SOCIAL SECURITY AND STIGMA IN AUSTRALIA
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This report is the output of research project exploring stigma in relation to social security and income support, produced collaboratively with Centre for Social Impact team members from Swinburne University of Technology (Swinburne), and the University of New South Wales (UNSW).

This report was commissioned by the National Mental Health Commission to inform the development of the National Stigma and Discrimination Reduction Strategy. The views and recommendations in this report are those of the Centre for Social Impact, and do not necessarily reflect the views of the National Mental Health Commission or the Australian Government.

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REPORT STRUCTURE

This report has been divided into eleven main sections, as follows:

1. Key points
2. Executive summary
3. Introduction
4. Review approach
5. Overview of Australia’s social security system
6. Experiences of the social security system for people with mental ill-health
7. Experiences of the social security system for carers of people with mental ill-health
8. Potential pathways for improvement
9. Conclusion
10. References
11. Appendix
1. KEY POINTS

The key points identified here are based on our analysis of the available evidence on how Australia’s social security system supports people who are unable to work (or unable to secure adequate income through work) due to their experience of mental ill-health, or caring for someone with mental ill-health. This review of the evidence has identified several ways in which the current social security system does not serve people with mental ill-health, or mental health carers as well as it could.

1.1 Key issues

- Policy reforms that aim to reduce spending on the Disability Support Pension have restricted people’s access to adequate income support.
- The complexity of the social security system and lack of information and support disadvantages people who are likely to be seeking support at times of increased distress.
- Decisions about what income support someone can access are influenced by the perceptions of decision makers about mental ill-health, and through assessments that are often more suited to physical disability.
- Current income support payments are inadequate to meet people’s essential needs. This includes Disability Support Pension and Carer Payment, but JobSeeker is even more inadequate, and this severely impacts people’s ability to survive on income support, and their mental health.
- The current system is harming people’s economic dignity in various ways. Many of the identified areas for improvement would align with efforts to address structural discrimination.

1.2 Key recommendations

- Ensuring that social security policy and practice is grounded in human rights and does not discriminate (directly or indirectly) against people with mental ill-health or mental health carers.
- Enabling people to have a voice and influence on systems that affect their lives.
- Changing current assessment processes, compliance and exemption rules that systematically disadvantage people with mental ill-health and mental health carers.
- Providing clear information and support that facilitates access to income support and responds to other identified needs for healthcare, employment support or advocacy.
- Making income support payments adequate to support people’s meaningful participation in life, and to meet people’s essential needs (including the need for adequate mental healthcare or other supports as required).
# 2. EXECUTIVE SUMMARY

This report provides an analysis of the available evidence on how Australia’s social security system supports people who are unable to work (or unable to secure adequate income through work) due to their experience of mental ill-health, or caring for someone with mental ill-health.

Key findings from this review are:

1. Clear and accessible information about available supports and application requirements is lacking for both people with mental ill-health and carers. This is particularly the case for culturally and linguistically diverse people. This contributes to people missing out on support.

2. People experience the social security system as complicated, and navigating the system successfully is challenging for people who are experiencing distress or mental ill-health. In addition, the confusion, frustration and uncertainty people experience through their interactions with the social security system can contribute to increased mental distress for both people with mental ill-health, and their family members or carers (Gewurtz et al., 2018; Social Security Rights Victoria, 2019).

3. Administrative burden and personal cost for application processes, along with compliance obligations, are high, particularly for people with mental ill-health who are required to obtain a psychiatrist or clinical psychologist assessment at their own cost.

4. Recent reforms, including reforms to the Disability Support Pension (DSP) have limited input by people with lived experiences, and focused on lowering costs to government. Targeting programs that support people with mental ill-health for budget cuts is described by Holley, Stromwall, & Bashor (2012) as a form of oppression.

