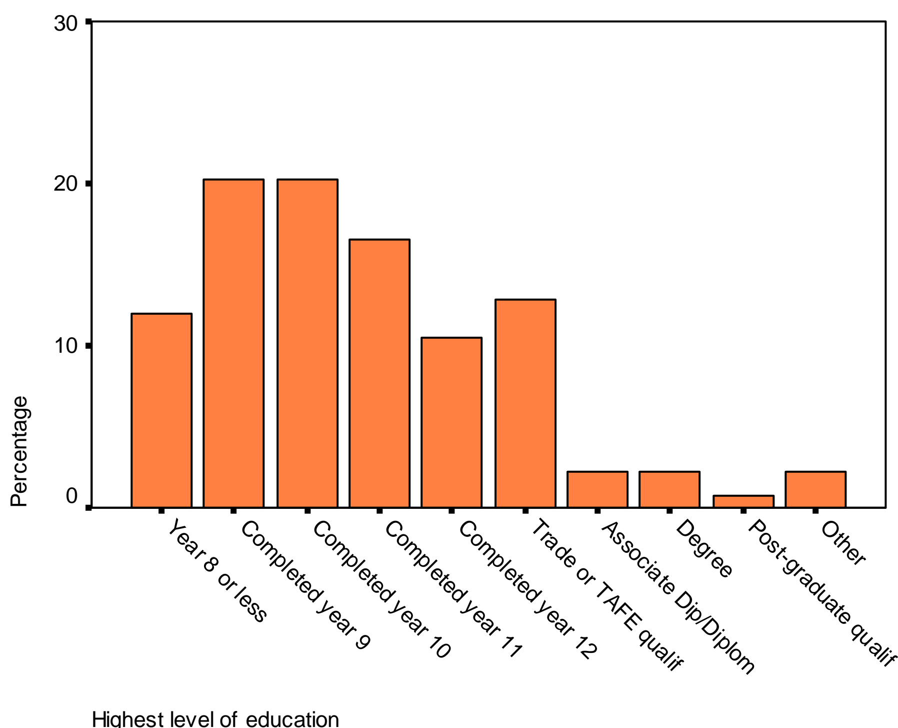
The sample had limited representation of PSP clients from CALD (Culturally and Linguistically Diverse) backgrounds, with 89% born in Australia and 80% having neither of their parents from a non-English speaking background. Moreover, only 2% of respondents reported that English was not the main language 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 client from each from Ireland, Vietnam, the Philippines and Holland. Around 3% of participants reported that they were of Aboriginal or Torres Strait Islander descent.

Education

The vast majority (69%) of participants in the sample listed the completion of year 11 or lower as their highest level of education (see Figure 5.2). A further 11% had completed year 12, 13% had completed a trade or TAFE qualification, 2% a diploma or advanced diploma, 2% a degree and 1% a post-graduate qualification.

Figure 5.2 Participants' highest level of education



Case managers' ratings of the English language abilities of participants are show in Table 5.1. Spoken English did not appear to be a significant problem for any participants in the sample, but case managers listed 5% of respondents as not reading well and 9% as not writing well.

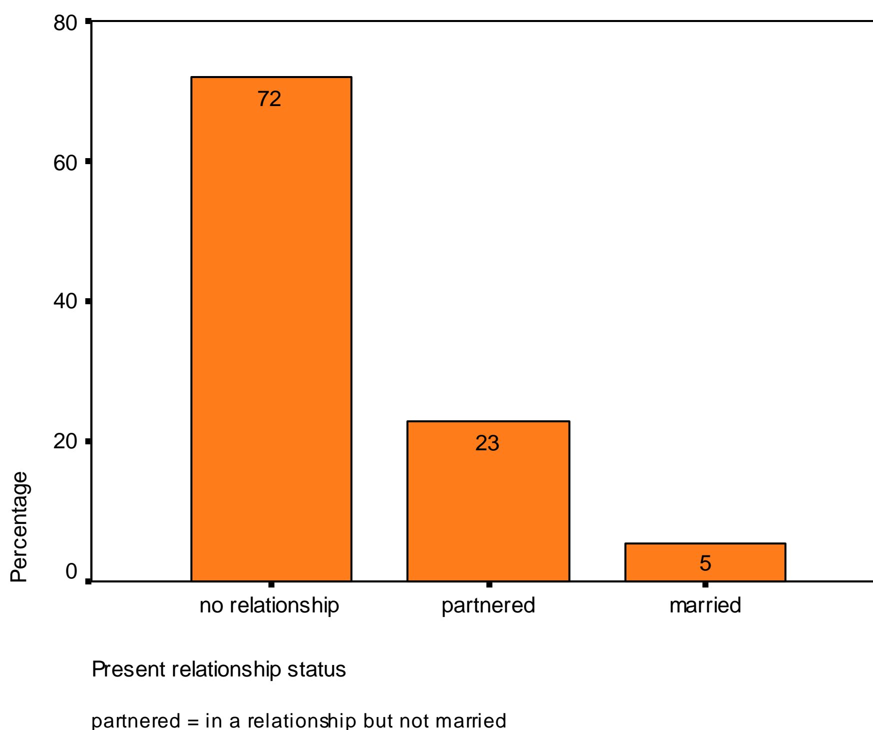
Table 5.1 Clients' English language abilities

Rating	Speaks English	Reads English	Writes English
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 5.3 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 5.3 Participants' living arrangements



Almost half (49%) of the sample reported that they were living alone, more than five times the percentage living alone in the general Australian population (8%) (ABS 2002). 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. This was followed by public housing rental (22%), private home owned by client or client's parents (14%) and private home being purchased (8%) (see Table 5.2). Approximately 14% reported less stable housing arrangements: supported accommodation (4%), living in a rooming/boarding house or caravan (6%), or moving frequently between temporary forms of accommodation (4%).

Table 5.2 Participants' current housing arrangement

	Number	Percentage
Renting privately	43	33
Renting public housing	29	22
Private home, owned by you or your parents	18	14
Private home, being purchased by you or your parents	11	8
Living in a rooming/boarding house or caravan	8	6
Supported accommodation	5	4
Moving frequently between temporary accommodation	5	4
Other	14	11

No respondents reported they were currently living on the street, but a significant finding was that 50% of respondents reported that they had experienced homelessness in the previous five years. Table 4.3 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 5.3 Factors contributing to homelessness*

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 4.4). Just 2% reported other main income sources.

Table 5.4 Participants' main source of income

	Number	Percentage
Newstart Allowance	109	82
Disability Support Pension	10	8
Youth Allowance	7	5
Parenting Payment	5	4
Other	2	2

Recent activities and employment

Table 5.5 shows the proportion of respondents who have taken part in various activities over the last 2 years. The most commonly reported activities were looking for work, unpaid or voluntary work, caring for children or others and studying or training. Among those that had engaged in 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%), full-time and seasonal work (each 10%), and finally regular part-time work (8%).

Table 5.5 Participants' activities over the last 2 years

Activity	Percentage
Looking for work	65
Unpaid work/voluntary work	40
Caring for children/others	34
Studying/training	30
Irregular casual	22
Regular casual	13
Working full-time	10
Seasonal work	10
In prison or institution	9
Working regular part-time	8
Employment/labour market program	7
Other activities	14

A total of 58% of those in the sample reported being in some type of paid employment during the past two years. Some 93% reported having engaged in some paid work at some time in their past and the rest reported having never done any paid work.

