Submission to the

State Budget
Consultative Process
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ANGLICARE
TASMANIA

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1. EXECUTIVE SUMMARY AND RECOMMENDATIONS

1.1 Executive Summary

During 2003, Tasmania has continued to experience strong growth in the economy in response to the effective management of the State's finances along with a booming property market, increased tourism and a reduction in unemployment. While many Tasmanians are already feeling the benefits of this improving situation, there are many others for whom increased activity in the housing market results in homelessness and new opportunities in the labour market bypass them because of their age, education, skill level or health status. In this year's submission to the State Budget Consultative process Anglicare focuses on those members of our community who are most significantly disadvantaged, people living with psychotic illness and the long-term unemployed.

Thirty six per cent of Tasmanians rely on Commonwealth Government pensions and benefits as their main source of income. This figure vastly exceeds the national average of 28 per cent (ABS, 2003a). Many low income families live in communities in which their entire social and family network have very restricted access to financial resources. This submission outlines a number of initiatives to help address this socio-economic disadvantage.

The concessions system is an important way for the State Government to assist low income Tasmanians to achieve a decent standard of living. In its response to the 2003-04 Budget, Anglicare welcomed the initiative regarding electricity concessions. The $2.8 million allocated to extend the concession to Health Care Card holders for the two winter quarters was an important step in assisting the lowest income households to keep their homes warm. The actual take-up of this concession has been significantly lower than the Budget estimate, around $2.2 million per annum expected to remain unspent. Anglicare argues that these allocated and unspent funds should be used to provide the full-year electricity concession to Health Care cardholders.

The public dental system is facing a serious crisis, which was recognized in part by the $5.3m allocated to Oral Health Services in the 2002-03 State Budget. It is clear from the report of the Tasmanian Auditor General, and the experiences of the target client group, that further investment is desperately required to make the service viable.

People living with serious and disabling mental illness are among the most disadvantaged members of our community. Due to the chronic and episodic nature of their illness, this group is highly vulnerable to the cluster of factors of social disadvantage, such as living in poverty, family breakdown, social isolation, poor general health and dental health status, a high risk of homelessness or inappropriate and insecure accommodation and unemployment. As a result of their illness, they also experience extreme financial hardship and social marginalisation. Anglicare argues that it is essential to meet the fundamental needs of this group to ensure the good health, stability, financial security and optimal

social functioning in the community. This submission makes specific recommendations to address the housing, dental health and financial management needs of people with psychotic illness.

Long-term unemployment continues to be a significant problem for Tasmania. Although there has been a welcome reduction in the number of Tasmanians unemployed for 12 months or more, the rates are still well above the national average. Prolonged unemployment has severe impacts on individuals, families and communities, creating heavy demand on services delivering health care, community support, education and justice. Anglicare welcomed the announcement of the $1.4 million Partnership to Jobs scheme in the 2003-04 Budget. However, Anglicare believes that the State Government needs to implement a much more significant program to achieve the employment goals outlined in the Tasmania *Together* process.

1.2 Recommendations

1. That the State Government allocate $550,000 of the unspent recurrent allocation for the winter electricity concession to cover the cost of providing the full year concession to Health Care Card holders.

2. That the State Government uses the remaining unspent winter electricity concession allocation to cover the cost of indexation for the Electricity Concession for all concession card holders.

3. That the State Government removes the upfront $20 fee for the Tasmanian Dental Service for adult concession cardholders. This could be achieved with the addition of $800,000 recurrent funding based on current estimates and other improvements in the public dental health scheme.

4. That the State Government allocates $3.5 million annually to restore dental health funding to pre-1996 levels. This is in addition to the $5.3 million allocated in the 2002/03 Budget.

5. That the State Government allocate $6 million for capital infrastructure costs and establishment funding for a range of housing options for people with psychotic illness in each region. These options would provide long term accommodation with low level support and include boarding houses and supported community housing models.

6. That the State Government allocates $100,000 for a 12 month pilot project to increase access to dental health services for people with psychotic illness.

7. That the State Government provide additional funding to the Public Trustee to meet the costs of Financial Administration for CSO clients and ensure the abolition of fees and charges for Administration clients relying on Centrelink pensions and with assets of less than $100,000.

8. That the State Government establish a CJP and CJP+ program with an initial allocation of $14 million over two years and a further $42 million over three years contingent on a positive evaluation of the initial program.

9. That the State Government set aside $1 million to implement a Building on Experience Program.

2. PROFILE OF ANGLICARE TASMANIA

Anglicare Tasmania, the largest statewide community service organisation in Tasmania, operates under the auspices of the Anglican Church and is part of Anglicare Australia. Anglicare has offices in Hobart, Glenorchy, Launceston, Devonport and Burnie and provides a range of community services throughout Tasmania including many outreach services to rural areas.

In operation since 1983, Anglicare employs over 400 staff and has developed strong networks and relationships with peak bodies, ministerial advisory committees, local inter-agency networks, other community service agencies, Commonwealth and State governments and the broader community.

Anglicare provides a range of services across the state. These include financial counselling, family and relationships counselling, marriage and relationships education, problem gambling counselling, domestic violence services, services to homeless youth and people at risk of homelessness, group homes for people with disabilities, employment services, a needle exchange and emergency relief services.

In 1995 Anglicare established a Social Action and Research Centre (SARC) which engages in research and policy development. SARC's role is to engage in social action, policy development, advocacy and public debate based on appropriate research. Its focus is Tasmanians living in poverty. SARC exists to support Anglicare's mission to achieve social justice and provide the opportunity for people in need to reach fullness of life. SARC's work is informed by the direct experience and involvement Anglicare has developed through its community service work.

For further information about this submission please contact:
Rev Chris Jones
Anglicare Tasmania
GPO Box 1620
Hobart Tasmania 7001
Ph: 62 34 3510
Fax: 62 31 6480
Email:c.jones@anglicare-tas.org.au

3. THE IMPORTANCE OF STATE GOVERNMENT INITIATIVES TO ADDRESS SOCIO-ECONOMIC DISADVANTAGE

> *"You thought it would be simple; it is extraordinarily complicated. You thought it would be terrible; it is merely squalid and boring. It is the peculiar lowness of poverty that you discover first; the shifts that it puts you to, the complicated meanness, the crust-wiping."*

We are 70 years and a continent away from George Orwell's description of poverty in Paris and London but the experience of being 'down and out' is remarkably similar. Tasmanians struggling against the closed horizons of poverty find their attempts to gain a pathway out thwarted on many fronts. Income support payments are too low and employment hard to find. The withdrawal of income support on receipt of earnings quickly erodes most advantages gained from casual work. Further education and vocational training is costly and affordable housing is remote and inaccessible.

Thirty six per cent of Tasmanians rely on Commonwealth Government pensions and benefits as their main source of income. This figure vastly exceeds the national average of 28 per cent (ABS, 2003). The widespread nature of low income status in Tasmania means that many low income families live in communities in which their entire social and family network have very restricted access to financial resources.

These are bald statistics for those paid comfortable salaries to develop or decide on Government policy. Buffered by steady employment and good wages, it is difficult to imagine the anxiety of being unable to afford food or a trip to the doctor or of having an unpaid utility bill. Yet in research projects conducted between 1999 and 2003, Tasmanian low-income earners have repeatedly told Anglicare researchers of regular food shortages. The following exchanges, shocking in a country experiencing such sustained economic growth, are typical.

> ***Researcher****: So are you ever worried that you won't have enough food to last the week?*
> ***Ruth (Disability Pensioner):*** *Well many a time I have had cereal for tea …because it was all that was left.*
> ***Margie (Disability Pensioner):*** *In fact I have cut breakfast out because I find I just can't afford it. (Launceston 2003)*
>
> ***Researcher****: What about you Greg, do you ever run out of food before pay day?*
> ***Greg (Disability Pensioner)****: Yeah. Usually run out about three days before pay day.*
> ***Researcher****: What do you do for those three days?*
> ***Greg****: Drink coffee. It fills up your stomach, you don't feel hungry. (Hobart, 2003)*
>
> ***Researcher****: Have any of you ever had the experience of running out of food before pay day?*
> ***Beth (Disability Pensioner):*** *Yeah! Of course! Everyone does.*
> ***Researcher:*** *How do you get through it?*

***Beth**: Go to City Mission and get the bread. I live on the bread[1]. (Launceston, 2003)*

***Kathleen:** I've had days when I've gone without food to feed the kids. I've done that a lot, you get used to it. It probably happens every couple of months – when the Hydro bill comes in. (Zeehan, 2000)*

***Jenny**: I've gone to the Salvos and to Anglicare for Emergency Relief (food) parcels but I'm not allowed to have any more this year. You can only have four a year. I don't know what I'll do now. (Burnie, 2000)*

Time and time again as they have travelled across the State, Anglicare researchers have been told of remarkably consistent figures to quantify people's budgets. Typically, single people, both those who are unemployed and living on Newstart Allowance and those on the Disability Pension, have stated that their grocery budget each week is in the range of $25 to $30 a week. This is between $3.60 and $4.30 **a day** for food. For those people fortunate enough to be on the affluent side of Australia's broadening wealth divide, this is the cost of a café latte.

***Denise:** I live on basics. If I want something, I go without something else. My diet is cereal, sandwiches, cheese, eggs on toast, sausages, mash. It's rare to go outside that. I spend $25 a week on food. Groceries are the only area where you can cut back. (Zeehan, 2000)*

These quotes are not extraordinary. They are the people behind the Healthy Community Survey's well publicised findings about the food shortages experienced by low income Tasmanians (DHHS, 2001).

The simplest budgeting exercise demonstrates the extremity of the problem. An unemployed adult on Newstart Allowance receives $346.60 a fortnight plus Rent Assistance if they are renting privately. Someone paying the average rental of $140 a fortnight would receive an extra $42.90. Their total income would be $28 a day.

Table 3.1 Example of a daily budget of an adult on Newstart Allowance and Rent Assistance

Budget items	Budgeted cost/day
Rental	**$10**
Power	**$3**
Phone	**$2**
Transport	**$4**
Food	**$4**
Other	**$5**
Total	**$28**

The $5 for 'other' has to cover the cost of looking for work, pharmaceuticals, doctor's gap charges, child maintenance, dental fees, clothing, newspapers, parking, participation in sport, house insurance,

[1] Inside the front entrance of Launceston City Mission is a wooden bin of day old bread for distribution to low income Tasmanians. People are asked to limit themselves to one loaf a day. The clients call it 'duck bread' because it is the bread other people on higher incomes use to feed ducks.

feminine hygiene products, contents insurance, car insurance, car maintenance, club memberships, haircuts, new clothes, personal loans, any social interactions and credit card bills. Transport costs must cover the cost of travelling to meet Activity Test Requirements. Failure to meet those requirements leads to 18 – 100% loss of income.

