# New Disability Employment Services from 2018 DISCUSSION PAPER

*A brief, evidence based critique by Ken Davis (OT B.App.Sc.;MA-Counselling)*

Having read the *New Disability Employment Services from 2018 DISCUSSION PAPER* I am once more despairing that Australia will ever be able to provide a decent quality of life, including meaningful employment for people with disabilities. This does not mean I disagree with the report. I concur with its findings of extremely poor outcomes (effectively no change above baseline/placebo) despite huge amounts of funding since 2010. Even the 5 star performers are ordinary. This is consistent with my own experience as a client of the program and the experience of EVERY client I have worked for who has been a participant.

What surprises me is that anybody is actually surprised. The employment market in its current form is highly competitive with an estimated 20 jobseekers for every available job[[1]](#footnote-1). Despite the documented benefits of employing someone with a disability, what employer in their right mind is going to freely employ someone who needs frequent rest breaks, adaptive equipment or just being treated decently and fairly, when they can employ someone desperate and 100% fit? This is the inevitable, perverse outcome of a market system. Also, if you make the "Assistance" market competitive, then you will automatically create incentives to game the system by maximising financial outcomes and minimising expenses. This results in the widely known practices[[2]](#footnote-2) of "cherry-picking" and "parking". You can tweak the parameters all you like, but each tweak simply results in new groups being cherry-picked and parked.

This review is destined to fail, because it openly acknowledges that it is:

 1. Ignoring the external employment market

 2. Ignoring the interaction with other programs

 3. It also fails to consider nature of disability employment requirements and solutions that might actually work (which I will outline).

First some background about my story. I was a successful Occupational Therapist before becoming ill with what would eventually be labelled "Chronic Fatigue Syndrome". Its onset was around 1990 following an episode of Glandular Fever and a return to work when still ill (in response to market, employer and medical pressure). Diagnosis took seven years and was fraught with difficulty, medical ignorance and completely unnecessary expenditure of time, money and resources. I attended 2 DES providers, firstly Essential Personnel and secondly the Commonwealth Rehabilitation Service. Both were useless and readily admitted there was nothing they could do to help.

The CRS did suggest I consider self-employment and I successfully applied for a small grant for an arts project which helped me get started in a small amount of self-employment. I also taught myself web-design and generated some extra income in that area (although it was a poor fit). I independently found a series of low hours jobs which allowed me to return to work in the Transition to Work and Personal Support programs, eventually managing 18 hours per week, including a stint doing Job Capacity Assessments on a casual basis. Since then I completed a Masters in Counselling over 5 years part-time and currently work as an OT/Counsellor in a private medical practice, seeing clients mostly under the Better Access to Mental Health Scheme. My work capacity has remained fairly static at around 15-18 hours per week, although I am now able to cope with somewhat higher physical and cognitive demands. So I have had the opportunity to see the Employment Services sector as it relates to disability from almost every possible angle. I have seen it as a referrer, a client, an assessor, a service provider, and the support service provider for clients.

From this perspective, the report reads as an abstract piece of fiction, completely out of touch with real world practicalities – such as actually helping someone with a disability develop their capacity, obtain and maintain a job.

I will outline a series of requirements to actually build a system which has a chance of working better than the present one. These recommendations are evidence based, although my ability to provide detailed references is limited by my own capacity and limited time frame. I have ignored the limitations of the scope of the review because in my personal and professional opinion such limitations are not only folly, but the reason that the huge amounts of money and effort expended to date have been useless. The prime beneficiaries of the current system have been a small group of wealthy DES business owners and an army of unskilled "consultants" who would almost certainly otherwise be unemployed. There may be some social value in this, but the losers have been the people whom the system was allegedly designed to help. **Every** client I have ever seen who has been a client of the DES has gone from being initially excited about the prospect of getting help and support to find work to being bitterly disappointed.

The following nine recommendations are discussed in more detail below.

1. Eliminate disability related poverty

2. Ensure equitable, affordable access to the required diagnostic services

3. Make decisions on income support and interventions based on where the client is at the point of assessment, not some theoretical guess two years down the road

4. Provide genuinely evidence based treatment of the cost, intensity and duration determined by client needs

5. Use job capacity assessments to direct employment and quality of life related interventions, not eligibility

6. Develop new models of work and support that acknowledge the realities of economics and disability

7. Implement mandatory disability employment targets for medium to large employers and similar entities. Apply significant penalties for non-compliance

8. Use strategic, broad based, client centred case management to assist clients to navigate through the complex systems and pathways

9. Use the skills of Game Theorists and Behavioural Economists to minimise the risk of "gaming the system" by unscrupulous providers and employers, Governments