Approximately 96% of respondents reported that they were unemployed before coming on to PSP and 87% were receiving either Newstart or Youth Allowance. The length of time registered as unemployed ranged from nil for 5% of the sample, presumably for participants on DSP or Parenting Payment, to 18 years for one individual. The average time registered as unemployed was 2.4 years, but the median was significantly lower at 1.2 years.

Of those who had been employed, 59% reported that their last job was casual, 31% permanent and 11% contract (see Figure 5.4). At the same time, Figure 5.5 shows that many had been working substantial hours: some 50% had worked 35 hours or more per week, followed by 21% who reported working irregular hours, 16% less than 20 hours and 13% between 20 and 25 hours. The average duration in the last job was around 14 months, although this was skewed by a small number of long durations; and the median figure was 6 months.

Figure 5.4 Basis of employment in participants' last job

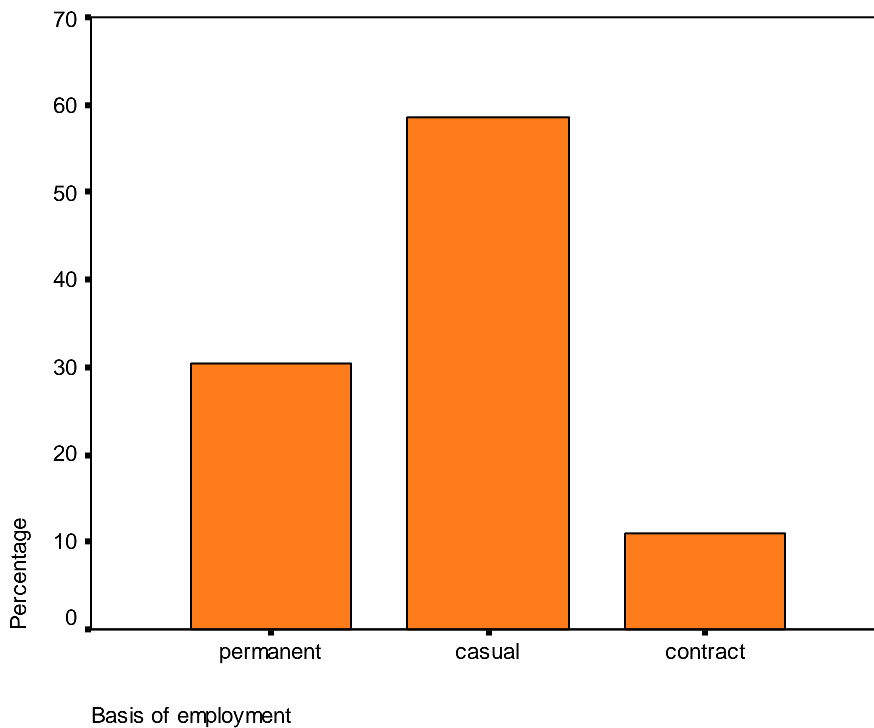


Figure 5.5 Usual hours worked in participants' last job

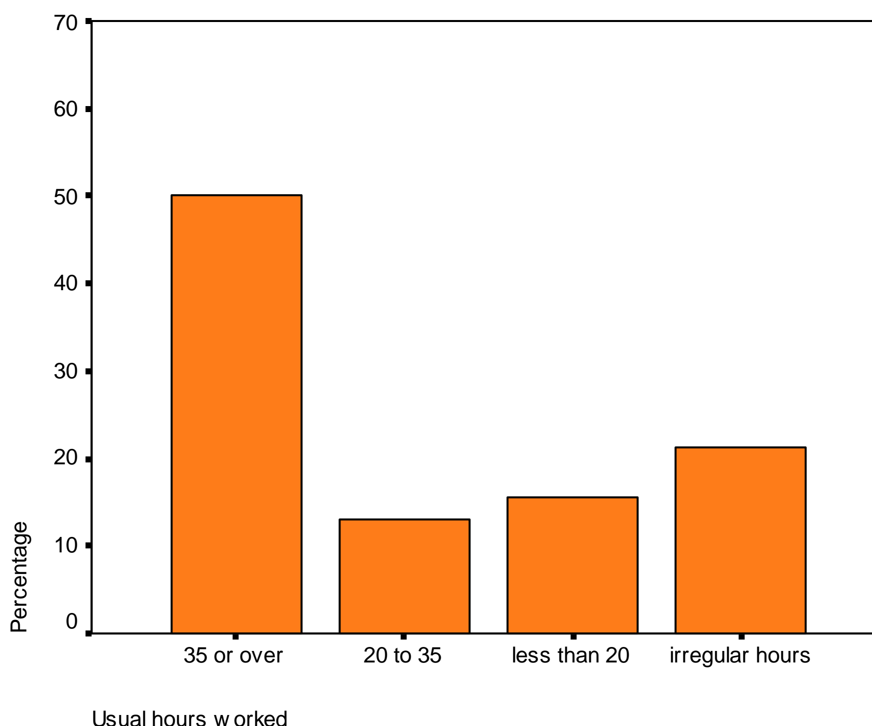


Table 5.6 shows the activities that respondents selected as the one they would most like to be doing now. The most common preference, selected by 40% of the sample, was full-time, part-time or casual work, although the clear preference was for full-time employment which was selected by around twice the number of people that wanted part-time or casual employment. It is important to note that this data looks at one preferred activity, so it may understate the number of people who want to work in combination with other activities such as studying or caring.

Studying or training was the second most selected type of activity (33% of respondents). Small proportions of people chose caring for children or others (5%), voluntary work (3%), supported employment programs (1%), or other activities; around 14% did not know what they would like to be doing now.

Table 5.6 Which activity respondents would most like to be doing now

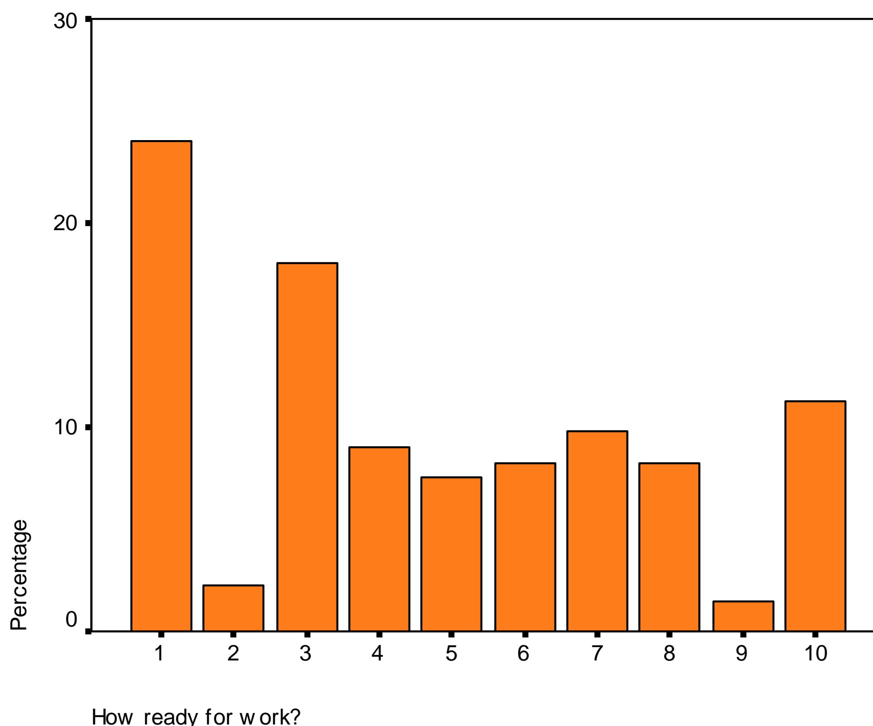
Activity	Number	Percentage
Studying/training	44	33
Full-time work	35	26
Part-time or casual work	18	14
Don't know	18	14
Caring for children or others	7	5
Other activities	6	5
Voluntary work	4	3
Supported employment program	1	1

Interestingly almost all participants (84%) said that they would like to stay on PSP while undertaking their selected activity, indicating a definite need for ongoing support.