5. A recent reform removed the ‘Treating Doctor’s Report’, which enabled a health professional who knew the person’s history and impact of their health condition to provide evidence for their application for DSP, and to bill this item under Medicare (National Social Security Rights Network, 2018). Instead, assessment of people’s applications for DSP has been shifted to government-contracted medical professionals and Job Capacity Assessors, who have varying degrees of mental health knowledge and little knowledge of the individual being assessed. The current processes have contributed to more administrative burden and uncertainty for people with mental ill-health, particularly given that single time-point assessments are less likely to demonstrate the full impact of episodic conditions such as psychosocial disability over time (Brophy et al., 2014).

6. There is some evidence of high rates of granting of DSP upon appeal for those who are able to access advocacy or legal support and take their case to the Administrative Appeals Tribunal. This requires individuals to know how to access (and potentially pay for) an advocate (National Social Security Rights Network, 2018).

7. Social security requirements (such as assessments for DSP and Carer Payment) are not adequately responsive to the impacts of mental ill-health, its sometimes episodic nature, and the nature of caring needs associated with this (McAllister, 2017; National Mental Health Carer and Consumer
8. There is considerable stigma and devaluing of people with mental ill-health amongst the public, and this is likely exacerbated by the reforms previously mentioned. People with mental ill-health and carers may not always explicitly identify their situation when seeking support, in some cases due to concerns about stigma (Groot et al., 2020; Mental Health Council of Australia, 2009). When people do not feel safe to openly discuss mental ill-health, this can limit the support they have access to, but in some cases may also protect them from social harms (Kokanovic, Petersen & Klimidis, 2006) – so people are forced to weigh the costs and benefits of either decision.

9. Legislation and policies that require conditions to be “fully diagnosed, treated and stabilised” can create structural disadvantage for people with mental health conditions, as diagnosis relies on the judgements of health providers, and people’s symptoms and diagnosis may change over time (Economic Justice Australia, 2021; National Mental Health Carer and Consumer Forum and Mental Health Council of Australia, 2014). Similar challenges impact mental health carers.

10. Alongside reforms to the Disability Support Pension, both the nature of employment (e.g. casualisation) and unemployment benefits have changed over time. Insecure employment has negative impacts on mental health, and bad work conditions can be worse for mental health than unemployment (Butterworth et al. 2011) – yet current compliance frameworks create pressure for people to accept any job offer they get. Unemployment benefits that were originally designed to provide temporary support are now being utilised for extended periods of time in cases where people either cannot access work, or are underemployed (Collie, Iles & Di Donato, 2018).

11. Evidence over the past two decades has consistently found high rates of mental ill-health among people who access unemployment benefits (previously NewStart Allowance, now JobSeeker Allowance) (Butterworth, 2003; Butterworth, Crosier & Rodgers, 2004; Collie, Sheehan, & McAllister, 2019). This means that the policies and practices of the social security system disproportionately affect the lives of people with mental ill-health.

12. People receiving JobSeeker Allowance are required to comply with job-seeking activities unless they have a medical exemption. However, research indicates that the current exemption system does not adequately support people with mental ill-health whose conditions are ongoing/episodic (Economic Justice Australia, 2021; Mental Health Australia, 2019). Evidence suggests that people are required to continually seek medical certificates to substantiate the same (ongoing) health condition, and that certificates for a condition that is characterised as permanent are not accepted for obligation exemptions. While these issues may also affect other people with episodic health conditions, they are commonly reported by people with mental ill-health, and the evidence suggests that this is compounded by the subjective nature of mental health diagnoses (Economic Justice Australia, 2021).

13. Compliance obligations are widely viewed as punitive and unhelpful for supporting people to access work (Black, 2009; Humpage, 2007; Mental Health Australia, 2019). Compliance measures such as suspensions and cancellations of payment can result in significant stress, deterioration of mental health, loss of income and housing - increasing the need to access other community and social services (National Social Security Rights Network, 2019).