The lives of poor people are played out in a spiral of issues such as poor health and poor educational outcomes, poor access to services, tenuous connection with the labour market and long term, intergenerational disadvantage. At the heart of this spiral of 'extraordinary complexity' of poverty lies the simple fact of insufficient income.

For those people who have the responsibility for care for a vulnerable person – a child or a person with a disability, the distress is magnified by their inability to help someone they care about.

Stephen is a volunteer carer who works through the Red Cross's MATES scheme, a program which links volunteer carers with people with psychotic illness. He described to an Anglicare researcher his attempts to help his frail elderly 'mate', the mentally ill and lonely resident of a Tasmanian boarding house whose cracked dental plate made it impossible for him to eat the special food his medical condition required.

> ***Stephen**: He had had a colostomy, and nobody could take him and no family would sort of look after him and he had a cracked top plate … [When I was introduced to him] I thought, well I had better get this teeth problem sorted, so I went up to the State teeth … and they made an appointment for me about three or four months down the line - with this cracked plate and this man has a colostomy, mind you. And I explained to them about the cracked plate. But unfortunately he died [before the appointment].*
>
> Stephen went on to describe his friend's diet. *"He had obviously been living on soup and soft food, you know because he couldn't chew it properly…he certainly probably wasn't having a proper meat diet or anything like that, he was living on sandwiches and soup and things like that…He had had it* [the cracked plate] *for about two or three years, he told me. It was just sort of clicking, you could hear it clicking when he was talking. He was quite an elderly man …And she [Tasmanian Public Dental Service] said 'oh you would have to bring $20 with you'. And I said, 'can't we get it a bit sooner than this? Because he's got a colostomy with an eating problem, it's pretty important'. She said 'no, no', … … I think it [the appointment] was March or April or something, it was about four months down the track. I couldn't get any help for that or anything.*

What made the situation particularly difficult for Stephen was that he was also a Disability Pensioner, and he knew that even had they made it to the appointment neither he nor his elderly 'mate' would have had the $20.

The story of a sick old man captures a number of well publicized social policy issues: the impact of co-payments on access to the Tasmanian Public Dental Service, the problem of waiting lists with the

Tasmanian Public Dental Service, and the widespread nature of disadvantage in Tasmania, which means that many Tasmanians have no-one in their network to turn to for a loan in a financial crisis[2].

> ***Stacey**: My sister had severe stomach pains and went to the Royal, we waited two hours and they turned her away because they said she should see her GP. She didn't have any money to go a doctor. She had to wait two days for her (Centrelink) payment before she could go to the doctor. I would have given her the money to go if I had it, but there is no spare money." (Hobart, 2000)*

The level of income on which pensioners and beneficiaries live is beyond the power of the State Government to address. The levers the State Government can use to assist the most disadvantaged are through the provision of affordable housing, lowering the cost of essentials, utilities and providing work and training opportunities.

Through the State Budget process the State Government will be presented with many requests for its attention and resources. Who should have a greater claim on their assistance than the most disadvantaged in their community?

[2] Just over 40% of Healthy Communities Survey respondents (representing almost 129,000 adult Tasmanians) indicated that they would not be able to raise $2000 in a week for an emergency (DHHS,2001).

4. STATE CONCESSIONS

4.1 Introduction

The concessions system is an important way for the State Government to assist low income Tasmanians to achieve a decent standard of living. Anglicare welcomed the initiative regarding electricity concessions in the 2003-04 Budget. The $2.8 million allocated to extend the concession to Health Care Card holders for the two winter quarters was an important step in assisting the lowest income households to keep their homes warm. The actual take-up of this concession has been significantly lower than the Budget estimate. This lower take-up rate is due to a range of factors including:

- the number of households which include both a Pension Concession Card holder and a Health Care Card holder (who would already be accessing the more generous Pensioner Concession);
- the number of households which include more than one Health Care Card holder; and
- the number of households where the electricity account is not in the name of the Health Care Card holder (for example a dependent student living with their parents).

This lower than expected take-up rate means that the State Government has unspent funds from the existing allocation which should be used to provide full-year concessions to Health Care Card holders and further assistance with electricity bills for low income earners.

4.2 Background to Concession Cards

The Commonwealth social security system is set up with two main concession cards, the Pension Concession Card and the Health Care Card. As shown in Table 4.1 income support payments by the Commonwealth to people holding Pension Concession Cards are higher than for comparable individuals holding Health Care Cards. All pensioners, including part-pensioners (who may be receiving only a very small pension to supplement their retirement income) are eligible for Pension Concession Cards. Health Care Cards have much tighter income qualification criteria. It is Health Care Card holders who have the greatest need for assistance through the state concession system. However, for historical reasons the majority of State Concessions have only been available to Pension Concession Card holders. The State Government's decision to provide the partial electricity concession to Health Care Card holders has been a significant step towards a fairer and more equitable concessions system.

Table 4.1 Comparison of Pensions and Concessions

	Pension Concession Card	**Health Care Card**
Major groups holding card	Aged Pensioners; Disability Support Pensioners; Single Parents	Newstart Allowees; Youth Allowees Sickness Benefit recipients
Annual income for a single adult (no children) with no other income as at October 2003	$11,772 (Pension)	$10,010 (Newstart)
Percentage increase in payment since October 2002	5.4% (Pension)	2.7% (Newstart)
Annual maximum allowable income to qualify for card (single adult, no children)	$32,929	$17,472

(Source: Centrelink)

The Federal Government has been pushing for the extension of State Government concessions to a third group of card holders - retirees holding Commonwealth Seniors Health Cards (CSHC). These cards are provided to people who do not qualify for the Aged Pension due to their income and assets but who earn $50,000 or less (singles) or $80,000 or less for couples. Anglicare strongly opposes any extension of State concessions to CSHC holders on the basis that government concession funds must be concentrated on people who are on low incomes.

4.3 The Importance of Electricity Concessions

Anglicare continues to believe that the electricity concession is the State's most effective tool for delivering financial relief to low income earners. The two other major state concessions, the council rates remission and the vehicle registration concession rely on home ownership and vehicle ownership as pre-requisites for assistance. Those who have been unable to afford to buy a home or car miss out on this State Government assistance. The electricity concession by contrast has the potential to assist almost all low income families as very few households are without electricity.

Assistance in reducing the cost of electricity is highly valued by low income Tasmanians. A combination of cool climate and high costs mean that Tasmanians in the lowest two income quintiles pay around 15% more for household fuel and power than the national average for this income group (ABS, 2000a, 2000b). Many low income families report trying to reduce electricity costs by turning off heating and other rationing. However, the high fixed costs for residential electricity consumers mean that such attempts are not very effective in reducing overall bills. The relief provided by the full-year Pensioner Electricity Concession (approximately $180 per annum) is very significant in this context, as the reduction in consumption which would be required to make similar financial savings, is very large.

4.4 Tasmania *Together* Targets

The Tasmania *Together* process clearly states as its first goal: "Ensure all Tasmanians have a reasonable standard of living with regard to food, shelter, transport, justice, education, communication, health and community services."

The 2005 target for Standard 1 Indicator 1.1 is that: The cost of food, electricity, housing, transport and health as a percentage of income for low income earners should be 65%. Housing costs and electricity costs are two areas where the State Government can assist in achieving the goal benchmark. Unfortunately, in the past year there has been movement away from the target. An increase in the cost of petrol between May 2002 and May 2003 was largely to blame for the movement away from the target in the past year (to 73% for an unemployed couple and 74% for an unemployed family). The positive impact of the winter electricity concession was not reflected in this year's figures as it was not yet in place at the time the figures were calculated. The winter-time extension of the 48.4c per day Aurora Concession to Health Care Card Holders will assist towards the reduction of the cost of essentials as a proportion of income, however, the provision of the full-year concession would reduce the figure by around 1% for each household.

Indicator 1.5 states that the proportion of households that report that they are unable to buy enough food for the household is presently 10% and that this should drop to 0% by 2005. The extension of the Aurora Concession would be expected to have a significant impact on this indicator as electricity bills have been identified as a key cause of financial difficulties for low income families.

An Anglicare survey of Emergency Relief (ER) providers found that after food costs, electricity bills were ranked as the issue of greatest concern for people accessing ER services (Anglicare, 1999). Most ER providers give the majority of their assistance in the form of food parcels which accounts for the high ranking of food costs but also indicates that electricity bills are a major cause of food crisis for low income Tasmanians. Just over 50% of those seeking ER were holders of Health Care Cards (Anglicare, 1999).

4.5 Full Year Extension of Electricity Concession to HCC holders

The lower than expected take-up rate for the Health Care Card holder winter electricity concession will leave about $2.2 million per annum of the original $2.8 million allocation unspent. Anglicare believes that the most appropriate way to use the unspent portion of these funds is to provide the full-year electricity concession to Health Care Card holders. This would ensure that the funds are used for their original purpose, to assist the lowest income group, and also ensure further progress towards the Tasmania *Together* benchmarks.

The DHHS Concession Unit reports that registrations for the concession have slowed following several surges after newspaper articles on the scheme. Registrations for the Health Care Card electricity concession as at the end of August 2003 were just over 4600 households. Anglicare would not expect that the number of Health Care Card holders registering for the concession would go much beyond 6000 in the next few years. This provides the State Government with the opportunity to extend the electricity concession for Health Care Card holders to the full-year concession without the need for any additional funding allocation.

Recommendation 1: That the State Government allocate $550,000 of the unspent recurrent allocation for the winter electricity concession to cover the cost of providing the full-year concession to Health Care Card holders.

4.6 Indexation

The 2002-03 State Budget allocated funds to cover full indexation of Pensioner Rates Remissions. As discussed previously, the electricity concession is a far more equitable concession than the rates remission as it is available to almost all low income earners rather than restricted to pensioners who have been able to afford to purchase a home. The 2004-05 Budget should ensure that the real value of the electricity concession is not eroded over time by providing for full indexation of this concession. Such indexation should, however, be seen as a secondary step to the provision of the full-year concession to Health Care Card holders.

Assuming the rate of inflation continues to remain within the Reserve Bank of Australia's target of 2-3% per annum the cost of indexation in the first year would be around $300,000. Even after extending the winter concession to a full-year concession for Health Care Card holders, the unspent allocation would be expected to cover about five years of indexation for *all* concession cardholders.

Recommendation 2: That the State Government use the remaining unspent winter electricity concession allocation to cover the cost of indexation for the Electricity Concession.

5. THE PUBLIC DENTAL SERVICE

5.1 Introduction

> *"Australia is now a country where you can pick the poor by their teeth."* (Durri Aboriginal Corporation Medical Service (NSW) to the Senate Inquiry into Public Dental Services, 1998)

Access to dental care for Tasmanians living on low incomes is a widely recognized problem. This issue has repeatedly been identified as a major concern for Tasmanian low-income earners in a series of Anglicare's research projects between 1999 and 2003. The particular oral health needs of people with serious mental health disorders have emerged through research undertaken by Anglicare in 2003 (see Section 6.5).