Participants were also asked to rate how ready they felt for work on a scale of 1 to 10, where 1=not ready and 10=very ready (see Figure 5.6). The average score given was 4.7, with a median of 4. However, 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 employment suggests the need for integrated employment assistance within PSP if and when clients reach this point. Asked whether there were things that were holding them back from working, 93% of clients identified one or more factors that they believed were holding them back.

Figure 5.6 Participants' readiness for work
(Scale: 1=not ready and 10=very ready)



Respondents were also asked to describe what they would like to achieve through their participation on PSP. Their goals were diverse and included:

- addressing physical health or emotional issues
- resolving family problems
- finding a job
- resolving mental health issues
- improving confidence or self-esteem
- undertaking education, study or training
- stop taking drugs/alcohol
- gaining stable accommodation
- developing own business
- getting a driver's licence or car
- getting a forklift licence
- to work out where going in life
- developing a positive attitude/healthy lifestyle

Barriers

Case managers' responses about barriers identified by Centrelink or providers illustrate the very high level of disadvantage experienced by PSP clients. The number of barriers facing individuals in the sample ranged from 1 to 25 (out of a possible 42), and on average, participants faced nine barriers when entering PSP. Most significant was the finding that nearly 4 out of every 5 clients (78%) suffer from a mental health problem such as anxiety, depression or personality disorders. Other common barriers include:

- family breakdown (66%)
- lack of self confidence/low self esteem (65%)
- social isolation / alienation (56%)
- drug problems (40%)
- homelessness (35%)
- alcohol problems (31%)
- anger / conflict / behavioural difficulties (26%)
- physical disability (23%)

These results were obtained by asking case managers to select all barriers facing individuals in the sample from a list. For each selected barrier, they were also asked to rate its impact on the respondents' economic and social participation on a scale of 1 to 10, where 10=extreme impact and 1=no impact. (The impact of the barriers identified will be measured again after twelve months on the program.)

Case managers were first asked to identify and rate all of the barriers that had been identified by Centrelink when referring the client, and then to select any of these or any **additional** barriers that they had identified since the client's referral from a list including the Centrelink and some additional barriers. As Tables 5.7 and 5.8 show, the Centrelink list of barriers is made up of personal or family barriers, while the additional barriers used in the present study include some human capital or labour market and situational barriers.

It is important to note that the method of data collection relied on the case manager's assessment of the presence 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 relationship between the case manager and participant should assist with accuracy and disclosure of information relating to other barriers.

As Table 5.7 indicates, the four most common individual barriers (Centrelink and provider identified), reported by over half of the sample, are family relationship breakdown, confidence or self-esteem problems, mood disorders including depression, and social isolation/alienation. The rate of depression (63%) is much higher than estimated for the general population (5–15%) (Butterworth 2003b), but consistent with Waghorn and Lloyd's estimate for long-term welfare recipients (57%) (Waghorn & Lloyd 2005).

When mental health is treated as a composite barrier made up of one or more of: mood disorders including depression, anxiety conditions including agoraphobia and panic disorders, and personality disorders, this is present in around 78% of respondents.

Table 5.7 Clients facing Centrelink barriers, identified by Centrelink and by providers

Centrelink barrier	Barriers initiallyidentified by Centrelink	Barriers subsequently identified by providers	Total
	%	%	%
Family relationship breakdown	44	22	**66**
Confidence or self-esteem problems	39	26	**65**
Mood disorders including depression	52	9	**63**
Social isolation / alienation	30	26	**56**
Anxiety conditions including agoraphobia & panic disorder	41	8	**49**
Drug problems	28	12	**40**
Financial management problems	17	22	**39**
Homelessness	25	10	**35**
Alcohol problems	23	8	**31**
Anger / conflict / behavioural difficulties	19	7	**26**
Physical disability	17	6	**23**
Domestic violence	11	5	**16**
Literacy / numeracy problems	10	6	**16**
Personality disorders	9	4	**13**
Poor communication / language skills	8	3	**11**
Torture or trauma	6	2	**8**
Learning disorder	5	2	**7**
Acquired brain injury	3	3	**6**
Gambling problems	3	3	**6**
Intellectual disability	2	0	**2**

Table 5.8 Clients facing additional barriers used in this study

Barrier	Percentage
Lack of suitable jobs in area	41
Very long term unemployment (more than two years)	32
Lack of confidence and skills in seeking work	31
Motivational problems	30
Limited education, training or skills	23
Insufficient work experience	23
Facing significant grief or loss issues	23
Ongoing medical or dental condition	21
Lack of access to private or public transport	19
Significant legal issues	17
Periods in custody and / or criminal record	12
Experienced / experiencing physical abuse or assault	11
Age	10
Caring responsibilities	10
Experienced / experiencing sexual abuse or assault	10
Limited independent living skills	8
Difficulties in accessing child care	3
Significant post-migration adjustment difficulties	2
Limited English language skills	1
Workplace injury	0

Table 5.9 shows the proportion of all cases with each barrier that were identified by Centrelink. This gives some indication of the relative accuracy of Centrelink procedures for identifying client barriers. However, it would be expected that, due to their ongoing intensive work with clients, case managers would be in a better position to uncover many barriers than a Centrelink worker doing a one-off assessment. Other factors that may impact on the identification or reporting of barriers by Centrelink psychologists and other workers include the staff member's specialisation or background, as well as clients' requests that information not be recorded on the system.

Table 5.9 shows that barriers which Centrelink is less successful at identifying include financial management problems, social isolation or alienation, confidence or self-esteem problems, literacy or numeracy problems and family relationship breakdown, all of which were identified by Centrelink in two-thirds of cases or less. 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 could also be partly due to different working definitions of barriers.

Table 5.9 Proportion of cases of each barrier identified by Centrelink

Barriers	Percentage
Anxiety conditions including agoraphobia & panic disorder	84
Mood disorders including depression	83
Torture or trauma	75
Alcohol problems	74
Physical disability	74
Anger / conflict / behavioural difficulties	73
Poor communication / language skills	73
Homelessness	71
Learning disorder	71
Drug problems	70
Domestic violence	69
Personality disorders	69
Family relationship breakdown	67
Literacy / numeracy problems	63
Confidence or self-esteem problems	60
Social isolation / alienation	54
Financial management problems	44
Acquired brain injury	*
Gambling problems	*
Intellectual disability	*

* Insufficient sample size

Tables 5.10 and 5.11 show the prevalence of barriers by location. While the limited sample size makes it difficult to draw any firm conclusions, some differences do stand out. Surprisingly, given transport issues and the greater potential for geographical remoteness, social isolation or alienation was lower amongst respondents in non-metropolitan areas than inner or outer suburbs (47% compared with 63% and 67% respectively).