14. The available literature (both academic and grey literature) is extremely consistent in stating that
the current rate of unemployment income support (JobSeeker Allowance) is inadequate, and results in people being unable to meet their basic needs for decent housing, food, heating, healthcare, and social participation (The Senate Community Affairs References Committee, 2020). This harms people’s economic dignity and is counter to the human rights frameworks to which Australia is a signatory, and to several major government strategies and programs (for example, the National Disability Strategy and the National Disability Insurance Scheme) (Humpage, 2007; Productivity Commission, 2011).

15. There is also some evidence that Disability Support Pension and Carer Payment may not be adequate to cover the increased costs associated with healthcare needs or supporting someone with mental ill-health (Li, Brown, La, Miranti & Vidyattama, 2019; Morrison & Stomski, 2019).

16. A new systematic review of international research in high-income countries (such as Australia) has shown that increased restrictions to social security programs are associated with decreased mental health, while more generous social security measures are associated with improved mental health (Simpson et al., 2021).

17. A survey of 738 people from across Australia accessing community-managed mental health services was conducted to explore the impacts of COVID-19, and what would support people’s wellbeing. This survey found that the supplementary income support payments introduced in response to the impacts of COVID-19 improved wellbeing for 89% of respondents who received it (Flourish Australia, Mind Australia, Neami National, One Door Mental Health, Open Minds, Stride & Wellways, 2020). However, people receiving DSP or Carer Payment were not eligible to access the fortnightly Coronavirus Supplement payments.

18. Improving employment service effectiveness, and employer willingness, would help enable people who are able to and wish to work to access employment opportunities. Supports and rules regarding paid work/income should be more flexible about maximum hours, and not punish people for undertaking more work when they are able (Productivity Commission, 2020).

19. Barriers to accessing other income supports should also be addressed. These include addressing systematic disadvantages that currently apply for people with mental ill-health within income protection insurance (Collie, Iles and Di Donato 2018).
3. INTRODUCTION

This report is based on a review of the literature on Australia’s income support/social security system and processes, and how they contribute to stigma and discrimination in relation to mental ill-health. This research was conducted by an academic team with expertise in mental health and social policy research and lived experience of mental ill-health.

3.1 Terms used in this report

**Discrimination** refers to a person being treated less favourably because of certain characteristics they have. Under Australia’s federal discrimination law, it is unlawful to discriminate against people on the basis of protected characteristics such as disability (including psychosocial disability), or family responsibilities (Australian Human Rights Commission, n.d.) in specific areas of public life, such as employment and education.

**Family members and carers** refers to people with a lived experience as a carer, family member, friend or other supporter. The term acknowledges that not all family members wish to identify as a ‘carer’, and there may be other important relationships in a person’s life or recovery process.

**People with mental ill-health** refers to people with a lived experience of mental health distress, challenges, illness, or experiences of disruption or harm to social and emotional wellbeing.

**Psychosocial** refers to psychological and social factors that can impact or support a person’s mental health and wellbeing. For example, access to meaningful activities, supportive relationships, belonging and safe housing are all psychosocial factors affecting one’s wellbeing and mental health.

**Psychosocial disability** refers to the impacts that mental ill-health may have on a person’s participation in meaningful activities, relationships, and community life. Not everyone who experiences mental ill-health identifies as experiencing psychosocial disability.

**Social determinants of mental health** refer to the social, economic and physical environments in which people live, and the resources they have access to.

**Social security system/income support system** refers to Australia’s social security system, which, under the Social Security Act 1991 and the Social Security (Administration) Act 1999 provides for a range of entitlements and income support payments for people, including people with disability, and carers (Australian Government, n.d.). Income support is administered by Services Australia.