The correlation between low income and poor oral health is well documented (for example AIHW, DSRU 2001b; Zigarus and Moore, 2001) and this is a particularly significant factor for Tasmania with the highest proportion of concession cardholders of any Australian state (ABS, 2003a). There is also a growing recognition of the significant health and social consequences of poor dental health. Poor oral health, tooth decay and periodontal diseases have a significant impact on people's everyday experiences such as eating, sleeping, speaking and general social roles. There is also abundant evidence to suggest that poor dental health is a causal factor for a range of other medical conditions including pneumonia, cardiovascular disease, diabetes and pre-term low birth weight babies (ADASA, 2002; Spencer, 2001:5-6) and that it compromises the treatment of patients with gastro-intestinal conditions (ADASA, 2002).

Dental disease is almost entirely preventable and the costs of preventative measures are insignificant when compared with the costs of providing restorative care (Senate Community Affairs Committee Enquiry, 1997). However, current funding levels have led to a dental program that is skewed towards the provision of emergency dental care. This is poor economic and social policy. The provision of a preventive based dental program is more effective primary health care and leads to better dental health outcomes. It is also more cost efficient because of the avoidance of the complex dental treatments that are required to try and save heavily diseased teeth.

This submission argues for increased investment in the Tasmanian public dental service and the establishment of a programme to facilitate access to this system for people with serious mental health disorders.

5.2 Tasmania *Together* Targets

Tasmania *Together* recognizes the poor dental health of adult Tasmanians. The key goals and indicators for dental health are based on the premise that good dental health is critical to individual wellbeing and the maintenance of a healthy lifestyle. The specific indicators are intended to address

the issues of access to dental services, the lengthy waiting lists and the high rates of extractions and Tasmanians requiring dentures. The relevant indicators and goals are Goal 5, Standard 1, indicator 1.5, the number of fillings and missing or decayed teeth in the population. It is also addressed through Goal 6, Standard 1, Indicator 1.1: The number of people on the waiting list for more than six months for full or partial dentures; and Indicator 1.2: Level of satisfaction with access to health and community services

Previous investment by the State Government in progressing these indicators has seen positive movement on Goal 6, Standard 1, Indicator 1.1: a reduction in the waiting lists of people waiting for full dentures from 1145 in 2001 to 923 in 2002 (Tasmania Together Progress Board, 2003).

5.3 The oral health status of Tasmanian low income earners

Tasmanian adults have the worst dental health in the nation with the highest percentage of edentulous (complete loss of natural teeth) adults per capita. At 15.3% of the adult population, the Tasmanian rate is 5.6% higher than the national average (AIHW DSRU, 2001a). There is a combination of factors that contribute to this. The correlation between low income and poor oral health is a particularly significant factor for Tasmania with the highest proportion of concession cardholders of any Australian state (ABS, 2003). The problem is further compounded by a chronic shortage of dentists. Tasmania has the lowest dentist to population ratio of any State or Territory in Australia – 26.5 per 100,000 compared to the national average of 43 per 100,000 (ADASA, 2002).

National research demonstrates that the oral health problems experienced by people living on low incomes are worsening. In a recent analysis of the National Dental Telephone Survey data, the Australian Institute of Health and Welfare Dental Statistics and Research Unit argue that the gap between the 'deprived' and the 'privileged' in Australia in oral health outcomes and the use of dental services is growing. The DSRU found that people who are uninsured and living on a low income have:

- higher rates of complete tooth loss;
- problem oriented dental visiting;
- higher rates of extractions and lower rates of fillings;
- longer periods since the last visit;
- greater likelihood of avoiding or delaying care due to cost; and
- More self-reported treatment needs (AIHW DSRU, 2001b).

Tasmanian low income earners are severely affected in all these areas and their situation compares poorly with low income earners in other states. Specifically, the high rates of edentulism (complete tooth loss), high rates of extractions, barriers of cost and prolonged delays in accessing dental care are pressing issues.

5.3.1 High rates of tooth extraction

> *"You never get an option of keeping a tooth when you are poor, do you? None of these root canals or that sort of business" (Shelley, aged 21, Hobart)*

Australia-wide, the rates of oral surgical or extraction services in public dental care are 122% more than those in private dental care (Spencer, 2001). Tasmania has the highest percentage of persons wearing a denture in the nation by a significant margin in all age categories from 25 to 65+ (AIHW DRSU 2001a).

Anglicare researchers collected the focus group findings and client case studies referred to in this submission in 2001. All the clients referred to fall within the 17 – 30 year age group. This group is highly susceptible to poor oral health. For these clients a lack of focus on preventative health strategies was often compounded by unstable housing arrangements and lack of income, as the following explanation by Shelley illustrates.

> *"Four years ago, which is a long time, and that's when I had my left eye tooth out, and I was told to book for dentures. I've never had a permanent home or anything until recently, so I haven't got in for my dentures…[T]he dentist didn't explain it to me. He just said 'Oh you'll have to get in for dentures' and so I just went 'Oh well, whatever' and I left it for years. Now my whole face…the top of my teeth is pulling towards this way, making the right eye tooth (that's missing as well) forcing this over here. It's causing pain through my nose, it's really weird, it pulls through my jaw. Now I need braces to pull all that across, then get a denture put in and all sorts of stuff." (Shelley, aged 21, Hobart)*

The extremely high percentage of people wearing dentures Tasmania can be explained by a number of factors. First, the lengthy waiting times for general dental care during which dental problems deteriorate from restorative treatments to acute surgical ones. Second, the limited resources and time in the public system strongly influence dentists' treatment options (Spencer, 2001:34). Third, people find it more effective to substitute emergency care for the long wait for basic dental care. People making this choice are 4.5 times more likely to have an extraction. The lack of choice available to low income earners and the lengthy delays for general dental care is a source of profound frustration for both clients and service providers in the public dental health clinics and is repeatedly identified as a reason for the difficulty in attracting dentists to work in Tasmania. All of the issues identified here preclude the development of preventative dental care.

The following comments from focus group participants illustrates this emphasis on emergency dental care in the Tasmanian public dental system:

> *"I have early stage gum disease which needs to be treated regularly but you can't get in unless you have an emergency."*

> *"They are not really interested they just looked at the sore tooth but they didn't check any of my other teeth."*

"Apparently you are meant to have your teeth checked during pregnancy but what chance has a pregnant woman got when there is a three year waiting list?"

5.4 Issues of access to dental care for low income Tasmanians

5.4.1 Cost as a barrier to treatment

The introduction of fees for adult dental care in 1998 has been touted as an important tool for the management of waiting lists. While it certainly has acted to suppress access to public dental services, the necessity for this strategy in a context of 20 year waiting times has to be questioned. Anglicare would argue that co-payments increase inequity, even among the eligible target group, decreasing access for the multiply disadvantaged, undermining preventative care and treatment plans.

The introduction of co-payments nationally saw a dramatic one-third reduction in the demand for non-emergency treatment in public dental care (Dooland 2000; Spencer 2001). National research indicates that more than one quarter of adult Australians avoid or delay visiting a dentist because of cost. This has the most significant impact on those with the lowest incomes. This research further shows that, nationally, cost prevented 40% of concession cardholders from seeking recommended or wanted dental treatment and this represents an 11% increase from the previous year (AIHW DSRU, 2001a). In Tasmania 44.5% of concession cardholders avoided or delayed treatment due to cost compared to the national average of 37.5%. Cost prevented 38.5% of Tasmanian concession cardholders seeking recommended or wanted dental treatment compared to the national average of 32.3% (AIHW DSRU, 2001a).

The imposition of fees in many cases results in low income earners accessing dental services only for emergency treatment, rather than for preventative or restorative procedures. One of the negative outcomes of this fee schedule or co-payment policy is the net increase in the total cost of dental care by increasing the number of more expensive emergency treatments (Ziguras and Moore, 2001). Tasmanian data on the number of public patients in public hospitals for dental procedures between 1994 and 1998 suggests that more extreme intervention is being required by concession card holders in Tasmania (Cameron, 2002a).

Anglicare researchers have consistently found that research participants identify cost as a major barrier to accessing dental care for either general or emergency care. As indicated in previous sections of this submission, the extremely low income of concession cardholders means that the $20 co-payment for a dental visit is often beyond their capacity.

The case of Jenny, a young mother aged 22 years old, illustrates the effect of both cost and the lengthy waiting list on her dental health and the manner in which the existence of the fee undermined the value of the initial treatment.

"I was on the waiting list for two years. My tooth ended up crumbling so I got in as an emergency case a week later and the dentist told me off for leaving it so long. He said there was nothing left to pull out. That was the week before Christmas and they said I needed to have five other teeth done. I could have got in but I didn't have the twenty dollars. I'd had to lend the $20 before I went the first time and it was the week before Christmas. I needed time to save up but now I've been on the waiting list ever since. I've given up on my teeth entirely." (Beth,Hobart,2001)

Clearly financial problems can over-ride even the incentive to seek emergency treatment. Jeremy is 28 years old. His tooth was broken two years prior to this interview.

"Just lately it's just starting to give me headaches, enough to deal with after two or three Panadols. I've got to go and get it out but I haven't got around to it. So what I've done is I've probably chewed through enough Panadols to have almost been better off to have gone to the dentist, but I haven't had all the money in one go. Sometimes when we are hard up for cash I'll find it easier to say, you know, just buy me a cheap packet of Panadols and I'll get through the week. So we don't get there [to the dentist]." (Jeremy, Hobart, 2001)

The elimination of fees would remove one significant barrier to accessing dental care for low income earners. This would be a powerful strategy to improving access and attitudes to preventative and general dental care. The estimated revenue raised for dental co-payments in 2000-2001 is $760,000 (Jackson, 2001a). Based on this estimate an additional injection of funds to this amount would increase the dental health options for Tasmanian low income earners.

Recommendation 3: That the State Government remove the upfront $20 fee for the Tasmanian Dental Service for adult concession cardholders. This could be achieved with the addition of $800,000 recurrent funding based on current estimates and other improvements in the public dental health scheme.

5.4.2 Length of waiting lists and waiting times

The official waiting time for clients of the public dental service is the expected time for all clients on the waiting list to receive treatment at current treatment rates. Waiting times are key performance indicators for the Service. In its November 2002 report, the Auditor-General published the following table with the Oral Health Service data readjusted to take into account factors such as the audit of the waiting list, the suppression of the list due to well publicized waiting list blow outs, and the reduction in general care provision due to reduction in dental resources (see Table 5.1).