Alcohol problems are reported as a barrier for 50% of inner metropolitan respondents, compared with roughly half that percentage at outer suburban or non-metropolitan providers. Domestic violence, personality disorders, and periods in custody or a criminal were all significantly less common in respondents from non-metropolitan providers, while limited independent living skills were significantly more common in respondents from inner metropolitan providers.

Lack of access to public or private transport followed an expected pattern, being a barrier for only 4% respondents from inner-metropolitan providers, but 14% from outer metropolitan and 28% of non-metropolitan providers. Amongst the employment-related barriers, lack of suitable jobs in the area was reported as a barrier for 63% of respondents from non-metropolitan providers, but only 19% from inner metropolitan and 24% from outer metropolitan providers. However, long-term unemployment was actually slightly lower amongst the non-metropolitan part of the sample, and limited education, training or skills was reported as a barrier twice as often by inner metropolitan providers (41%) than outer metropolitan (17%) or non-metropolitan (19%) providers.

Table 5.10 Prevalence of barriers by location (Centrelink list)

Centrelink barriers	Inner metropolitan	Outer metropolitan	Non-metropolitan
	%	%	%
Family relationship breakdown or issues	67	69	64
Confidence or self-esteem problems	56	74	63
Mood disorders including depression	75	67	56
Social isolation / alienation	63	67	47
Anxiety conditions including agoraphobia and panic disorder	46	60	42
Drug problems	43	43	38
Financial management problems	32	48	36
Homelessness	39	29	38
Alcohol problems	50	26	27
Anger / conflict / behavioural difficulties	36	21	25
Physical disability	21	24	23
Experienced / experiencing domestic violence	21	21	9
Literacy/numeracy problems	12	5	25
Personality disorders	25	14	6
Poor communication / language skills	11	7	13
Torture or trauma experience, or other stress disorders	7	5	9
Learning disorder	14	-	8
Acquired brain injury or other organic mental disorder	14	2	5
Gambling problems	11	10	2
Intellectual disability	4	-	3

Table 5.11 Prevalence of barriers by location (additional barriers used in this study)

Additional barriers	Inner metropolitan	Outer metropolitan	Non-metropolitan
Mental health	79	83	73
Lack of suitable jobs in area	19	24	63
Very long term unemployment	33	36	28
Lack of confidence and skills in seeking work	41	24	31
Motivational problems	41	31	25
Limited education, training or skills	41	17	19
Insufficient work experience	30	14	25
Facing significant grief and loss issues	18	29	22
Ongoing medical or dental condition	11	24	23
Lack of access to private or public transport	4	14	28
Significant legal issues	21	19	14
Periods in custody and / or criminal record	22	17	5
Experienced / experiencing physical abuse or assault	18	14	6
Age	11	14	6
Caring responsibilities	15	12	6
Experienced / experiencing sexual abuse or assault	11	14	8
Limited independent living skills	25	2	5
Difficulties in accessing child care	4	2	3
Significant post-migration adjustment difficulties	4	2	-
Limited English language skills	-	-	2
Workplace injury	-	-	-

Interestingly these results show some significant differences from those obtained in an evaluation of the Community Support Program (CSP), the predecessor to PSP, done in 2000 by the same

agencies involved in this study (see Table 5.12). Most of the barriers used then were used again in the present study, but a number of barriers were modified and others were added.

The most significant difference is the reporting of social isolation as a barrier, which increased from 3% in the CSP study to 56% in the present study. It is likely that this is influenced by the broader definition of barriers used by PSP, embracing not only barriers to employment, but also barriers to economic or social participation. Other barriers that appear to affect a greater proportion of respondents in this study include financial issues (39% compared with 14%), homelessness (35% compared with 12%), physical disability (23% compared with 9%) and addiction (40% compared with 25%). Although the numbers involved are too small to make definitive statements, these figures suggest a move towards working with participants facing a greater level of disadvantage.

Issues that were significantly less reported as barriers in the current study included long-term unemployment (32% compared with 55%) and limited English language skills (16% compared with 1%).

Table 5.12 Prevalence of barriers: comparison with CSP study

Barrier identified	CSP study	Current PSP study
	Percentage	
Long-term unemployment	55	32
Lacks job search confidence or skills	40	31
Grief or loss	27	23
Motivational problems	27	30
Addiction	25	40
Lack of work experience	25	23
Ongoing medical illness	23	21
Limited English skills	16	1
Caring responsibilities	14	10
Domestic violence	14	11
Financial issues	14	39
Homelessness	12	35
Torture or trauma	12	8
Age	11	10
Legal issues	10	17
Access to transport	9	19
Physical disability	9	23
Sexual abuse	7	10
Periods in custody	6	12
Post-migration adjustment	3	2

Case managers were also asked about the participants' insight into the barriers they face, desire to bring about change, support required and current engagement. These were answered on a scale of 1 to 10 (where 1=no insight, no desire, minimal support, and no engagement; and 10=complete insight, complete desire, very high support and complete engagement). The results are presented in Table 5.13.

Bivariate correlations reveal strong positive relationships between a client's insight into their barriers and desire/motivation to bring about change (.63; $p<0.001$) and the current level of engagement (.441; $p<0.001$). A strong positive relationship was also found in the desire to bring about change and level of engagement (.472; $p<0.001$). These results suggest that interventions that assist clients to understand the barriers they face may lead to a greater desire to bring about change and a higher level of engagement.

Table 5.13 Case managers' ranking of client insight, motivation, support required and engagement

	Client's overall level of insight into their barriers	Client's desire/ motivation to bring about change	Level of support required by client	Client's* engagement level
Mean	7.38	7.20	6.77	7.92

*This measure of engagement includes only those clients who have stayed on the program.

An additional mechanism to understand client needs and measure change over time (which will be looked at again in survey 2) was to ask case managers and respondents to rate abilities in the areas listed in Table 5.14. Clients provided a self-rating in the self-complete section of the survey.

Case managers and respondents provided a rating on a 1 to 7 scale (where 1=not able and 7=very able). The average scores presented below indicate that although case managers generally give higher ratings than participants, the ordering of abilities was fairly similar. The areas that both case managers and clients rated lowest were dealing with emotional issues and coping with stressful events and situations. The areas rated highest by both were abilities to manage day-to-day living and manage money or budget. Ability to achieve goals and to organise their lives as they wanted were both rated significantly lower by participants than case managers.

Table 5.14

Client abilities	**Case manager rating**	**Client rating**
To achieve their/your 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 their/your 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

Table 5.15 shows the extent to which clients reported that physical health or emotional problems had interfered with their normal social activities during the past four weeks. This can be seen as indicating the extent to which personal barriers were impacting on social participation. Significantly, three out of every four of respondents had physical health or emotional problems that interfered with normal social activities moderately, quite a bit or extremely over the previous four weeks. This was more than four times the rate of people in the general population, where only 17% reported that social activities had been interfered with extremely, quite a bit or moderately over the previous four weeks (HILDA 2002–03).