While this report uses the terms ‘mental ill-health’ and ‘mental illness’ because they reflect the conceptualisations within the literature reviewed, it must be acknowledged that the concept of mental health/illness is grounded in western medical tradition, and understandings and language for distress and wellbeing differ across people and cultures (Knifton, 2012; Westerman, 2004). For example, “Aboriginal and Torres Strait Islander social and emotional wellbeing (SEWB) is a multifaceted concept that acknowledges that a person’s wellbeing is determined by a range of inter-related domains: body, mind and emotions, family and kinship, community, culture, Country, and spirituality” (Dudgeon, Bray, D’Costa, & Walker, 2020, p.316). While western culture largely conceptualises mental illness as a medical condition located within an individual, other cultures and communities conceptualise this experience differently, for example, as “distress caused by social and economic factors and life challenges” (Knifton 2012, p.292).
The diversity of perspectives and beliefs that people have about mental health/illness and social and emotional wellbeing are informed by culture and experiences, and influence how people describe their own experience, and what people view as sources of harm, and healing (Dudgeon et al., 2020; Westerman, 2004; Knifton, 2012).

3.2 The focus of this report

For the most part, this report focuses on the government-funded social security system - although some discussion of other income supports is included below. In particular, this report focuses on the main income supports accessed by people with mental ill-health, and carers of people with mental ill-health who are unable to work (or unable to secure adequate income through work). Of course, it is possible that people with mental ill-health or carers could be receiving different income support payments depending on their circumstances (for example, as a young person, a student, a parent, or an older person). However, the literature largely discusses three primary categories of income support – Disability Support Pension (DSP), Carer Payment, and JobSeeker (previously NewStart) Allowance. DSP and Carer Payment are pensions and are paid at a higher rate than JobSeeker Allowance, which comes with obligations to seek work or participate in other employment-related activities (McClure, Aird, & Sinclair, 2015).

People with mental ill-health continue to face stigma and discrimination at individual, societal and structural levels in Australia, and we know that these experiences impact people’s wellbeing and opportunities in life (Groot et al., 2020; Reavley, Jorm & Morgan, 2017). Research shows that stigma continues to shame people who experience psychosocial and mental health challenges, and those who receive government supports, particularly income support (Kiely & Butterworth, 2013; Soldatic & Morgan, 2017). Poverty in and of itself is stigmatised, with people who are perceived as “the undeserving poor” particularly stigmatised and shamed (Hansen, Bourgois, & Drucker, 2014). People with mental ill-health often fall into this category due to broader negative attitudes and beliefs that view mental illness as a weakness, or even associate it with violent behaviour (Corrigan, Markowitz, & Watson, 2004).

Research shows that bureaucratic processes relating to receipt of income supports in Australia can be experienced as burdensome, punitive, or shame-inducing (Soldatic & Morgan, 2017). These kinds of experiences can result in people withdrawing from services, in response to real and perceived stigma (Gewurtz et al., 2018; Soldatic & Morgan, 2017); and can negatively impact mental health (Collie, Sheehan & Lane, 2021; Gewurtz et al. 2018; Social Security Rights Victoria, 2019). This points to the need to create social and welfare support systems that can decrease stigma, and that are more amenable to supporting people with mental ill-health. To inform social security policies and systems that best support health and wellbeing for people with mental ill-health, family members and carers, we need to examine current evidence of how Australia’s social security system operates.

This report draws on the concept of economic dignity, which has received growing interest as a framework for understanding how we construct social security and welfare systems, and their implications from policies through to citizens’ lived experiences (Abdelal, 2020; Brown, 2020; Brown & Bowman, 2020; Sperling, 2020). Economic dignity is defined in the following section.

This report also draws on the conceptualisation of structural stigma outlined in the scholarly literature (Link & Hatzenbuehler, 2016; Corrigan, Markowitz & Watson, 2004) and articulated in Livingston’s (2013) framework. This conceptualisation informs one of the most comprehensive stigma-reduction approaches to date – the Canadian “Opening Minds” campaign (State of Victoria, 2021b). Throughout the report, fictional stories based on the reviewed evidence are used to illustrate the ways in which structural
3.3 **Economic Dignity**

3.3.1 **The four types of economic dignity**

**Economic dignity as intrinsic** refers to the idea that people possess inherent worth by virtue of being a person, and that they need to be treated in a way that is respectful of this. Their inherent worth is bound up in the human capacity to freely will and choose things for ourselves (Kant, 2002; Nussbaum, 2013). In turn, this means that people need to be treated in ways that are respectful of their agency. When a person’s agency is ignored, or undermined, this positions them as not worthy of being treated as a person, and this can be harmful to them (Brown, 2020, p. 13).