Table 5.1 Waiting list for general dental care (adjusted)

Region	Waiting List	Waiting times (months)	Waiting times (years)
South	5211	200.4	16.7
North	6610	241.2	20.1
North-West	1526	234.8	19.5

(Source: Auditor-General's Report, 2002: 49)

The length of the waiting times led the Auditor-General to conclude:

> *"Waiting times for general care are at unacceptably high levels, with no reasonable chance of an adult obtaining general care in Tasmania's public oral health system."* (Auditor-General's report, 2002: 5)

And further,

> *"Dental resources are insufficient to provide general care and there was some evidence that in the Southern region the service is struggling to meet the demand for emergency care."* (Auditor-General's report, 2002: 6)

The size of the waiting lists and the length of waiting times raise a number of critical issues. While there has been an increase in the number of people on the waiting lists, there is evidence that people do 'drop off' for reasons other than seeking alternative dental care. Changes in eligibility and death are often cited as key reasons, as is seeking alternative treatment although this is a less likely explanation for very low-income earners. Residential mobility however is a significant factor that can impact negatively on oral health outcomes of particular low-income groups. For example, insecure and short term tenancy is a problem for many low income groups, with recent Anglicare research showing that low income earners on the Tasmanian private rental market move, on average, every 10 months (Cameron, 2002b). Young people and people with special needs such as mental health problems are particularly vulnerable. Transience and homelessness result in this group falling off the waiting list and being lost to the public dental health system, until their dental problems become acute.

The length of waiting lists for dental care in combination with the co-payment costs meant that many low income earners, like Jenny, just give up on their teeth altogether. The Auditor-General has estimated that 'only 26% of eligible adults are actively participating in attempting to access general care. Of those only one-third were successful', that is only 9% of eligible adults (Auditor-General, 2002:15). As Dooland (2000) argues this makes co-payments a 'dangerous tool for controlling waiting lists'.

Nationally, the growth of waiting lists to 'absurd lengths' has dramatically increased the demand for urgent dental services. The complexity of the problem has been described as a system 'trapped in a vicious cycle' in which the predominance of emergency treatments limits the scope and depth of dental services, leading to quicker visits by orally sicker people or "poor dentistry for poor people" (Spencer, 2001:30). There is strong evidence to show that when the waiting lists have grown, there is a corresponding increase in the rate of tooth extractions (Dooland, 2000).

Clearly the response to these complex problems must be multifaceted and the Department has piloted some initiatives. However, urgent attention is required. In the 2002 report, the Auditor-General recommended that the State Government give serious attention to Oral Health Services, with the warning to the Department of Health and Human services that "…providing sufficient levels of general care to achieve acceptable standards of oral health in the target population will require a substantial injection of funding" (Auditor-General's Report, 2002:16). The Auditor's analysis, based on a number

of models, was that Oral Health Services required twice as many dentists to meet a suggested national minimum standard.

5.5 Conclusion

Anglicare acknowledges the abrogation of responsibility in regard to oral health funding by the Commonwealth Government and the financial constraints the State Government must work within when funding oral health. The investment of $5.3m in the Tasmanian Dental Service in the 2002-03 Budget should have assisted in addressing some of the critical issues affecting the service but a history of poor strategic planning in Oral Health Services (Auditor General's Report, 2002) has meant that little of this money has been expended. With the Tasmanian Auditor-General questioning the actual viability of the service without further investment, the Government must act to address this urgent health issue, particularly as the State will experience increasing demand over the next few decades as the population ages and more people will retain their own teeth into old age. Anglicare recommends the formation of a high level working group with representation from Treasury and the Department of Health and Human services to oversee the development of a business plan and strategies and to kickstart the expenditure of allocated funds. Anglicare believes that the provision of recurrent funding will enable the Public Dental Service to begin to move towards the provision of general care to its client group, making it a more attractive employment option for oral health workers.

Recommendation 4: That the State Government allocates $3.5 million annually to restore dental health funding to pre-1996 levels. This is in addition to the $5.3 million allocated in the 2002–03 Budget.

6. LIVING WITH MENTAL ILLNESS

6.1 Introduction

The increasing incidence of mental illness in Australia and the corresponding growth in demand for mental health services is a major concern for all Australian states. The National Survey of Mental Health and Well Being for Adult Australians (ABS, 1998; Andrews et al, 1999) found that almost 1 in 4 people had experienced a mental health problem in the previous year. This statistic encompasses the broad spectrum of mental health problems.

Within that statistic are a smaller percentage of people who experience serious and disabling mental illness. Described as 'low prevalence disorders' this category of mental illness includes schizophrenia, bi-polar affective disorder, forms of depression and other psychotic illnesses. Although a smaller proportion of the community suffers from these forms of mental illness, the social disadvantages experienced faced by this group are multiple and extreme (Frost et al, 2002; Harvey et al, 2002; Jablensky et al, 1999).

It is widely acknowledged that it is difficult to calculate accurate figures on the number of people affected by psychotic illness. The best available data estimate that 34,250 Tasmanians are living with a major mental illness and being cared for by public sector mental health services (Burgess et al, 2002: 170). These people have affective disorders, personality disorders, psychosis or cognitive impairment. Of these, approximately 1,300 Tasmanians have a serious and disabling psychotic illness.[3] However, it is reasonable to assume that this figure is an underestimation.

Due to the chronic and episodic nature of their illness, this group is highly vulnerable to the cluster of factors of social disadvantage, such as living in poverty, family breakdown, social isolation, poor general health and dental health status, a high risk of homelessness or inappropriate and insecure accommodation and unemployment. As a result of their illness, they also experience extreme financial hardship and social marginalisation.

Anglicare believes it is essential to meet the fundamental needs of people with psychotic illness in our community to ensure their good health, stability, financial security and optimal social functioning.

6.2 Anglicare's research with people with psychotic illness

The data and recommendations outlined in this section of the submission are drawn from the preliminary findings of research conducted by Anglicare in 2003 into the issues and concerns for people living with a serious and disabling mental illness in Tasmania. This qualitative study includes a

[3] This figure is based on the conservative estimate used by the Low Prevalence Disorders Study Group component of the National Study of Mental Health and Well Being (1999) which found that 4.7 adults per thousand in urban areas in Australia have a psychotic disorder.

series of focus groups with people living on low incomes with mental health issues and their carers, in addition to individual interviews with service providers and other key stakeholders. Participants had to be adults with a medically diagnosed mental illness which regularly prevents them from participation in the labour market, education or training for periods of three months or more, and eligible for a Health Care Concession Card or Pension Concession Card. Similarly, the carers and family members who participated looked after a person who met those criteria.

6.3 Tasmania *Together* Targets

The key themes emerging from Anglicare's research highlight the strong links between mental illness and social disadvantage. The first broad goal identified by Tasmania *Together* "to ensure all Tasmanians have a reasonable standard of living with regard to food, shelter, transport, justice, education, communication, health and community services" is critical for this specific group because of the multiple disadvantages they experience due to low income, lack of appropriate housing options with adequate support, limited access to services, in particular the public dental service, and discrimination.

Goal 5 addresses the issues of health and wellbeing is particularly pertinent to the issues identified by people living with psychotic illness. Two of the indicators against which this goal is benchmarked measure social participation: Indicator 5.2.1: to increase the proportion of Tasmanians who feel part of the community; and specifically, Indicator 5.2.2: to increase the level of acceptance and understanding of mental health in the community[4]. Participants in Anglicare's research repeatedly spoke of the stigma and discrimination they experienced as a result of their illness. This was a key factor in their sense of well-being and strongly affected their mental health status.

6.4 Access to appropriate, secure and supported accommodation

Secure, safe and stable housing is an essential factor for individual health and social well being. People with serious mental health problems experience significant difficulties in accessing and maintaining appropriate and secure housing for a range of reasons including poverty, difficulties with managing finances, inappropriate type or location and incapacity to maintain housing due to illness. Stable housing is consistently shown to be critical to the effective management of mental illness and enhanced social functioning (Harvey et al, 2002; O'Brien et al, 2002; Robinson, 2003).

Anglicare's interviews with key stakeholders and service providers in this area consistently identified lack of appropriate housing options for people with psychotic illness as one of the most critical issues for this group in the State. This is strongly supported by the accommodation histories of the majority of participants in Anglicare's research that illustrate the transient and insecure nature of housing for

[4] These indicators were included in the original Tasmania Together document (2001) but not the subsequent reports because targets have not been established. Nonetheless inclusion in the original document is indicative of the importance of these issues to the Tasmanian community.

many people with mental illness. Participants were currently living in a range of tenure types including public housing, private rental, crisis accommodation and boarding houses. Many participants described feeling isolated and insecure, a lack of safety and social discrimination which were stressors exacerbating their illness and often precipitating a psychotic episode, resulting in hospitalization.

It is difficult to measure precisely the level of unmet need for accommodation types throughout the State (DHHS, 2003). This is largely due to problems in identifying the population group, lack of data collection in existing services and the highly transient nature of many people with psychotic illness. The following issues are indicative of the need for increased housing options which include a range of short, medium and long term tenancies with corresponding capacity to maximize independence, choice, security of tenure and adequate disability and clinical support provision.

6.4.1 Insecure housing or iterative homelessness

Iterative homelessness is a term used to refer to "the repeated and ongoing loss of, or movement through accommodation in the short and long term contexts of homelessness" (Robinson 2003:3). It explains the tenuous nature of accommodation for many people with mental illness, who often live in a cycle of inappropriate or unacceptable forms of accommodation including the range of hostels, boarding houses, caravan parks, staying with friends or on the streets. Many participants in Anglicare's research live in a cycle of iterative homelessness. Twenty of the 54 participants with mental illness had moved five times or more in the past five years, with one person moving 14 times.

A number of research participants talked about the benefits of hostel or boarding house accommodation. This was often the only way they were able to ensure that their basic needs such as regular meals, personal hygiene and sleep, were met.

The experiences described below by two young men, both in their 20's and both with schizophrenia illustrate clearly the pattern of transient accommodation common to people with psychotic illness. As in both these cases, the marginal accommodation available to this group exposes them to risks factors which erode their self confidence and set off episodes of illness.

> *"I'm living in [a boarding house]. It's good. It's warm and you get your food. I was living there before but then a bloke that lived there asked me if I wanted to move into a flat with him. I said OK but I shouldn't have. It was terrible. He was OK to begin with but then he went mental and he couldn't sleep and he kept banging on my door and waking me up. He never used to pay his part of the bills either and he expected me to buy all the food. In the end I couldn't sleep either. So I was really glad when I could go back to [the boarding house] but I still can't sleep because of what happened when I was living with Bill. I used to live with my Gran but after she died my uncle decided he wanted to put tenants in the house and make some money so I had to leave. I moved into my car and I lived in it for a few months until the police found me one day. They were good – they got me into [the boarding house]." (Steven, 28, regional city)*

"The [crisis accommodation] is alright. I came here when I came out of detox because I had nowhere to go. Before I went into detox I was living in the caravan park. I'd got really sick and I was in hospital for a long time and when I got out I had nowhere to go. I wandered around for a while and then I ended up in the caravan park because it was all I could afford. But everyone there was into drugs and drinking and I got into it too because I wanted to fit in. But I've got out now. [Crisis accommodation] is all right but the rooms are real small and I stay inside all day because if I go out everyone I meet wants to talk about drugs." (Troy, 26, regional centre).