**Step 1 - Address disability related poverty**

The level of poverty in people with disabilities (whether they qualify for DSP or not) has been well documented[[3]](#footnote-3). Sometimes this poverty is simply the result of the impact of the disability on earning capacity, but often it has been lifelong as a result of intergenerational trauma and disadvantage. In recent years the tightening of DSP eligibility criteria has had the impact of subjecting large numbers of people with diagnosed and undiagnosed medical and mental health conditions into abject poverty of NSA. This is often compounded by the impact of breaches and suspensions caused by the person's inability to comply with unrealistic, non-evidence based requirements imposed arbitrarily by Centrelink and Employment Service Providers (or whatever they happen to be called this week). One in four people accessing Newstart Allowance have a disability according to the Department of Human Services own statistics[[4]](#footnote-4). Until you address this poverty, people with disabilities will have almost zero hope of being able to "compete" in anything - let alone the open job market.

Recommendation 1 - Remove the discrepancy between NSA, DSP and other payments and raise all payments at least to the poverty line - allowing for housing costs and cost of living disparities between regions.

**Step 2 - Address problems of diagnosis**

Qualification for DSP and correct streaming of clients, presently depends on diagnosis. The usefulness of diagnosis varies across conditions, but even in the most functionally oriented system, diagnosis would still be important as it relates to treatment and prognosis. Some diagnostic categories are relatively straightforward, where valid, reliable assessments exist - such as visual impairment or hearing impairment. In others, such as musculoskeletal injuries, clear categorisation and description of mechanical defects is relatively straightforward, but the correlation with function and prognosis is much vaguer.

People with mental health conditions have an even harder time obtaining a clear diagnosis. Sometimes this is due to the poorly understood nature of many conditions. Sometimes it is due to well-intentioned desires by professionals not to label or stigmatise clients. Mostly it is because in mental health, co-morbidity is the norm. Few people fit neatly into any one diagnostic box and most conditions unfold over a period of time.

The more unusual neurological and autoimmune type conditions are even more problematic with no clear diagnostic tests, few evidence based treatments and the tendency for health professionals to assign anything they do not understand into the "Psychosomatic" category - despite a long history of psychosomatic opinion turning out to be plain wrong.

Classic examples are conditions such as Epilepsy, Tourette's Syndrome, Multiple Sclerosis, Lupus and Parkinson's Disease - all formerly considered "hysterical" conditions. In the modern world - those who have diagnoses such as Fibromyalgia, Chronic Fatigue Syndrome, ADHD, Learning Disabilities, Chronic Regional Pain Syndrome and even more general Chronic Pain, tend to get lumped into the wastebasket of "Medically Unexplained Symptoms" (even where there is abundant evidence of biological abnormality).

This is compounded by Centrelink's perverse requirement for people to "prove" their disability with specialist reports, despite such investigations being manifestly expensive, beyond the means of most people dependent on income support and routinely not bulk-billed or available in the public health system. In my clinical experience, even when a GP can be convinced to write a specialist referral specifically asking for a clear diagnosis for Centrelink purposes, over half the time, the client returns WITHOUT a written diagnosis. That after having spent around $150-$300 for nothing - only to have to do it again at further cost. Furthermore, some assessments - such as detailed neuropsychological or psychiatric evaluations for brain injury, learning disabilities or complex psychopathology have long waiting lists if they are available in the public system at all.

A recent client of mine, brain injured for 10 years from domestic violence is still waiting on assessment after 6 months. Also - it is assumed that clients have the knowledge, skills and capacity to navigate complex, obfuscated and sometimes abusive systems to obtain the information required. At least once weekly I hear stories from clients about negative encounters with disbelieving and condescending health professionals who fail to provide a competent, evidence based assessment due to their own ill-informed belief systems about complex conditions.

Also, a common feature of many conditions is impaired insight and self-awareness and an inability to comply with the normal routines and demands of society. Strict participation requirements for this group are like asking a blind person to describe the colour red and punishing them when they fail.



Rather, concerned professionals, friends and family members should be able to report concerns re client impairments which are investigated sensitively and professionally to ensure that people with genuine incapacity are not punished for experiencing disability.

Recommendation 2 - Whatever system is in place to "case manage" clients with disabilities, it must have the capacity to fund and arrange the assessments that the client needs to document their condition satisfactorily for Centrelink. These assessments need to be performed by truly independent professionals, competent in their fields and free of bias and the tendency to resort to negative stereotyping.