**Economic dignity as status** refers to the dignity associated with holding different positions in our society. Some positions and groups are accorded positive status, while others are treated negatively, and stigmatised (Herzog, 2012). In modern society, often the status accorded to different positions is linked to wealth (Brown, 2020, pp. 13-14). This can be both positive and negative, for example, wealthy people like Bill Gates are accorded a level of respect linked to their wealth, while there can be stigma associated with those experiencing poverty (Hamilton, 2012), who can at times be blamed for their experiences and treated in a paternalistic manner (Curchin, 2017).

**Economic dignity as function** refers to the dignity associated with serving a function that one has reason to value. This is commonly connected to the idea of economic dignity through work, and the social value placed on the work that people undertake (Bowie, 2019; Sperling, 2020; Wisman, 1998). In many cultures, there is stigma or shame placed on those who are unemployed (Anderson, 2014). Different jobs are treated with worth, and in this way, people can be deemed worthy or stigmatised for the type of work that they undertake (Simpson, Slutskaya, & Hughes, 2019). Notably, the social valuation of different types of work varies, and some forms of work are undervalued both in terms of the financial compensation provided and in the social valuation of it – for example, care work is either undervalued, or not valued at all in certain circumstances.

**Economic dignity as manner or bearing** refers to the dignity associated with how a person acts. This type of dignity aligns with the idea that there are good and bad ways to act, and there is something special that happens when people act in a morally good way (Rosen, 2012; Schiller, 2005). When there are tensions between what the right thing to do is – when people are faced with tough choices – it can place pressure on people to act in ways that force them to act against things that they value. This can erode their belief or sense of commitment to those values. This is important in circumstances where a person may not be able to meet all of their basic needs, as they are forced to actively participate in their own experience when they choose which needs are not met (Brown, 2020, p. 15).
3.4 Structural stigma framework

Our analysis of the literature draws on the series of questions identified by Livingston (2013, p.11) to understand whether a policy or practice constitutes structural stigma:

- “Does the institutional practice/policy contravene provisions of existing human rights statutes?
- How broad/specific is the criteria being used to restrict persons’ rights or opportunities?
- How broad/specific is the domain that is being restricted?
- Are public and private institutions making reasonable efforts to assist individuals (e.g., providing services or supports) to enjoy access to the full range of rights and opportunities?
- To what extent will the restriction remain in place when the impairment diminishes?
- Do alternative methods (e.g., less restrictive or less onerous) exist that may be equally, or more, effective at achieving the same outcomes?
- Would the stigmatizing institutional practice/policy be rejected by those who may be affected?
- What is the nature and scope of harm (e.g., social isolation, health or economic inequalities) that will be produced by the institutional practice/policy in comparison to its expected benefits?”

We also draw on the definitions given in Link & Hatzenbuehler (2016) and Corrigan, Markowitz & Watson (2004, p.658) – that structural stigma and discrimination occur when cultural norms, societal conditions or policies limit people’s opportunities, resources or wellbeing – whether or not these effects are intended.

3.5 Applying an intersectional lens

Figure 1. Visual model of intersecting types of stigma based on known evidence

Stigmatising societal and structural responses to people with mental health challenges contribute to exclusion from work (Gladman & Waghorn, 2016). Providing care to a family member or friend with mental ill-health can also impact work capacity (Diminic, Hielscher, & Harris, 2019).

Lack of access to adequate financial and material resources is associated with higher psychological distress (Emerson et al., 2012) and impacts people’s full participation in life (Morgan et al., 2017).