6.4.2 Public housing options

In acknowledgment of the particular and acute housing needs of this group, current national housing policy stipulates that targeted priority public housing be made available for clients with complex and high needs. As Category One clients, people with psychotic illness are most likely to be housed relatively quickly in Housing Tasmania units. However, these highly vulnerable individuals can often become the victims of others in an unsupported environment. Findings from Anglicare's research indicate that a substantial minority of participants feels unsafe in this housing option.

The following example highlights the problems experienced by a number of participants. Dennis has schizophrenia and anxiety disorder and is currently living in crisis accommodation.

"Yeah, I lived in a housing unit in [regional city] and I had a lot of people using me, borrowing money off me and not paying me back. They was drug addicts, shooting up and smoking dope, got cones and all that stuff. And I just wanted a unit to be by myself because I couldn't face crowds or anything like that. I was too paranoid. And I just didn't like living in there and I am never ever going to get another one. I'd rather sleep in the street than get one of them again. You get different people and they move in but they haven't got an illness, and they think you should be just normal like them. [They would say] "Come down the pub, come over and move the car", I can't do those things so I get sick and end up in the hospital. So I was very unhappy living in Housing. [Now I just want] to get away from them all to start a new life". (Dennis, 51, regional centre)

Joan's son Phillip has been unwell with paranoid - schizophrenia for ten years. Now aged 30, Phillip has lived at home with his parents, in and out of hostels and crisis accommodation and often on the street. He had recently been allocated a public housing unit, but lack of support, his own inability to care for himself and the problems caused by his neighbours combined to bring on another serious psychotic episode resulting in his hospitalisation.

"Well, he's back in hospital again now, but they've put him into a housing commission unit because they tried him in all these hostels around the place, you know [boarding house], and [crisis accommodation], and all the hostels and he has been asked to leave all of them. So, I mean you know, there is absolutely nowhere, you know. I suppose he should be out at Longford[5] but there's no room. So in the end, they put him in a unit on his own and, ah, he is very bad, he is getting a lot worse, his psychosis…He is a lot worse, you can't talk to him about anything or anybody you know, they're conspiring against him." (Joan, 70, son Phillip aged 30, regional city).

[5] The Howard Hill Centre is a 15 bed residential care unit for adults who have been incapacitated by psychotic illness.

6.4.3 Renting in the private market

The current housing boom in Tasmania has dramatically reduced the amount of affordable private rental accommodation in the state. Low income earners are significantly disadvantaged in a housing market in which rental prices are soaring. Research conducted by Anglicare in 2002 identified the multiple barriers to the private rental market experienced by socially disadvantaged groups such as people with disabilities (Cameron, 2002b).

Those people living with a psychotic illness are highly susceptible to discrimination by landlords and real estate agents which often results in their exclusion from this form of housing tenure entirely. In some cases, people with psychotic illness can be challenging tenants. Many may have difficulties with basic life skills such as housekeeping and shopping. Anglicare argues that with adequate support and assistance, people with mental illness can function effectively in the private rental market and sustain long term tenancies. However without that support it may be extremely difficult to maintain the tenancy because of the nature of the illness. For example, people with schizophrenia and bi-polar disorder often have problems managing money. In a manic phase, it is not uncommon for people to spend all their money in a spending spree, as exemplified in the following narratives.

> *"I've been living in my place for 9 years and it's nice. But now I've been given a notice and I'm going to be evicted and I don't know what I'll do. I think what happened is I was sick before and I was really racing and I didn't pay my rent. I think that's what happened. I've worked out though – I've paid $32,000 in rent in the time I've been there and now they're just kicking me out." (Annie, 31, regional town)*

> *"I got evicted last year because I didn't pay my rent. I'd got sick. I spent all my money shopping, I guess. I think that's what happened. Anyway I had to leave so I had to move in with my mother. She lives in a little two bedroom Housing Tasmania unit so it was really hard. I had furniture and stuff that I'd bought when I was working and I had to take it all with me to Mum's. It was really hard to find a new place because I didn't have good references from my landlord." (Donna, 32, regional city)*

Research participants who had private rental housing with sympathetic and understanding landlords were much more likely to have maintained their tenure over a longer period and feel more secure about their lives. However, for many others the expensive and competitive market context and the nature of mental illness made them particularly vulnerable to exploitation by unscrupulous landlords. This situation often leads to people being forced to move on a regular basis and to living in inappropriate or substandard accommodation. As previous Anglicare research found, the most vulnerable groups in the private rental market are the least likely to know their rights as tenants or to pursue them, if they do know them at all (Cameron, 2002b).

> *"I lived underneath a dodgy massage parlour once. Actually it was available and it happened to belong to someone we knew and so we rented it. We knew it was a massage parlour, we didn't know it was a 'dodgy' massage parlour…It was OK. It was a bit of a dungeon basically with no windows. Yeah, well I had a window that was the size of a brick in my room, so it was really dark. I just sort of got by in the near*

darkness. It didn't help me at all – I had some very lonely 3ams. I think I was there for about six months and that was on …….St." (Patrick, 23, metropolitan centre).

"I'm renting a place. It's really hard to find places. We had to move out of our place suddenly so I saw an ad and I took this place in … St. Ron [the Anglicare worker] said, 'Don't do it, it'll just be trouble' but I said 'Nah I have to'. So I took it and we moved all our stuff in and when we got there, we'd been there one day and I was hanging the washing out. The place didn't have a clothesline so I was putting the washing on chairs and the landlord said 'You can't put your washing out like that' and I said 'I have to, I haven't got a clothesline', so he kicked us out! Just like that! So we had to move again. Ron said 'I told you it would be trouble.'" (Wes, 42, regional centre)

6.4.4 When living with family is inappropriate

A further concern is the number of adults with psychotic illness who are living with family members in circumstances that are unsuitable. A number of family members who participated in Anglicare's research recounted experiences in which their adult children were forced to live with them because there was no where else for them to go. This often resulted in increased stress and anxiety for the parent, particularly in cases where the adult child was inclined to violent, threatening or otherwise frightening behaviour when unwell.

"He is about 6 foot 2, right, so he pinned me against the wall like that and I am black and blue from head to toe, and I accepted that… And it's not very nice but that's what you live with. And then I get bailed up in my own home and he sat at the door and he is so big and he sat like this up in the doorway and then you get locked in a room if you have got a key. You have to hide all keys or otherwise he padlocked himself in the room. How do you feel in your own home being locked outside for about 3 or 4 hours or so, that's what you've got to live with. And that's what you live with." (Karen, 53, son Mike 26, Hobart)

Caring for a family member with a psychotic illness can also have a very destructive and distressing effect on other family members. In the following example, the mother of a young man with schizophrenia, now in his early 20's, describes the painful choices she had to make about her son living with the family. In this case, Patrick was able to live successfully for periods with other members of his extended family in close proximity to the family home but in many cases such an option is not available.

"We hadn't ever encouraged him to come back to our house because his illness his, um, um, imaginings that he really thinks are absolutely part of life, is all to do with vampires and creatures of the night and all that dark side…And he is paranoid, and he's into lots of blood letting and cutting, and blood and this is all part of his world. He cuts himself all the time and he was getting pictures of the people cutting themselves and people sucking blood and sticking them up all over the bedroom. And at the time his younger brother and sister were much younger than him, and especially Jeremy, and um, and we were really concerned about the other children having to live with this. So we didn't encourage him to come home. And he, he has knife collections, lots of knives, and it is all to protect himself and he has knives to protect himself and to protect us. You know, so it is all, it is rather a concern when you have got younger children." (Meredith, 53, son Patrick 23, metropolitan city).

6.4.5 Conclusion

Safe, secure, affordable and adequately supported accommodation is essential for people living with psychotic illness to manage their illness, maintain good health and maximise their capacity to participate in the community. Research shows strongly that this is the most critical and effective way to prevent frequent and prolonged hospitalisations that are both detrimental to the person with mental illness and extremely costly to the community.

Preliminary findings from Anglicare's research with people living with psychotic illness indicate strongly the need for a range of appropriately supported housing options with an emphasis on long term tenancy to maximise security and stability. Anglicare recommends that the State Government develops housing options, operational in each of the three regions and which should include:

- the establishment of boarding houses with appropriate level support;
- cluster style two bedroom units in a supported community housing model; and
- an increase in the number of mental health community support workers to assist people living in their homes or living with family.

6.4.6 Recommendations

(a) The establishment of a Boarding House in the North and North West

Anglicare is aware that funding for a Boarding House in the southern region was allocated in the 2003-04 State Budget (estimated at $2.36 million). It is anticipated that Housing Tasmania will be calling for tenders for this project in the near future. Anglicare recommends that the boarding house model be replicated in the North and North West of the state.

Anglicare recommends the allocation of $4.6 million for the purchase, refurbishment and establishment costs of two boarding houses with full facilities for 25 people. Additional recurrent support funds are required to maintain this housing option for the initial 12 months after which the boarding house would be self-sustainable from tenants' rental payments. This amount also includes costs of 2 support workers and infrastructure costs for 5 years.

2 properties @ $2 million = $4 million
2 x .8 Support Workers Level 5 Community Services Award @ $30,000 pa plus infrastructure costs over the next 5 years
$120,000 x 5 years = $600,000

(b) Supported Community Housing Models

Research into the housing needs of people living with mental illness indicates that many people prefer to live alone in independent units rather than a boarding house model (for example Harvey et al, 2002). Independent living is preferred for a range of reasons including safety, more privacy and greater opportunity for social interaction with friends and relatives. For many people with psychotic illness intensive assistance and support is essential to link them into community based support networks and activities.

Support worker model: TAMOSCH

A supported community housing model, TAMOSCH, has been operated by Anglicare in the North West of the State since June 2002 in conjunction with Curraghmore, a residential facility in Devonport. The pilot of this project has been successful and the project is now receiving recurrent funding. Anglicare is currently working with Housing Tasmania and Mental Health Services to establish a similar model in the Northern region.

This model consists of one support worker who provides personalised and intensive support for 10 people with psychotic illness, who are living independently in one or two bedroom units owned and managed by Housing Tasmania in Devonport. The support includes assistance with living skills, social skills and linkages to social support networks with the express objective of reducing hospital admissions or premature admission to long-term institutional care. The support worker provides focused support planning, advocacy, information and referral as well as practical assistance such as transport, shopping and housekeeping, using brokerage funding.

Anglicare recommends that a similar supported accommodation model be established in the south of the state. While Anglicare does not suggest that this is the only model upon which to develop a supported community housing program, the budget for the TAMOSCH program is indicative.

The total cost of the current program is $113,630 per annum, which includes salary and on costs and full operating costs. Given the larger population in the south of the state, it is recommended that funding be committed for two support workers to meet the needs of 20 clients at a cost of $227,260.