**Step 3 - Abandon fortune-telling**

In Cognitive Behavioural Therapy (CBT) - an oft recommended treatment for psychological conditions - one of the classic, dysfunctional thinking errors is "predicting the future[[5]](#footnote-5)". Yet at present, the entire system is predicated on the opinion of an assessor as to what the client's status will be in two years' time IF the recommended interventions are provided AND they prove to be effective. While a "best guess" can be made on the basis of statistics, even that guess will be distorted by selection, reporting and confirmation bias, or as engendered in the recent PACE trial for CFS - downright fraud in medical reporting[[6]](#footnote-6). Many so-called evidence based interventions do far worse in the real world as compared to the skewed and filtered results that finally make it to publication. This predilection for faulty fortune-telling leads to the ludicrous situation where applicants are told to apply for DSP, are rejected on the grounds that "with evidence based treatment, it is likely you will be able to work 15 hours per week or more in two years". Two years later they reapply and the cycle continues. I have clients with conditions 20 years or more in duration, rejected time and time again, despite zero or minimal response to treatment. It is pointless and frankly abusive.

Recommendation 3 - Make decisions on income support and interventions based on where the client is at the point of assessment, not some theoretical guess two years down the road. If a client recovers, they will likely return to work without intervention. Failing that, regular reviews can determine whether there has been a significant change in functional capacity (and it ultimately doesn't matter as due to recommendation 1, there is no incentive for the Government to game the system by dumping the genuinely disabled into poverty).

**Step 4 - Provide genuinely evidence based treatment**

In many areas of health at present, there are widespread claims of "evidence-based treatment" - which are clearly NOT evidence-based. One example is the Better Access to Mental Health program (which I practice in). Guidelines state that practitioners MUST use evidence based interventions, but the program framework makes it impossible by limiting treatment to 10 sessions in a calendar year. This limit is manifestly inadequate even for the majority of simple mental health presentations, but is woefully inadequate for severe depressive and anxiety disorders, personality disorders, psychosis, substance abuse and the sequelae of complex trauma (i.e. Child Abuse and Domestic Violence victims). While the Government proclaims that BAMH was never meant for such complex conditions, in the vast majority of regions, there is no alternative, and the majority of users of the service ARE complex and high needs. These limits are also evident in almost all ATAPS and Headspace programs as well.

In the Workers Compensation system, injured workers with poor outcomes often have a predisposing history of physical or mental health issues which leave them vulnerable. The system guidelines require practitioners to focus on the effects of the injury and on return to work, which limit their capacity to deal with so-called "side issues". The only option for such injured workers is to seek to address these issues through BAMH - which is also limited, unless they are fortunate enough to be the victim of a crime or in an area that has a specific program that meets their need. In the Workers Compensation system, there is ample evidence that the current inquisitive, adversarial system actually produces perverse outcomes[[7]](#footnote-7).

Recommendation 4 - Provide clients with disabilities with the resources to engage in treatment programs of the cost, intensity and duration determined by their needs and the best available evidence, regardless of their nature or origin. This will require workforce measures to deal with problems of skill shortages and the underutilisation of skilled workers due to professional gatekeeping and monopoly practice. This will require significant and complex interventions to address the problems generated by complex trauma and undiagnosed learning disabilities and the like.

**Step 5 - Abandon the concept of Job Capacity Assessment as an eligibility criteria**

Also a fundamental issue which has been raised relates to work capacity assessment. At present the task of job capacity assessment is fraught with difficulty, and most instruments are unreliable, invalid and do not translate well with real-world work capacity.[[8]](#footnote-8),[[9]](#footnote-9). The best predictor and assessor of work capacity is working in a job. The current Australian model is worthless. The best assessor is the client, based on their experience - not some "independent expert". There are far too many variables in a person's real-world work capacity to reduce it to a 2-day assessment, let alone a 45-minute interview. That is not to negate the value of strength testing, Range of Motion, personality assessment or cardiopulmonary testing and the like. They can all be used to inform the range of options to explore. However, the ultimate test is to provide structured, real world work where experts act as consultants to the client and the employer. Of course, such consultation is pointless if the employer will not facilitate the clients return to work. Assessment should focus primarily on identifying suitable work, skills, knowledge, attitudes, retraining and education options as well as the need for adaptive equipment and task modification. Of course, if recommendation 1 is followed, recommendation 5 is a natural consequence.

Recommendation 5 - Use job capacity assessments to direct employment and quality of life related interventions, not eligibility.

**Step 6 - Stop ignoring economic reality**

Australia has had over 200 years of "jobs and growth". It has not solved the problem of unemployment, underemployment, exclusion, discrimination and disadvantage. More of the same will not suddenly start producing outcomes the current system has not produced to date. Unless structural unemployment is addressed, people with limited work capacity will ALWAYS be at the bottom of the pool of preferred employees. This requires major structural change to the approach to job creation, working hours and conditions, remuneration structures and the way the economic benefits of a modern technological society are shared. Stephen Hawking understands this - it is a shame most politicians and economists do not[[10]](#footnote-10).