An additional 10% of the sample reported that physical health or emotional problems had interfered slightly with normal social activities, compared with 20% of the general population, and 14% reported that no interference, compared with 54% of the general population. This underscores the significant impact that personal barriers appear to have on the social participation of this group.

Table 5.15 Interference of physical health or emotional problems with normal social activities

Degree of interference	**PSP sample**	**Australian population***
	%	%
Not at all	14	54
Slightly	10	20
Moderately	22	9
Quite a bit	38	6
Extremely	15	2
Missing	0	9

*Source: HILDA Wave 3 (2002–03)

Provision of assistance

Table 5.16 shows the types of assistance that case managers report their clients require. Counselling stands out as the most required assistance type, required by two-thirds of the sample, followed by self-esteem or confidence training and goal setting or decision making which are required by over half of the respondents.

Table 5.16 Case managers' assessment of assistance required by clients

Type of assistance	Percentage of clients
Counselling	66
Self-esteem/confidence training	62
Goal setting/decision making	59
Study/training opportunities	49
Drug and alcohol program	36
Job search skills/support	37
Language/literacy/numeracy	34
Accommodation/housing	33
Work experience/voluntary work	30
Financial/budgeting skills	28
Health/fitness	25
Mental health support services	25
Assessments	20
Anger management/behaviour management	18
Legal assistance	12
Independent living skills	6

Case managers were asked in a subsequent question about any difficulties their agency might face in providing the required assistance. The results, presented in Table 5.17, show that cost is a barrier to providing required services for around 90% of clients. This is a key finding given that the clients have very high levels of need, the program is centred on a case management model and it relies on the ability to refer clients to required external services.

While some types of assistance can be provided by PSP case managers, the low levels of program funding (despite some increases) and lack of brokerage funds available to case managers suggest that a large proportion of clients are missing out on required services due to cost. Interviews with providers confirmed this situation, with the discretionary funding per client that agencies are able to allocate (from general program revenue) ranging from nil at a number of providers up to $120 per client per year. Clearly, this is insufficient to access critical services such as counselling, which a number of providers reported was unavailable at no cost. Even low-cost counselling through community health centres often carries a fee of between $20 and $30 which is outside the reach of most providers. One case manager commented that even sending participants on short courses which cost only $50 to $70 'would sometimes just make the difference' but was beyond the reach of their agency.

Another critical area where cost is likely to have a significant impact is education and training. Given the low levels of education and lack of labour market attachment of this client group, investment in human capital is clearly an important mechanism to improve economic outcomes and prevent long-term disadvantage. As discussed earlier in relation to clients facing drug problems, education can also form an important pathway for people to step back to participating in the labour market.

By contrast, agencies providing assistance to disadvantaged job seekers in the Job Network are able to access brokerage funds of up to $1350 per client through the Job Seeker account. The lack of any such funding for clients in PSP, who are suffering from a much greater level of disadvantage, is a clear impediment to the effectiveness of the program. Agencies were unanimous in their support for being given access to this or a similar account.

Table 5.17

Difficulty in providing assistance	Percentage of clients
Cost	90
Waiting lists	45
Not available in area	38
Available service not appropriate for client	35
Lack of transport	28

Waiting lists and services not being available locally were both reported as difficulties in providing assistance for a significant proportion of clients (45% and 38% respectively). Available services not being appropriate and lack of transport were also reported as difficulties for 35% and 28% of clients.

Table 5.18 shows difficulties in providing assistance by location. Where services were available, problems of cost or waiting lists were somewhat worse at inner metropolitan providers than outer or non-metropolitan providers. However, services not being available in the area at all was a far greater problem for participants at non-metropolitan providers (51%) than outer (28%) or inner metropolitan providers (14%). While lack of transport was a difficulty for only 4% of participants at inner suburban providers and 9% at outer suburban providers, it was reported as a difficulty for almost half of all participants at non-metropolitan providers (46%).

Table 5.18 Difficulty in providing required assistance, by percentage of clients at each location

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

Program elements

Referral and engagement

The referral process for clients to enter PSP is through Centrelink. Referrals can be made by Centrelink psychologists, disability officers or social workers, but in practice, almost all referrals are done by the psychologist. Initial assessment of the level of disadvantage of all job seekers is done when clients complete the Looking for Work Questionnaire, usually with a Centrelink Customer Service Officer. 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 the job seeker's disadvantage.

Depending on the issues facing a client, the Looking for Work Questionnaire can trigger a Special Needs flag, a Disability or Personal Factors flag. Clients who receive a Special Needs flag (SNA) are then assessed by a Centrelink psychologist. Clients with a Disability flag see a Disability officer and those with a Personal Factors flag see a social worker.

During the Special Needs assessment, program options including PSP are considered. The overall process relies on clients' disclosure during the initial JSCI interview to trigger a Special Needs flag, which one Centrelink psychologist reported as problematic. This psychologist suggested 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 not be able to take enough time on the Looking for Work Questionnaire.

An alternative pathway is for a Centrelink staff member or clients themselves to make an appointment to see the Centrelink psychologist directly. This can also be arranged by PSP or other employment program providers.

In deciding whether to refer a client to PSP or other programs, the Centrelink psychologists undertake a one-hour assessment interview to consider capacity to work and barriers. One Centrelink psychologist reported that clients are not referred to PSP unless they demonstrate a willingness to address barriers and take part in the program. Considerations include:

- Is the person work-ready and able to go into a work-focused program?
- Are they able to benefit from the Job Network?
- How many barriers are they facing?
- If actively looking for work, are they dealing with significant other issues that require additional support?
- Have they had problems keeping work because of personal problems such as anger management issues?
- Will they be able to cope with the pressure of the Job Network?
- Will they be able to handle activity test requirements? (This pressure was considered potentially detrimental for some clients.)

Once a decision is made to refer a client to PSP, the referring Centrelink worker enters into the system a range of information which is then supplied to the provider; however, a client can request that information is kept confidential. Information provided to PSP providers includes the barriers (from the prescribed list discussed above) that are required to be addressed whilst the client is on PSP and incorporated into the action plan. Up to eight barriers can be coded and can be accompanied by descriptive text, but generally two to four barriers are reported.

Once notified about a referral, a provider has six weeks to meet with the client. However, clients may wait over ten weeks for a vacancy before they are referred. The amount of time a client has to wait will depend on places available in their area or with their provider of choice, as well as the priority assigned to them. Clients are given a priority level of 1 to 4 depending on need, with higher priority clients referred first FaCS 2002).

If the client does not commence with the provider within six weeks of the referral, a re-engagement interview is conducted by the referring Centrelink worker. This delay was recognised as a weakness by the Centrelink psychologists, who felt that a more rapid system would reduce the number of clients who fail to commence.

Table 5.19 shows the length of time that respondents reported having to wait before getting a place with their provider. A significant proportion (15%) reported waiting over ten weeks while 58% reported waiting over three weeks. One provider reported that they currently had 16 people on their waiting list, which would result in a six-month wait for some clients.

Table 5.19 Time between Centrelink referral and placement

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

Quality of referrals

Providers were generally positive about the quality of referrals they received from Centrelink, with many commenting that they had only received one or two that were inappropriate. However, some case managers felt that they sometimes received clients because there was nowhere else for them to go. This was also recognised by 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. The other (less than ideal) option is for people to be put on medical certificates where they are exempt from mutual obligation reporting but also receive no support to cope with barriers.