Cluster housing model with low level support

An additional model could provide cluster housing style two bedroom units in an area with close proximity to a corner shop, public transport and a public telephone. This model would offer the opportunity for independent living with access to a central community room with kitchen. An on-site support worker could provide low level support and regular contact with specialist services as required.

Projected establishment costs for a cluster housing model is $970,000 which includes a Support Worker Level 5 Community Services Award for a year @ $38,000, construction and land purchase. These figures are based on the estimated costs by Housing Tasmania for the construction of a standard two bedroom unit, excluding land cost, at approximately $130,000, making a total cost of $780,000 for six units. To meet the minimum dwelling density factor for urban residential zoned land, the block of land would need to be 2,000 square metres. The approximate value of land this size in Glenorchy is currently $150,000.

Recommendation 5: That the State Government allocate $6 million for capital infrastructure costs and establishment funding of a range of housing options for people with psychotic illness in each region. These options would provide long term accommodation with low level support and include boarding houses and supported community housing models.

6.5. Issues of access to dental care for low income earners with psychotic illnesses

Anglicare recommends that in its strategic planning Oral Health Services look at strategies for facilitating access to dental services for vulnerable and disadvantaged groups as a priority. These groups include but are not limited to: people with a mental illness; people living in supported accommodation; homeless people; people using drug and alcohol treatment programs and those on methadone programs; people with disabilities; Aboriginals and Torres Strait Islanders; new arrivals to Tasmania under refugee or special humanitarian programs; new arrivals to Tasmania on Bridging and Temporary Protection Visas and young people. As a pilot programme Anglicare recommends that funding be provided for a pilot project for people with psychotic illnesses.

Marilyn: complex issues for dental health care

Marilyn is a young woman living in Ulverstone. She has complex mental health issues and days when medication confusion severely limits her capacity to function. When she experienced severe pain with toothache, the Dental Health Clinic rang her at short notice with an appointment time for treatment. She was advised that she had to attend that appointment and pay the $20 fee upfront. Marilyn was unable to make the appointment for a number of reasons including that she did not have transport to get to the clinic in Devonport, she did not have the money readily available and her mental health condition made it particularly difficult for her to organize herself in the short time given before the appointment. Her non-attendance was interpreted as a sign that she did not require emergency care and she was placed on the waiting list. (Client case study, June 2001)

The issues confronting concession cardholders in accessing the public dental health care system are compounded when people have complex needs such as mental illness.

Good oral health is critical for people with mental illness. Pain and discomfort associated with oral disease can result in a cycle of poor diet, poor sleep and aggravation of their mental health problems. It is recognized that people with mental illness are:

- extremely vulnerable to oral disease;
- likely to have poorer oral health than average;
- less likely to access available dental care, unless for an emergency leading to more complex and invasive treatment;
- more difficult to provide appropriate and acceptable care to.

People with mental illness have substantial oral health needs. Chalmers et al (1998) found that for a number of reasons people with mental illness are noted for experiencing chronic and significant oral disease. This is due to the effects of both the illness and the medication prescribed to address it. For example, both depressive illness and schizophrenia are associated with disinterest in oral hygiene, some psychotic conditions are linked with high levels of smoking, which both causes dry mouth and affects the process of periodontal healing. Other conditions can lead to a disinterest in a balanced diet, disordered thinking and difficulty performing tasks, remembering appointments or homecare instructions. More specific symptoms may result in extreme fear of the dentist, hallucinations centring on the mouth, hypochondriacal delusions, fear of body secretions, fear of contamination or ritualistic tooth brushing resulting in abrasions to the gums. Psychiatric medications also have side effects that compromise oral health. Some anti-psychotics have the side of effect of creating sugar cravings or dry mouth (a reduction in the saliva flow, reducing the mouth's natural cleansing process and increasing plaque build up and the incidence of oral disease). Similarly, the lithium treatment commonly prescribed for bipolar disorder increases dental decay and disease. Clients with mental health problems have a high need for gum treatment, restorations and extractions. However, research shows that their extensive oral health needs are largely unmet (Chalmers et al, 1998; Yarra Oral Health Project website, accessed Sept. 2003).

Psychotic illness is strongly associated with poverty. In addition to the health issues which act as barriers to this group accessing dental services, the financial barriers and waiting lists which face all Tasmanian low income earners are significant concerns for people who face the additional burden of mental illness. A simple example of how the tools used to manage over-demand for the dental service effectively bar access to those with multiple disadvantages is the current practice of requiring patients in need of emergency treatment to ring the Dental Service at 8.30am. All emergency appointments are routinely filled by 9.30am. To compete in this flurry of activity would be enormously difficult for a group characterized by lack of access to telephones; difficulty organizing thoughts and activities; difficulties with motivation; and a tendency to sleep through the mornings due to the side effects of medications.

The carers who participated in Anglicare's research identified oral health as a major problem for this group. While displaying clear visual evidence of substantially decayed teeth and partial and broken dentures, none of the consumers were accessing regular or preventative dental care and only a minority were attempting to access emergency care. For those who had made an effort to access dental care the barriers to access (the charging of co-payments and the existence of an extensive

waiting list) had exhausted their motivation to pursue this assistance. Other barriers cited included an actual lack of interest or concern about oral health. For example, an edentulous consumer with partial dentures missing explained to the researcher that 'he had had no reason to go' to the dentist. Another significant barrier was fear of the dentist. In this, as in other areas of their health care, the pressing concerns of their mental illness made other health needs of secondary importance to them.

A number of carers of people with serious mental health disorders believed that the Public Dental service was effectively inaccessible to their relatives/friends. The overwhelming reason cited for this was the co-payment charged by the service. The carers also noted that the symptomology of mental illness itself contributed to the poor oral health of their relatives/friends. They cited lack of motivation, lack of appetite and/or disinterest in a balanced diet, disordered thinking, lack of interest, poor memory, lack of forward planning and the way these symptoms contributed to poor financial management skills.

Many of the carers were themselves living on low incomes and were eligible to use the Public Dental Service. They noted that even without the complicating problems of mental illness they themselves could not get affordable or accessible treatment from the Public Dental Service. This contributed to a sense of hopelessness about the crisis in the public dental system ("none of us can afford the dentist") which undermined motivation to advocate for access to existing services for their mentally ill relative/friend.

Addressing the oral health needs of low income Tasmanians who are experiencing mental health problems requires an inter-disciplinary and strategic response from Mental Health Services and Oral Health Services. Programmes to maximize access for this group within existing resources have been piloted successfully in Victoria and NSW (Yarra Oral Health Project; Chalmers et al, 1998). Case management for people with mental health problems must include facilitating supported access to dental services, and liaison with dental staff to ensure availability of appointments timed to suit the client. With client permission, case managers also play an important role in communicating important information to the dental service such as current medication regimes, the client's medical history and current mental health status. Similarly dental services staff play an important role in assisting case managers, carers and clients to understand the importance of oral hygiene and ways in which to instruct and reinforce the importance of participating in both preventative and emergency treatment. Using models of group appointments, peer support, cross-disciplinary training, and case management the pilot programmes have successfully addressed the issues of client anxiety and fear, access, and consistency of treatment in ways which have maximized usage of dental appointments and reduced problematic behaviour.

Clearly exemption from co-payments is critical to access for people with psychotic illness. The symptomology of these disorders causes poor oral health both directly and indirectly and at the same time makes the organization of the personal resources required to access preventative or emergency dental care almost impossible.

Anglicare recommends the development of a prevention and treatment service targeted at this client group. The pilot project would include the development and trial of a multidisciplinary dental programme for adults with low prevalence mental health disorders living in the community. Anglicare recommends further that concession cardholders with low prevalence mental health disorders be exempted from the co-payment system.

Recommendation 6: That the State Government allocates $100,000 for a 12-month pilot project to increase access to dental health services for people with psychotic illness.

6.6 Management of finances for people with psychotic illness

6.6.1 Introduction

Many of the participants in Anglicare's research spoke about the difficulties of managing their finances, particularly during episodes when they were severely ill. The options for obtaining assistance with managing finances are very limited for people with psychotic illness. Some have formal or informal arrangements with family members, their GP, boarding house managers or mental health services however, such arrangements can place additional strains on personal and professional relationships. The Public Trustee can also be appointed as Financial Administrator, however, for many who are dependent on the Disability Support Pension as their sole source of income, the cost of using this service is prohibitive. This section of the submission examines the costs and fees imposed by the Public Trustee for clients under Financial Administration, considers the problems associated with these fees and makes a recommendation for change.

6.6.2 Financial Administration

The Guardianship and Administration Board is able to order the appointment of an Administrator to make legal and financial decisions for an adult with a disability who cannot make reasonable judgments about financial or property matters because of their disability. The Board cannot appoint an administrator if there is a less intrusive, less restrictive way of managing a person's financial affairs. An Administration order is a last resort option to be used when no other realistic alternative is available.

An Administrator can be an individual (for example a relative or friend) or an organization (for example the Public Trustee or a private trustee company). The Public Trustee may be judged as the most appropriate administrator for a range of clients but is also appointed as Administrator where clients do not have another person who is willing or able to take on this role.

Administration clients with the Public Trustee are divided into two categories (i) Community Service Obligation, (CSO) where clients have assets to the value of less than $100,000 and (ii) Commercial, where clients have assets to the value of more than $100,000.

In March 2003 The Public Trustee had 246 clients under Financial Administration. Of these 76 were commercial clients and 170 were CSO clients. In 2003/04 the State Government will provide funding of $666,000 to the Public Trustee to assist in covering the costs of four types of CSO clients including those under Financial Administration.

6.6.3 Fees and Charges

In addition to the State Government funding, the Public Trustee covers its costs through the imposition of client fees and charges. Anglicare is particularly concerned about the level of fees and charges imposed on CSO clients. Fees that apply to Public Trustee Financial Administration CSO clients are:

- $550 Establishment Fee (payable in installments for those with less than $1000 liquid assets);
- 2.2% capital commission on assets that are retained and eventually transferred to the person entitled at the conclusion of the Administration;
- 4.4% capital commission on assets that need to be realised during the Financial Administration;
- 6.6% income commission on income received by the client;
- $5.50 per month Administration and Audit Fee;
- $4.40 per transaction Cheque/Periodic Payment Fee;
- $6.60 per transaction EFT & Direct Deposit to bank account fee; and
- $38.50 annual fee for a report to the Guardianship and Administration Board.

The Public Trustee has reviewed the financial records of 20 CSO Administration clients with assets of less than $10,000 completed over a 12 month period found that the monthly cost to clients was $76 including $55 in income commission and $21 in other fees.

The ongoing fees therefore represent about 8.5% of income for a single person relying on the Disability Support Pension (DSP) as their sole source of income. The Establishment Fee represents more than a full fortnight's income for this group. While the Establishment Fee can be paid off over time, a client relying solely on DSP will be paying more than 10% of their income to the Public Trustee during this period. Where the client has debts accrued prior to the Administration order to be paid off, as is often the case, the combined impact of debt repayments and Public Trustee fees can leave the client with much diminished income for their living expenses.