Receipt of social welfare is stigmatised (Schofield, Haslam, & Butterworth, 2019), and people with less visible or less well understood disability (including psychosocial disability) can face specific kinds of stigma or discrimination, including questioning of their status/entitlements or work limitations (Gewurtz et al., 2018). Receipt of disability and unemployment income support payments are both associated with worse mental health (Kiely & Butterworth, 2013).

Exclusion from work limits people’s opportunities for the benefits that come with decent employment, including higher income, social status, opportunities for development and social relationships (Morgan et al., 2017; Morrow et al., 2009).
The intersecting types of stigma outlined in Figure 1 highlight different harms that can occur in relation to a person’s economic dignity. Mental health stigma can attack a person’s intrinsic economic dignity when they experience forms of exclusion, as they are treated as being inferior or incapable of acting as a functioning agent (Corrigan, Markowitz & Watson, 2004). Poverty stigma and social welfare stigma can attack the status type of economic dignity, as both are treated as low status positions that are often associated with blame on the person in poverty and in need of support (Schofield, Haslam & Butterworth, 2019). Stigma against people who are not in the labour force attacks the function type of economic dignity because it targets a person’s sense of function and social value, positioning those in the labour force as more valuable to society than those who are not (Soldatic & Morgan, 2017). Being excluded from the labour force can lead to people having insufficient income to meet their essential needs (Morgan et al., 2017), and this can lead to harms associated with dignity as manner or bearing. Similarly, poverty stigma can drive social exclusion, leading to people being unable to meet their emotional needs, and this can also feed into issues related to economic dignity related to manner or bearing.
4. REVIEW APPROACH

The project uses a systematised literature review approach to examine how Australia’s social security system currently supports people who are unable to work due to their experience of mental ill-health or caring for someone with mental ill-health. The research explores the key issues and gaps within current social security supports and identifies potential pathways for improvement. The systematised review is informed by the team’s experience and deep knowledge of welfare policy and the social determinants of mental health – including financial wellbeing, structural stigma, and discrimination.

This literature review includes peer-reviewed academic publications, policy documents and other relevant grey literature, with a focus on lived experiences of current social security systems for people with mental ill-health who are unable to work, and people who are unable to work due to their caring responsibilities for someone with mental ill-health. The review involves exploration of potential improvements to existing policy or practice, and examples of effective or promising practice internationally.

### 4.1 Research questions

The research questions examined through our literature review are:

1. How does Australia’s social security system currently support people who are unable to work (or unable to secure adequate income through work) due to:
   - their experience of mental ill-health, or
   - caring for someone experiencing mental ill-health?
2. How do people become aware of the available income supports?
3. To what degree are the existing income supports taken up?
4. Where they are not taken up, what is the evidence of why this is the case?
5. Are the current available income supports adequate?
6. How responsive are the existing income supports to the episodic nature of some experiences of mental ill-health?
7. What other income protection mechanisms are available to people?
8. Are there insights from other countries that could help restructure our income protection?

### 4.2 Search strategy

We conducted a review of the literature by drawing upon systematic review methods. An initial list of search terms was compiled by the authors and further developed in consultation with the research team.

### 4.3 Search terms

Table 1 shows the search terms that were used in our search of academic databases. Further detail about the literature review methodology, and the target websites searched for non-academic papers can be found in the Appendix (Section 11).
Table 1 - Search terms used in academic databases

**Informit**
- Databases searched:
  - Analysis and Policy Observatory (APO);
  - Australian Public Affairs Information Service (APAIS);
  - FAMILY (Australian Family and Society Abstracts Database);
  - Aboriginal and Torres Strait Islander Health Bibliography (ATSIhealth);
  - Multicultural Australia and Immigration Studies (MAIS)

  ("mental illness" OR "mental ill*health" OR "psychosocial disability") AND ("income support" OR "welfare" OR "social security" OR "centrelink" OR "services Australia" OR "disability support pension" OR "newstart" OR "Jobseeker" OR "carer payment" OR "sickness allowance" OR "sickness benefit") AND ("well*being" OR "dignity")