This issue is indeed beyond the scope of this review, but is a fundamental requirement if there is to be any hope of improving current outcomes. Much theoretical work has already been done by The Centre of Full Employment and Equity at the University of Newcastle[[11]](#footnote-11). The most promising model appears to be the “Jobs Guarantee”.

Another economic reality, ignored even by Disability advocates is the reality of part-time work. Disability advocates (ab)use disability/inspiration porn to promote the idea that the only barrier is attitudes and that if you change attitudes, then "anything is possible".



For a small, select group of people with disabilities this may be true. For the significant majority, there are profound environmental, physiological and sometimes psychological barriers that cannot be overcome. Many will be physically and/or psychologically incapable of working full-time and require a fundamentally different approach to work and time-utilisation. To cope with chronic pain, fatigue, severe mental health conditions and the like - often requires a piecemeal approach to work that simply does not fit the modern profit and efficiency maximising productivity paradigm. These people require frequent breaks, time-off, the ability to work from home (or avoid long commutes), flexible and reduced hours and a focus on results rather than time-based work.

In some ways, self-employment is a good option, as the worker can set their own structures. But most start-ups require a sustained period of excessive effort to reach the point of viability that is usually beyond the capacity of someone with moderate to severe incapacity. There are no easy solutions to these complex challenges but the following recommendations would be a step in the right direction.

Also in the current economic system - there is an assumption that higher level jobs need to be performed full-time and a high level of availability is required. This tends to limit the entry level options available for a person with incapacity returning to (or entering) the workforce. It profoundly limits their opportunities for advancement and compensation, even if they do successfully (re)enter the workforce. So the reality for most people with disabilities who do "succeed" is they get stuck in jobs below their level of skill and competence and due to the low rates of pay, reduced hours and limited opportunities for advancement, they remain stuck in a poverty trap (even if it is better than unemployment)[[12]](#footnote-12). To add insult to injury, there is the expectation that people with disabilities should be grateful for any work they can get.

Recommendation 6 - Develop new models of work and support that acknowledge the realities of economics and disabilities such as:

 • Implement the "Jobs Guarantee"

 • Educate leaders to promote and develop the concept of quality part-time jobs - including the "Public Service"

 • As part of the job capacity assessment process, help clients to identify and work towards obtaining highly paid positions which make part-time work more financially viable

 • Develop disability oriented Incubator and Work-Co-operative models where self-employment and flexible work options can be practised in a low risk and supported context

**Step 7 - Apply carrots to potential workers and sticks to recalcitrant employers, especially the government**

The current approach uses a punitive approach for people with disabilities by applying harsh qualification, evidentiary and participatory requirements, steep taper rates which reduce the financial incentive to work and takes a "softly-softly" approach to employers and employment services. Despite decades of "education” and 6 years of significant financial investment - the participation rate for people with disabilities remains static. In the public sector, rates are declining[[13]](#footnote-13). Until major structural change occurs, disability participation will not increase without mandatory targets for all employers above a minimum size. The public sector should be leading by example. The same targets should apply to the leadership of political parties, cabinet, unions and the composition of corporate boards. Significant penalties should apply to those entities that fail to comply with their social obligation. These penalties could be used to fund an army of disabled workers in the "fair go compliance team".

Recommendation 7 - Implement mandatory disability employment targets for medium to large employers and similar entities.

**Step 8 – Use a quality case management approach**

To implement this range of interventions in the real world requires a high level of co-ordination. Complex care requires strategic, broad based, client centred case management to assist clients to navigate through the multiple systems and pathways required to have the best prospect of working. This really encapsulates all the steps outlined above in a manner similar to the NDIS, Lifetime Care and Support and Personal Helpers and Mentors programs. Again, priority should be given to employing capable, qualified people with disabilities in these positions.

**Step 9 – Reduce “gaming the system”**

I have previously identified the widespread and openly acknowledged practices involved in manipulating the system to extract maximum financial benefit for minimum input. In economics this is called productivity. In human services it is called neglect and exploitation. While it is impossible to completely eliminate, one option would be to use the skills of Game Theorists and Behavioural Economists to design and monitor the system to minimise the risk of "gaming the system" by unscrupulous providers and employers.

I am sure there are many more ideas which might just work. The one thing I am sure of is that tweaking a few parameters as recommended in the discussion paper will amount to little more than rearranging deck chairs on the Titanic. Unfortunately, like that ill-fated liner, the passengers are mostly doomed and the benefits will flow to the salvage workers, journalists and film-makers. I'm also pretty sure the owner of the ship will get a brand new shiny ship from the insurance premiums, ironically built into the price of the tickets paid for by the doomed passengers.

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