6.6.4 Problems with the Fees and Charges

In their combined 2001-02 Annual Report the Public Guardian, Lisa Warner and the (now former) Chairman of the Guardianship and Administration Board, John Blackwood raised concerns about the high level of fees and charges for Administration clients, particularly those on low incomes. These clients are among the most disadvantaged people in Tasmania. They are on very low incomes, have few or no assets, their disability means that they are unable to manage their own finances and they do not have anyone else who is able to look after their finances effectively. In the research conducted by Anglicare, clients, prospective clients and service providers identified the current level of fees and charges as a significant problem.

Clients under Administration and their families deal with the impacts of these fees and charges on a daily basis. The following case study illustrates the impact of the current system for an Administration client and his parent carers.

Michael - A Client's Perspective

Michael is a 33 year old man with schizophrenia who lives with his pensioner parents in Dunalley. Michael has been a client of the Public Trustee for four years after a case worker suggested he go under administration while he was being treated in hospital. Michael agrees that he needs someone to manage his money but is concerned about how much he has paid in fees and charges. "I can't manage my money very well, I just blow it but there's no option other than the Public Trustee." Michael has no assets and relies on the Disability Support Pension as his sole source of income. Michael said that finding the establishment fee was a major problem, "I didn't have the money straight away so I had to pay it off and I'm only on $440 a fortnight." The ongoing commission and fees of $80 to $90 per month also represents about 10% of Michael's total income. He says that he finds the staff at the Public Trustee very good to deal with but considers the fees to be a significant issue for him. Michael would like to use the money to improve his quality of life and have greater access to Hobart. Michael said that his illness and his income meant that he was unable to live independently. Although he pays board to his parents he said that there were still times when they needed to help him out financially.

The current fees and charges also act as a significant disincentive for people who might otherwise seek the services of an Administrator or for friends, family members or service providers who believe Administration would otherwise be in the best interests of a person with a disability.

Jim – Can't Afford the Public Trustee

Jim was diagnosed with schizophrenia 10 years ago and experiences chronic and regular psychotic episodes which lead to periods of hospitalisation. He is unable to work, finds it difficult to organise his thoughts to undertake self-care activities, to cook or maintain a tenancy. Jim is 41 and is currently living in a men's shelter on the North West Coast after periods of homelessness and a series of unsuccessful tenancies in the private rental market. He is constantly concerned about his financial state and regularly runs out of money. As a consequence of his inability to manage his finances Jim experiences substantial periods without shelter and often runs out of food before his next pension is due. Jim has some awareness of the Public Trustee's Administration service but does not think he could afford it. "Well (my mate) Jason, Jason went on the Public Trustee program you know, I, I actually asked about it when I went with him to pick up his food, you know he goes every Monday and Tuesday and picks up a load of groceries and that. The only thing is they charge you $500 a year to do it … I wondered if Anglicare had a service that was um, that didn't cost so much to run."

The prohibitive costs associated with the Public Trustee's Administration service have led to a range of other more informal arrangements for clients who are willing to have service providers manage their finances. However, such arrangements are time consuming for the services involved, may compromise client relationships and may involve risks of perceived or actual impropriety.

The Intensive Support Team at the Peacock Centre is one of the services which has reluctantly taken a financial management role for clients who are unable to manage their money and cannot afford to go under Financial Administration with the Public Trustee. The service is staffed by a team of clinicians who provide support, rehabilitation and assistance for people with a mental illness to manage their condition. The service is not an official Financial Administrator but about 15 clients have entered into a voluntary arrangement. This role does not fit with the core activities of the service, is time consuming and can impact on the relationship between clients and clinicians. Staff believe the arrangement raises a range of issues including:

- protecting the clients and their income;
- protecting the staff and service from accusations of impropriety;
- additional stress on staff at busy times such as pension day;
- the time consuming nature of administering the money; and
- the complications to the clinician/client relationship arising from managing client's money.

The service currently has 11.8 FTE positions including administration support and it is estimated that assistance with financial affairs takes about 45 hours a week of staff time. Client funds are kept in individual pouches in a safe with two staff members required to sign funds in and out.

The key reason these clients are not referred for formal Administration orders is the high fees and charges imposed by the Public Trustee. "Our preference would be to have nothing to do with any money, it would be ideal if the clients could go under the Public Trustee but they just can't afford it." (Peacock Centre staff member, 2003).

6.6.5 Tasmania *Together*

Goal 1 of the Tasmania *Together* document is to ensure all Tasmanians have reasonable standard of living with regard to food, shelter, transport, justice, education, communication, health and community services. Financial Administration is not a 'service choice', it is an absolute necessity for a small number of severely disadvantaged Tasmanians. However, even the very poorest clients pay ongoing costs of about $1000 per year for this assistance. Clearly this has a significant impact on their standard of living, particularly as clients may also face considerable costs for pharmaceuticals and other health care needs. The State Government has the opportunity to make a significant improvement to the standard of living for low income Administration clients at minimal cost to the State Budget.

6.6.6 Conclusion

A comparison of the fees and charges imposed on financial administration clients completed by the Public Guardian in 2002 shows that Tasmania is the only state where Administration clients relying on Centrelink pensions are charged significant fees. This situation is neither equitable nor appropriate. Anglicare argues that the State Government should meet the full costs of providing these services to low income clients through its CSO allocation to the Public Trustee and abolish Financial Administration fees and charges for this group.

Anglicare is aware that a review of the costs of providing Public Trustee services to CSO clients is currently being conducted. This review should provide a clear indication of the extent to which the current CSO payments to the Public Trustee cover the cost of services and the additional funding which would be required to meet the full costs for CSO Administration clients. Anglicare expects that the abolition of fees and charges would lead to some increase in the number of CSO clients under Administration with the Public Trustee where services such as the Peacock Centre sought to move clients from their existing system into formal Administration. However, as Administration would continue to be a last resort option it is not expected that the number of people under Administration will ever be large.

Recommendation 7: That the State Government provide additional funding to the Public Trustee to meet the costs of Financial Administration for CSO clients and ensure the abolition of fees and charges for Administration clients relying on Centrelink pensions and with assets of less than $100,000.

7. LONG TERM UNEMPLOYMENT

7.1 Introduction

The growth in the Tasmanian economy has had a very positive effect on the State's employment figures; however, it will take significant effort to fully overcome the legacy of 20 years of poor economic performance through the 1980s and 90s. Long-term unemployment continues to be a significant problem for the State. Although there has been a welcome reduction in the number of Tasmanians unemployed for 12 months or more, the rates are still well above the national average. Prolonged unemployment has severe impacts on individuals, families and communities, creating heavy demand on services delivering health care, community support, education and justice.

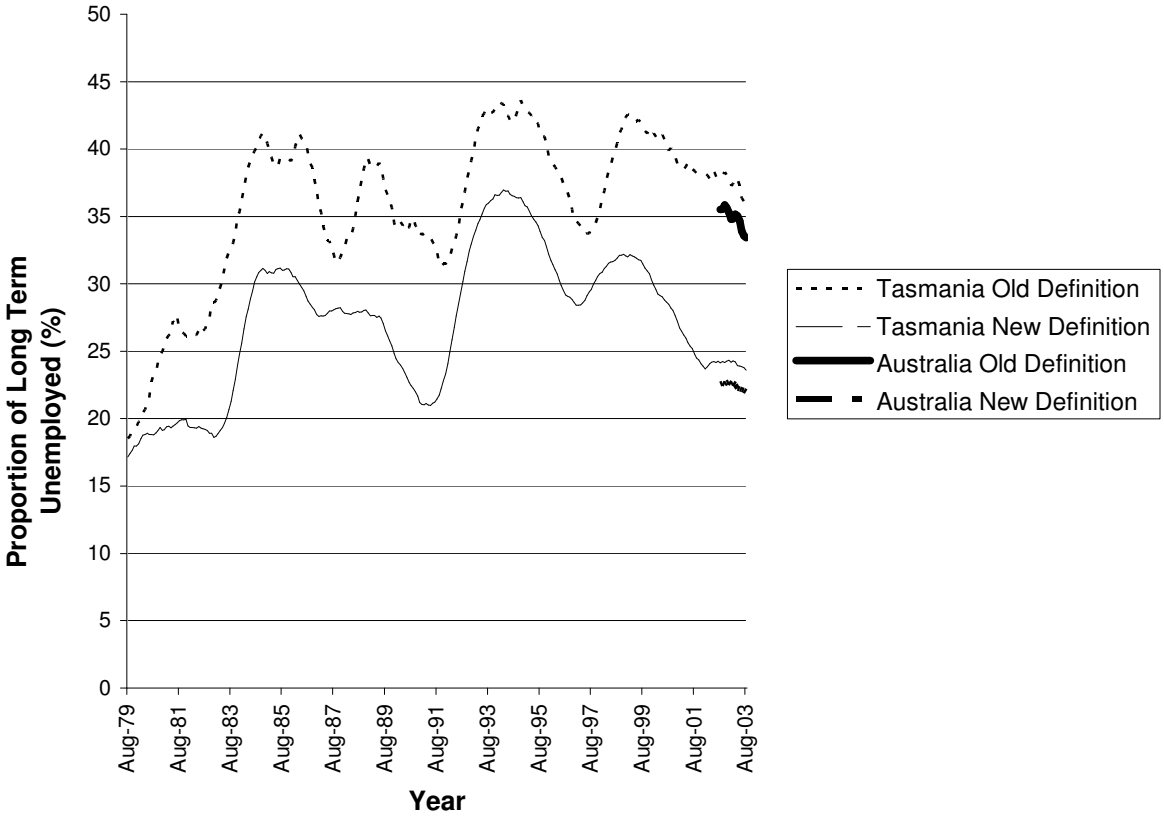
Anglicare welcomed the announcement of the $1.4 million Partnership to Jobs scheme in the 2003-04 Budget. However, Anglicare believes that the State Government will need to implement a much more significant program to achieve the employment goals outlined in the Tasmania *Together* process. Anglicare proposes the establishment of a Community Jobs Plan based on similar initiatives in Queensland and Victoria. Anglicare also proposes the establishment of a State Government traineeship quota for long-term unemployed people and a mature age building apprenticeship scheme.

7.2 Tasmania *Together*

The importance that Tasmanians place on reducing unemployment and ensuring adequate employment opportunities in the State is reflected in the Tasmania *Together* document which includes a range of employment indicators. Indicator 1.3 seeks to bring long-term unemployment down to the Australian average by 2005. In this year's Progress Report long-term unemployment in Tasmania was 36.1% compared to the national average of 20.9%. While this figure does represent an improvement towards the national average it is clear that significant further effort will be required to achieve this challenging goal.