**EBSCOhost**
- Databases searched:
  - CINAHL; eBook academic collection; Humanities International Complete;
  - Psychology and Behavioural Sciences; SocIndex

  ("mental illness" OR "mental ill*health" OR "psychosocial disability") AND ("consumer" OR "carer" OR "user" OR "patient" OR "caregiver") AND ("income support" OR "welfare" OR "social security" OR "centrelink" OR "services Australia" OR "disability support pension" OR "newstart" OR "Jobseeker" OR "carer payment" OR "sickness allowance" OR "sickness benefit") AND ("stigma" OR "discrimination" OR "right*" OR "equity" OR "equality" OR "dignity")

**ProQuest Central**
- Databases searched:
  - Aus & NZ; consumer health; public health; social science; sociology

  ("mental illness" OR "mental ill*health" OR "psychosocial disability") AND ("consumer" OR "carer") AND ("income support" OR "welfare" OR "social security" OR "centrelink" OR "services Australia" OR "disability support pension" OR "newstart" OR "Jobseeker" OR "carer payment" OR "sickness allowance" OR "sickness benefit") AND ("stigma" OR "discrimination")

4.4 Brief summary of the literature review sources

This review looked at 82 sources (46 empirical, 36 non-empirical), published in the past 18 years (2003–2021).

- Sixty-five articles were focused on Australia, and 17 on other countries.
- Twelve of the articles focused on carers.
- There were four articles with a focus on Aboriginal and Torres Strait Islander people.
- Two articles focused on the experiences of culturally and linguistically diverse people.
- Two articles focused on young people (aged 12-25).

The number of articles focused specifically on the experiences of Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people, and young people was quite low, which is a limitation of the body of literature reviewed.
5. OVERVIEW OF AUSTRALIA’S SOCIAL SECURITY SYSTEM

5.1 Overview of the Australian mental health system and funding

This section includes an overview of Australia’s social security system, with a focus on people with mental ill-health and carers of people with mental ill-health. This section also responds to Research Question 7: What other income protection mechanisms are available to people?

Australia’s social security system provides income supports to people in a range of circumstances, including young people, students, parents, people with disability, people who are caring for someone, and older people (Services Australia, n.d.). Australia’s social security system (alongside that of the UK and New Zealand) draws on government funds to provide set amounts of income support based on means testing and eligibility (Podger, Stanton, & Whiteford, 2014). This is in contrast to other countries such as the US and Germany, which have social insurance systems requiring individuals to make compulsory payments, and then providing earnings-related benefits if a person becomes unemployed (Podger et al., 2014; The Senate Community Affairs References Committee, 2020). The underlying purpose of the Australian social security system is to provide income support to people who are unable to work, to alleviate poverty, and enable people to meet their essential needs (Australian Government, n.d.; Podger et al., 2014).

5.1.1 Other income protection mechanisms

In addition to the government-funded social security system, other forms of privately-funded income support exist in Australia, including employer-provided entitlements such as paid leave, workers compensation, and life insurance - including disablement cover and income protection (Collie, Iles & Di Donato, 2018). However, people who experience disability related to mental ill-health remain among those most excluded from employment in Australia (Australian Bureau of Statistics, 2016). Research suggests that mental health related WorkCover claims are less frequently accepted than those relating to physical health, due to difficulties with attribution (Collie, Iles & Di Donato, 2018). In addition, recent research has found that only 8% of people with mental ill-health are able to access income protection insurance without extra exclusions or premiums being applied (Productivity Commission, 2020), and complaints about income protection are common (State of Victoria, 2021b).