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 reported that she had been working with a client whom she visited in his home alone and picked up to take to appointments, only to find out later that he had recently been charged with firing a bow and arrow at his girlfriend. Other reported incidents included a client making abusive phone calls and threatening to blow up a PSP office, and another physically assaulting his girlfriend in the PSP office. One case manager also observed that it can be difficult for providers to work with clients from non-English speaking backgrounds due to the costs of interpreters.

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

Referral information provided by Centrelink psychologists was seen as generally good, but there were some reports of information being missing or too brief to be of use. Issues included missing address information, abbreviated barrier codes which are difficult to understand, and a lack of any descriptive information with the referral. This was sometimes seen as being due to lack of time or clients' paranoia about personal information being entered on the system. Case managers reported ringing the referring psychologists for more information or occasionally sending referral files back.

Relationship with Centrelink

The overall feeling about the relationship with Centrelink, primarily through the referring Centrelink psychologist(s), was positive. Providers made comments such as that the psychologist they worked with was flexible, provided good information with referrals, saw people beyond what is expected in her job, was well informed about PSP.

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

The referral process for clients

A small proportion of clients on PSP had also been participants on the CSP (Community Support Program). Around 3% reported having been on CSP with the same provider, while 5% had been with a different provider. Table 5.20 shows how respondents first heard about PSP. Some 86% first heard about the program through Centrelink workers who are able to make referrals. Another 7%

respondents first heard about PSP through other Centrelink staff, with an additional 2% first hearing from Job Network providers or by word of mouth.

Table 5.20 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

In terms of the reason clients chose their present provider, the most common response, selected by around one-third of respondents, was that there was no choice given by Centrelink (see Table 5.21). One-quarter chose the provider because it was convenient or close to home, and around one in ten said they had chosen it because of hearing positive things, previous contact or a random choice. Five per cent said it was the only PSP provider in the area and 10% had some ‘other’ reason.

Table 5.21 Reason client chose this provider

Reason	Number	Percentage
No choice given by Centrelink	45	34
Convenient location/close to home	34	25
Heard positive things about this agency	13	10
Previous contact with the agency	12	9
Random choice	10	8
Only PSP provider in the area	6	5
Other reason	14	10

Client engagement

Case managers generally felt that engaging clients in the program was not a serious problem once they had managed to get them to come in initially and explained what the program was about, but that it sometimes took time to build up a trusting relationship. Often more intensive work was needed in the first few months to help stabilise the client’s circumstances before focusing on the ‘official’ barriers.

Agencies differed in the methods used to get more difficult clients to commence: many reported that after several failed attempts at contact they would not pursue the client any further, and one case manager said that after three letters they ‘just leave it till they drop off the end’. Others used more active strategies, and one provider reported that outreach and face-to-face contact was particularly useful for clients with mental health issues such as agoraphobia or anxiety conditions.

A number of case managers raised as an issue the amount of time involved in trying to get difficult clients to engage, as well as the fact that there is no payment to the agency if the client does not eventually engage successfully. It was also suggested that a significant factor in how well clients engage was their desire and readiness for change, over which the case manage had limited control.

Client groups that were identified as particularly difficult to engage were homeless clients with mental health issues, drug-using clients that are very deeply ensconced in their subculture, men who have been in jail, younger clients in general and clients suffering from social isolation. 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 in the program. There was also a suggestion that some clients are happy with their lifestyle even when it does involve a drug or alcohol issue and that they will turn up for their appointment every month but see no reason to move on to anything else.

One agency used movie vouchers as an incentive to get more difficult clients to come in for appointments, while another described it as 'a waiting game for a window of opportunity'. One rural provider commented that distance made maintaining engagement more difficult.

Bivariate analysis of survey data found that seven barriers were significantly negatively related to the clients' reported level of engagement (see Table 5.22). Many of these matched those reported by case managers in interviews. However, family relationship breakdown and intellectual disability were not mentioned by any case managers: in the case of intellectual disability this may be due to the small number of clients facing this barrier in the sample.

Table 5.22 Correlation between selected client barriers and level of engagement

Barrier	Correlation	Significance
Homelessness	-.193	.02
Very long term unemployment	-.240	.00
Periods in custody and/or a criminal record	-.258	.00
Drug problems	-.212	.01
Family relationship breakdown	-.269	.00
Anger conflict behavioural difficulties	-.294	.00
Intellectual disability	-.250	.00

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 5.23). This suggests that PSP is effective at working with the most disadvantaged clients.

Table 5.23 Correlation between participants' total barriers and level of engagement

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

When asked to describe the things that had helped the engagement of clients, case managers reported factors such as:

- home visits/outreach
- providing intensive support
- having appointments in a social environment
- client's motivation
- providing practical assistance as well as emotional support
- establishing good rapport
- consistency and flexibility in contact

Factors that were listed by case managers as hindering engagement for clients included:

- changes of case manager
- client ambivalence or lack of motivation to change or address barriers
- expense of travelling to appointments
- barrier-related issues such as homelessness

- long distances to support services
- lack of brokerage funds to connect to required services
- inability to meet as often as required because of high case loads
- geographical isolation

Program delivery

Client contact

When a participant commences on PSP, the provider is required to complete an action plan with the client outlining steps to address the barriers identified by Centrelink and to achieve the participant's goals. After this, the provider receives an action plan payment. However, if the participant leaves the program before the action plan is completed, the provider misses out on this payment for any initial work undertaken.

The program guidelines stipulate a minimum of one contact with each participant every 4 weeks, face to face or over the phone. In practice, providers reported significant variation in the contact depending on the level of need and noted that the same barrier can impact on individuals in very different ways.

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 on the program some time before they finally felt confident to reveal issues.

After the initial period, contact was reported as ranging from more than weekly up to once every four weeks, but many suggested that monthly was only sufficient for those clients who were 'on track'. One case manager reported that if the client has been on PSP for

> over 12 months, and the joint view between client and myself is that we've done what we can at this point at least, I'll be looking at working through phone contact for a few months and get them in every 3 or 4 months after that.

Although four-weekly contact was seen as insufficient for many clients, 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 would like to with clients. Some case managers and a Centrelink psychologist suggested that there were significant variations in the quality of PSP providers and that some may not go beyond the program's basic requirements and only have contact with the client every four weeks. 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.

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

Services model

Agencies delivering PSP varied considerably in the approach used to deliver services to clients. This included accessing other in-house services, employing psychologists or counsellors as PSP workers, developing partnerships with other organisations, or accessing almost all services through other external agencies. PSP guidelines require all agencies to undertake some client counselling, but many case managers do not have the background or qualifications to provide the more specialist counselling required by a large number of clients.

Services that agencies reported providing 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 employment, and the correctional services employment pilot/program)
- theatre projects for young people
- computer training
- marriage education counselling
- group activities

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 that had considered setting up some internal services 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 that had been set up 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 time required to organise and run them.

Due to varying client needs, PSP providers need to access a broad range of support services, and a number of case managers commented on the importance of strong knowledge of local services, while another stated that they do a lot of research and belong to a range of networks in order to locate new services. Given that the PSP operates with a brokerage model but that funding levels provide only $50 to $120 per client per year (and some agencies have no discretionary funds), the availability of free or low-cost services is crucial for the effectiveness of the program.