Figure 1 shows that since 1979 the rate of long-term unemployment has tended to be much higher than the national average and that the current gap, while closing, remains considerable. Despite the recent improvement in the employment figures, the pattern of unemployment in Tasmania continues to be strongly skewed towards long-term and very long-term unemployment compared with the national average. It is of particular concern that almost 10 per cent of unemployed Tasmanians have not had any paid work in the past 5 years (ABS 2003b).

Figure 7.1. Long-term unemployed as a proportion of all unemployed, Tasmania and Australia[6]



(Source: ABS, 2003b [13 month rolling average derived from original series])

The number of people who are long term unemployed has also been declining to around 6,000 in the year to August 2003 (ABS 2003b). However, reluctance by employers to take on the long-term unemployed means that declines in long-term unemployment tend to be much slower than unemployment generally. In this context it is clear that State Government efforts to assist the unemployed should be focused on the long term-and very long-term unemployed.

7.3 Labour Market Programs

While labour market programs have traditionally been the responsibility of Federal Government, State Labor Governments have been developing their own schemes to complement Federal initiatives.

[6] Old definition of long-term unemployment was 12 months or more since last fortnight of **full-time** employment. New definition of long-term unemployment is 12 months or more since last fortnight of **part-time or full-time** employment.

Those states with high rates of long-term unemployment have been particularly active in implementing such initiatives.

Tasmania's Partnership to Jobs Program, the Mature Age Support Centre on the North West Coast and the Project Hahn traineeship program for disadvantaged young people have demonstrated the State Government's willingness to directly assist groups with multiple barriers to employment to re-enter the workforce. This type of direct labour market intervention is an important step towards ensuring that the benefits of a growing economy and labour market are shared among all Tasmanians, particularly those who have been hardest hit by past under-performance. Such programs represent an investment in human capital to complement the significant investments the Government has made in the State's physical infrastructure.

Intervention to assist the long-term unemployed is expensive and evaluations of the Federal Government's Job Network model have raised significant concerns that programs have not adequately met the needs of the most disadvantaged jobseekers. Analysis of Job Network evaluations to date indicate significant concerns about 'creaming' where providers target assistance at clients who are already most likely to find jobs while providing little assistance to clients who have more barriers to employment (Dockery & Webster, 2001 and Eardley, 2002). Anglicare believes that State Government programs which are designed to meet the specific needs of a regional labour market are required. The stronger links developed between the State Government, Department of Employment and Workplace Relations and the Job Network providers over the past year also ensure that any State Government program will take full advantage of the incentives offered by the Commonwealth to assist long-term unemployed people.

State Government programs to assist the long-term unemployed should be evidence-based in design and rigorously evaluated. Dockery & Webster (2001) provide a useful overview Australian labour market program evaluations. They also suggest criteria for developing new programs based on international models to assist the long-term unemployed and very long-term unemployed including:

- guaranteed employment for 1-3 years;
- wide variety of placements;
- participant choice in the type of placement;
- community and government agency provision of placements;
- placements along side the normal workforce; and
- normal conditions of employment including wages and superannuation.

While these recommendations assume a national model providing placements for all long-term unemployed people, the broad principles are applicable in the Tasmanian context.

Labour market programs must also take into account the characteristics and skills of the target group. In Tasmania older workers have been particularly badly affected by very long-term unemployment with the average duration of unemployment for those aged over 45 years at well over two years (ABS

2003a). Dockery and Webster (2001) note that, compared to the rest of the labour force, those experiencing long-term unemployment tend to be characterised by lower levels of education and qualifications, previous work in less skilled occupations, residence in lower socio-economic locations and a greater likelihood of living with other non-working adults. Long-term unemployed people are also keenly aware of the issues which make it difficult for them to secure employment. Long-term unemployed Tasmanians were much more likely than those who were short-term unemployed to identify their lack of skills, age and ill health as the main difficulty in finding work (ABS 2003c). In this context it is important to provide significant support for people re-entering the workforce and focus on providing relevant skills and qualifications to assist people to make a transition into ongoing employment.

Anglicare therefore recommends the programs outlined below.

7.3.1 Community Jobs Program

The Community Jobs Program is based on initiatives which have been running successfully in Queensland and Victoria. The program proposed for Tasmania would adopt some elements of the interstate models as well as drawing on components of the traineeship program which has been run between Housing Tasmania and Project Hahn. It is proposed that the CJP would be piloted for two years with 200 participants per year. Additional funding for a three year program providing opportunities for 400 participants per year would be contingent on the successful achievement of outcome criteria. A positively evaluated CJP would provide traineeship opportunities for 1600 long-term unemployed Tasmanians over a five year period.

Outline of the Proposed Programs: CJP & CJP+

The CJP would provide 12 month traineeships for long-term unemployed people who have been receiving Youth Allowance or New Start Allowance for 12 months or more. A portion of the traineeships (perhaps 10 – 20 per cent) would be targeted at people who have been unemployed for more than two years or who face multiple barriers to employment (CJP+). The traineeships would be provided in community sector, local government and public sector organisations. Participants would be paid National Training Wage rates and complete traineeships in a range of disciplines including community services administration, tourism, information technology, information services (museum and library), hospitality and horticulture. Participants would also complete a two week pre-entry work readiness program and would be eligible for ongoing support from their Job Network provider. CJP+ participants would be provided with additional support through funding to provide access to social work, counselling and family support services.

Agencies seeking to be involved in the program would submit project proposals which would be assessed by a committee including representatives of State Government, local government, the community sector and Unions Tasmania. The assessment committee would meet twice annually in

March and September. The Victorian model provides a useful set of criteria for assessing which projects should be funded:

- Participant Development
    - provide adequate supervision and employer support;
    - provide strategies to assist participants into further employment during and after the project;
    - have links with local employers and local employment opportunities;
    - provide opportunities to gain skills in industries expected to experience employment growth;
    - provide experience and appropriate learning and work re-entry skills to meet the employability needs of the jobseekers and the local market; and
    - be delivered at no cost to participants.
- Community Development
    - new or additional community infrastructure (including social and administrative infrastructure);
    - demonstrated community support;
    - demonstrable benefit to the community (economic, social, environmental, cultural); and
    - not displace existing workers in any sector from employment and/or are not to be used to replace retrenched workers.
- Administrative
    - well managed and financially viable

Agencies could apply for one or more participants with most projects likely to take on several participants. Successful agencies would recruit their own trainees from the eligible target group.

Some examples of projects funded under the Victorian program include training in the refurbishment of second-hand computers for provision to disadvantaged households; training as guides and customer service officers for the Flagstaff Hill Maritime Museum; training in horticulture and construction in the redevelopment of a house as a respite centre and training for women from culturally and linguistically diverse communities in child care and aged care.

Funding

Federal Government

Agencies participating in the CJP would qualify for the Federal Government incentive payment of $1,375 on commencement of an AQF Level 2 Traineeship. An additional incentive of $825 on commencement and $825 on completion would be available for trainees who are disadvantaged mature aged workers.

Trainees under the CJP would also qualify for support from a Job Network provider. This support would be likely to include a payment of $800 - $1000 towards wages costs as well as some support. CJP+ trainees would be eligible for a payment of $1200 - $1400 towards wages costs. Participants with a training account (including people over 50 years, indigenous people and people who had completed Work for the Dole) will also be able to use these funds towards the cost of the pre-vocational training.

State Government

The State Government would provide funding to agencies participating in CJP to cover the remaining costs of work readiness training, wages, on-costs, general training and supervision. Anglicare estimates these costs at about $31,000 per participant for the CJP program and about $36,000 per participant for the CJP+.

Business and Community

Projects with significant capital expenditure costs would be expected to seek additional funding through business donations and charitable grant schemes such as the Tasmanian Community Fund.

Recommendation 8: That the State Government establish a CJP and CJP+ program with an initial allocation of $14 million over two years and a further $42 million over three years contingent on a positive evaluation of the initial program.

7.3.2 Public Service Traineeship Equity Quota

The State Government can play an important role in assisting long-term unemployed people back into the workforce by guaranteeing to provide placements for one quarter of the CJP participants. Anglicare believes that the CJP program is an ideal way to introduce State agencies to the concept of employing long-term unemployed people in traineeships. The provision of wage and supervision costs will allow agencies to experience the benefits of the program and will ensure that agencies maintain and increase overall traineeship numbers. At the completion of the CJP Anglicare believes the State Government should commit to ensuring that a quota (around 10%) of new traineeship positions in the state service are targeted to people who are long-term unemployed. Within this broad definition efforts could be made to ensure participation by a range of equity groups such as youth, people with disabilities, mature age and people from non-English speaking backgrounds. State Government departments accessing the CJP program would not be eligible for the existing State Government payments for trainee commencement in the public sector but would continue to be eligible for the Federal Government incentive payment and the State Government payment for providing continuing employment after the completion of the 12 month traineeship.

Anglicare notes that the 2003/04 Budget allocation of $10 million to look after national parks and heritage assets could have achieved dual goals had it been targeted to provide employment opportunities for long term-unemployed people. The allocation could have included a prescription that

at least 10% of the employment created with this funding be targeted for traineeships for long-term unemployed Tasmanians.

7.3.3 Building on Experience Apprenticeship Scheme

Data show that labourers and related workers are the occupational group with the highest levels of unemployment (ABS, 2002). This group are particularly over-represented in the Tasmanian figures compared to the national average (ABS, 2002). Anglicare research indicates that there is a group of long-term unemployed men with significant experience as labourers on building sites. Several research participants indicated that they would like to complete a formal apprenticeship in a traditional trade but felt that their age and lack of formal education would preclude this (Madden, 2003).

Anglicare proposes bringing together a range of stakeholders including representatives of the Unions, building industry peak bodies, the Tasmanian Building and Construction Industry Training Board (TBCITB), TAFE Tasmania, Job Network providers, the State Government, Centrelink and community agencies. This roundtable would be charged with determining appropriate incentives to employers and potential apprentices for a small program which would provide opportunities for 100 long-term unemployed adults aged over 30 years to complete apprenticeships in the building and construction industry. Preliminary discussions with representatives of TBCITB and TCCI indicate that key elements of such a program would include significant industry involvement. Potential apprentices would:

- be selected by a panel including industry representatives;
- complete a TAFE pre-vocational course with units selected in consultation with industry representatives;
- gain work experience during the pre-vocational course with several potential employers.

Funding

Federal Government

New Apprenticeship Incentives would be available to employers for participants employed after completing pre-vocational training. As with the CJP, participants would also qualify for support from a Job Network provider.

State Government

The State Government would cover the costs of convening the stakeholder round-table and provide funds towards the pre-vocational training and additional incentives to employers (above the level of the Small Business Employment Initiative). Incentives may also be paid to apprentices in their first year if the interaction between Newstart and apprenticeship wages were considered to be a significant disincentive.

Business

Employers (including Group Training organizations) will continue to have the standard responsibilities regarding the apprentice.

Recommendation 9: That the State Government set aside $1 million to implement a Building on Experience Program.

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