The service where providers reported the greatest shortfall in meeting the needs of clients on PSP was counselling, which was required by two-thirds of all clients. Some case managers were able to arrange six sessions through a community psychiatry scheme which provides counselling service through participating GPs for the cost of normal visit (sometimes bulk billed), but others reported that the service was not available through any of the local GPs or that it 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 reported paying for a couple of sessions, or matching half payment with clients, but one case manager commented that because there was no free counselling in their area 'mostly clients miss out'. Another case manager commented that clients who do receive low cost counselling, are often seeing a trainee psychologist, 'but for lots of people that's not adequate'.

Case managers reported great difficulty managing clients that required counselling. One consequence was that 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 different 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 GPs was difficult in some areas due to the lack of bulk billing doctors, with clients sometimes having to go to casualty for medical treatment. Dental services were reported as highly inadequate, particularly in rural areas where waiting lists were two to four years and 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, generally these appeared 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 the transient nature of accommodation available rather than homelessness as such. One case manager suggested that housing assistance, particularly 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 problem.

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 to afford even if some financial assistance could be provided.

Given the low level of program funding, providers reported being very restricted as to when and how they could assist clients financially. Some providers simply did not have funds available, while others had discretionary funds of $50 to $100 per client per year. One agency that was part of a national welfare organisation reported they had access to a direct relief fund. When financial assistance was provided some providers matched dollar for dollar with clients' contributions, which providers felt helped clients to retain a sense of ownership and pride. The money was used for things such as medicine, false teeth, food, petrol (to visit family members), education or

recreational courses and getting a licence. Other financial assistance was hard to access. For example, food vouchers were reported to be only available four times a year and assistance with rental arrears was not available unless an eviction notice had been issued.

Work

Case managers had mixed views about the usefulness of voluntary work for clients. Some reported that they had quite a few taking part in voluntary work and that it had helped people with socialisation, confidence and getting back into the pattern of normal life. Others had not found it particularly appropriate for many people, or said that finding a good match was difficult and that many options were unattractive. One case manager who thought it was a good option commented that volunteers often need to have skills: 'Voluntary work – it's not like therapy. It's unpaid work and there are expectations from the employer/organisation around standards of work etc. and clients usually aren't ready for this'. Another suggested that forcing people to do voluntary work would be counterproductive, but that if it is helping them pursue an overall direction then it 'can be the absolute start of them getting back into everything'.

The level of employment assistance offered also varied between case managers, but none reported employment focused activities to be a significant part of their PSP program. Employment assistance was usually limited to doing a bit of job search, helping with a resume or providing some vocational counselling.

In terms of attitudes to employment assistance, a division seemed to exist 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. This latter group often felt that moving clients into work before they had worked through their issues could be unhelpful, with a high likelihood of them not being able 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 view among staff that if other issues are worked out earlier than two years then job search can start earlier, but that achieving stability in employment requires primary issues to be sorted out first.

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

Another approach mentioned by some case managers was to assist clients in starting their own business. One case manager reported helping a client with producing a pamphlet for Bowen therapy and another had been looking at the New Enterprise Incentive Scheme for a number of clients who wanted to start their own businesses.

Some case managers felt that the structure of PSP was more conducive to people getting work because it involved less pressure and allowed clients to find a job 'more or less on their own terms', could better accommodate fluctuations in people's energy and motivation when dealing with mental health issues, and allowed them time to think about what they were wanting to do.

The lack of a more active employment component to PSP is of concern, given that 40% of PSP clients stated that the activity they would most like to be doing now is full-time, part-time or casual work. In addition, as Blankertz and Robinson (1996) identified, staff attitudes that clients lack the capacity to work as potentially a significant barrier for clients with mental health problems. They found that programs where case managers were more proactive in discussing work opportunities, had links with employers and provided significant post-placement support were much more successful than those that left it to clients to demonstrate an interest in working, as is almost universally the case amongst PSP providers.

However, it should also be remembered 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 while employment is the preferred activity for many participants, significant support will be required to achieve this in practice.

Program funding

Payment structure

Providers in PSP receive three main types of payments: administration payments, timing payments and outcomes payments, described in Table 5.24.

Table 5.24 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.
Timing 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 • Durable economic outcome payment: $1100 at 13 weeks and $440 at 26 weeks.

Other program payments depending on location or clients circumstances include a remote loading payment, interpreter payment and payments for transient participants (see Table 5.25).

Table 5.25 Other payments

- **Remote loading payment of $550 for providers to work with participants in remote areas ($275 at commencement and $275 with the 8 month timing payment)**
- **Interpreter payment of $220 paid on commencement (eligibility determined by Centrelink)**
- **Transient participant payments: a reconnection payment of $165 on referral to a new PSP provider; a $165 payment for production of exit report detailing progress to date; a recommencement payment of $330 for the new provider**

While some providers reported that the structure of payments was reasonably coherent, many found that it caused distortions in 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 frequently mentioned issue was the high level of administration involved in entering required information on to 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.

The lack of payment for work done chasing clients who do not commence was considered unjust by many providers. One PSP manager commented that they spend a lot of time, effort, money and petrol running after some clients without getting anything at all. Another who had worked across

many employment services in government and the community sector said that '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'. One suggestion was that the commencement payment should be increased and paid more gradually.

A more widespread concern than commencement payments was the action plan payment and the incentive this created to do the action plan as quickly as possible 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 reported that she 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 do it at the first meeting, they have started doing that also, to ensure they get 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.

and

> 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 when the client was ready. 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.

Timing payments were seen as much less of a problem but were also recognised as creating an incentive to try 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 they reach 8 or 16 months on the program. It was also of concern because it can count against providers in the High Performance Indicator Framework (an indicator framework developed to determine whether providers will be offered further PSP contracts).

Claiming payments for clients who move into employment was regarded as problematic by many case managers due to the difficulties in getting verification and the fact that Centrelink was unable 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 relocate close to the end of the two years and the final outcome payment is then claimed by the second provider, and when clients are transferred early on and have already had the action plan claimed. Another case manager had found the reconnection payments were '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.

Providers in rural and regional areas reported that due to the criteria for the remote loading payment, which is based on postcodes and does not apply to any Victorian locations (FaCS 2002), they did not receive this 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 amongst many case managers who made comments such as the following:

> 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 couple of agencies reported having no budget available for staff training, while one reported having $150 per staff member every two years.

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.

Transition and exit

Participants generally exit PSP after two years, or earlier if they achieve an economic outcome. Recognised economic outcomes include transition to employment assistance (Intensive Support or Disability Employment assistance), employment, study, vocational education and training, and apprenticeships and traineeships.

Providers are required to identify when participants are ready to move on and to provide transition support for up to six months. For those moving to Job Network, six months co-case managing is supposed to occur. During the six-month transition phase, the accumulation of PSP weeks stops and the participant is able to return to PSP if unsuccessful in the new activity. Providers receive an economic outcome payment (discussed above) plus half of the remaining timing payments for all economic outcomes attained (FaCS 2002).

Those who complete two years on the program and have not achieved an economic outcome are automatically considered to have achieved a social outcome. Recognised social outcomes include:

- improved self-confidence/self-esteem
- positive attitude to achieve goals
- increased ability to control anger
- effective coping strategies
- improved interpersonal skills
- able to set personal goals
- better able to make decisions
- improved personal care
- increased feelings of self-worth
- increased ability to cope in stressful situations
- improved family relationships (FaCS 2002).

Participants exiting PSP after two years are referred back to Centrelink for reassessment and the development of a new course of activities, based on the action plan developed by the PSP provider.

There was a range of views amongst providers about the effectiveness of the PSP transition and exit arrangements, either moving participants to other employment related programs or back to Centrelink. Some reported that once clients left the program 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'. This suggests a lack of a comprehensive transition strategy for many participants.

One Centrelink psychologist reported that they sometimes have difficultly linking high-need clients with appropriate programs and that in some cases they 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 able to take part in PSP again after being off the program for 12 months). This 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.

After PSP

Providers generally reported that only a handful of clients had moved to Job Network and 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 that they had more success working with Job Network agencies that were community-based or not-for-profits, 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 a number of 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 that 'there is 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 latest contract round.

Several case managers had had success transferring participants to Disability Open Employment (DOE) and CRS. These were reported to be easier to work with than Job Network, but only clients with a disability or requiring vocational rehabilitation were eligible. It was also suggested that it would be useful to be able to refer clients to Work for the Dole while they were on PSP (recent changes have allowed this to occur).

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 that many PSP clients still wanted to work and that the program was better suited to helping them achieving this goal because it allowed them to alter the intensity of their job search depending on the 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 being done in PSP in conjunction with employment assistance. This may not be a problem for clients who have made progress in dealing with issues, but appears problematic for those requiring ongoing support with non-vocational barriers.

Overall effectiveness

Case managers were almost unanimous that PSP was an effective and crucial program for assisting the most disadvantaged job seekers. They emphasised the significant and entrenched disadvantage that faced many PSP participants and 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 have a history of having been forced through a series of programs some of which are quite onerous but not helpful, so are desperately in need of a program that can focus on their needs and goals.

At an interpersonal level, particularly for the sizeable proportion of clients who are very isolated, the regular connection with a support person was seen as very helpful and an important foundation for achieving substantial change and helping clients to become more focused. And having a case manager that could empathise and relate effectively to the clients was identified as crucial. A few case managers made the point that a lot depends on how much clients are willing to take up the assistance on offer, with some clients simply moving from one crisis to another and others lacking the desire to change. However it was also noted that some clients changed over the duration of the program and breakthroughs sometimes came about unexpectedly.

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 addressing individual needs. Encouraging participation in non-vocational activities and increased social contact was seen as important in helping to develop relationships and reduce the fear of social interaction, which could then lead to reduced social isolation and a re-engagement with society more broadly. Some case managers felt strongly that improved social participation led to better employment outcomes down the track.

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

Size of caseloads was commonly mentioned as impacting on the overall effectiveness of PSP, and a number of case managers suggested that they would be able to achieve better outcomes if they could reduce their caseloads. However the actual case loads varied significantly between those interviewed, from around 30 up to 75. One view expressed was that once case loads become too high, PSP simply becomes a referral service to other agencies, and that the capacity to achieve results is seriously diminished. A minority view was that case loads which are too small encourage unhealthy dependence between client and worker.

Adequate access to services was also seen as a crucial element in PSP's overall effectiveness by many case managers. One commented that PSP's '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.

The overall lack of funding was also seen as a significant constraint on the program's effectiveness, with the potential to undermine its credibility and result in cynicism amongst clients of this being just another 'empty promise'.

The final reflection on the effectiveness of the program concerned achieving outcomes with difficult client groups, but there was some variation in the groups identified as difficult to work with. These included homeless clients with mental health issues; males in their late 20s or 30s with a long history of marijuana use; clients with personality disorders, which a number of case managers felt had support requirements beyond what could be provided through PSP; and other clients requiring highly intensive support and expensive support services.

6 Conclusion

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.

Research reviewed shows that personal barriers affecting many disadvantaged job seekers are a major impediment to employment and to social inclusion more generally. If not adequately addressed, they result in a significantly increased likelihood of staying on, or cycling on and off, welfare, resulting in 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.

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
- a recognition that some clients are unable to work or meet regular welfare-to-work requirements before addressing personal barriers
- a strengths-based approach
- greater flexibility to meet clients’ varied and complex needs
- 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
- ongoing barrier-specific post-employment personal support.

Data from participant surveys illustrates the high level of disadvantage experienced by PSP participants. Around 50% of the sample have been homeless in the past five years, 70% have year 11 or less as their highest level of education and 78% suffer from a mental health problem such as anxiety, depression or a personality disorder. They also have an average length of unemployment before entering PSP of around two and a half years.

Clients also appear to be at considerable risk of social isolation. They are significantly more likely than the general population to live alone and 75% experience physical health or emotional problems that interfere with their normal social activities, compared with only 17% of the general population.

Despite these barriers over 70% of clients reported a desire to participate in either employment or further education and training. This indicates that support and investment in capacities rather than

the increasingly punitive approach evident in much of Australia's welfare to work policy will be most successful in increasing participation amongst disadvantaged groups. However, intensive support to enter and stay in the workforce appears to be crucial: 84% of clients state that they would like to stay on PSP after gaining work or starting some other activity.

Despite many PSP participants' expressed desire to work, it appears that the program model is not well designed (or funded) to deliver employment assistance at the same time as providing assistance with non-vocational barriers. This seems to overlook the potential of work to assist in overcoming personal barriers, as well as the different abilities and goals across the client group.

This approach is significantly different from that used with similar client groups in the US and EU where there has been a greater focus on delivering intensive personal support in tandem with employment assistance developed specifically for clients facing non-vocational barriers.

The lack of better integrated and specifically developed employment initiatives is currently a significant impediment to the effectiveness of PSP. However, it is also important to note that PSP's focus on goals that are broader than employment and the recognition that some participants will be unable to engage in employment or employment related activities before addressing personal barriers are critical elements of the program. Moreover, around a quarter of participants consider themselves completely 'not ready' for work and 93% identify one or more barriers that are holding them back from work.

In terms of program delivery, the most significant concern is the inadequate program funding to assist a client group facing such significant disadvantage (recently announced small funding increases may improve this situation but are insufficient). This is evident in case managers reporting difficulties in delivering the required assistance due to cost in almost 90% of cases. Due to low program funding, agencies reported being able to allocate (from general program revenue) a maximum of $120 brokerage per client per year, and a number of agencies reported having no brokerage funds available.

The lack of funding is a key issue given the program's case management model and the scarcity of free or low-cost services in the community. It impacts on the provision of a range of services from counselling and mental health to education and training.

Other issues that were found to impact on the delivery of the program included long waiting times between referral and commencement, referral of clients with mental health support needs exceeding the scope of PSP, and issues with the structure of payments resulting in a significant administrative burden and distorting provider behaviour. A further concern is the finding that transition and exit arrangements do not appear to provide an integrated pathway of assistance for a significant proportion of clients and that in general post-PSP programs do not provide a continuation of support with the non-vocational barriers clients in PSP were facing.

Overall PSP appears to be a crucial and well-designed program for assisting people facing multiple barriers to employment, but there are also a number of elements which reduce its effectiveness. Since this group is among the most highly disadvantaged of all job seekers, adequate resourcing is essential to helping people back into the workforce. This is also represents an investment likely to provide substantial returns to the society as a whole, given the high likelihood of individuals remaining on some form of government benefit in the long-term without such assistance.

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