People may access other specific support systems for their health and related needs, including the Medicare system, and a small number access the National Disability Insurance Scheme, or private health insurance (Collie, Iles & Di Donato, 2018). People with the financial resources to do so may also self-fund time out of the workforce due to illness or caring responsibilities through drawing on savings (Collie, Iles & Di Donato, 2018). Currently, little is known about how people move through these different systems of income support, but research is being done to better understand this (Collie, Iles & Di Donato, 2018). However, the limited available evidence suggests the need to address barriers to these other income support mechanisms, including (Collie, Iles & Di Donato, 2018):

- income protection insurance, which the Productivity Commission (2020) found often involved exclusions or additional premiums for people with mental ill-health.
- Providing work-cover claimants with early access to mental health care regardless of liability decisions to support early healthcare access (Productivity Commission 2020).
Improving data collection across Australia’s various income support systems to better understand what’s required.

5.1.2 Current statistics on specific income support payments.

Recent Australian data shows that in 2017-2018, $160.6 billion was spent on welfare (excluding program administration costs), including:

- $10.2 billion (6% of total welfare expenditure) in unemployment benefits
- $26.6 billion for people with disability and carers (an estimated 16.6% of total welfare expenditure) (Australian Institute of Health and Welfare, 2019d).

In 2018-2019, 36% of people accessing the Disability Support Pension had a primary psychological or psychiatric condition - making this the most common primary medical condition for people aged 18-64 accessing DSP, and for care recipients of people aged 18-64 accessing Carer Payment (31%) (Australian Institute of Health and Welfare, 2019b; 2020).

The Productivity Commission report into mental health drew on various data sources to estimate key income support figures for people with mental ill-health (Productivity Commission, 2020, p. 932), and mental health carers (Productivity Commission, 2020, p. 912). These figures (reflecting the 2018-2019 period) are summarised in Table 2 and Table 3 below. These estimates will not reflect the entire population of people with mental ill-health or mental health carers who are unable to work or obtain adequate income through work, as people may not necessarily access these income support payments.

<table>
<thead>
<tr>
<th>Table 2 - Income support figures for people with mental ill-health 2018-2019 (Productivity Commission 2020, p.932)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment type</td>
</tr>
<tr>
<td>---------------</td>
</tr>
<tr>
<td>NewStart Allowance (now JobSeeker Allowance)</td>
</tr>
<tr>
<td>Youth Allowance</td>
</tr>
<tr>
<td>Disability Support Pension</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 3 - Income support figures for mental health carers 2018-2019 (Productivity Commission 2020, p.912)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment type</td>
</tr>
<tr>
<td>---------------</td>
</tr>
<tr>
<td>Carer Payment</td>
</tr>
<tr>
<td>Carer Allowance</td>
</tr>
<tr>
<td>Carer Supplement</td>
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</tbody>
</table>
5.1.3 Recent reforms

Several recent reforms to social security have taken place since 2006, most notably changing the eligibility criteria for the Disability Support Pension, resulting in anyone with a work capacity of 15 hours a week or more being placed onto a (much lower) unemployment payment (Li et al., 2019). Decisions about a person’s work capacity are made by Job Capacity Assessors, some of whom are allied health professionals (for example, psychologists, occupational therapists, physiotherapists, or dieticians) (McAllister, 2019). However, knowledge about mental health conditions differs between Job Capacity Assessors, and a person with mental ill-health could have their work capacity assessed by someone whose professional knowledge and qualification does not relate to mental health (McAllister, 2019). This is particularly problematic given that mental ill-health is still widely stigmatised (Groot et al., 2020), including among health professionals making decisions about access to the disability pension (McAllister et al., 2021).

A report by the Australian National Audit Office notes that efforts to reduce growth in DSP expenditure include changes to the impairment tables used in Job Capacity Assessments in 2012, with the aim of tapering DSP growth and reducing new grants (Australian Government, 2016). In line with these explicit goals of reducing the costs of disability income support, eligibility criteria for the Disability Support Pension were restricted further in 2012 and 2014-15 (Li et al., 2019). Recent research examining the effects of these reforms using population level data on Australian adults found that the changes in the impairment tables made it more difficult for people with mental health conditions to be assessed as eligible for the DSP (Collie, Sheehan & Lane, 2021). Since these reforms, there has been a significant reduction in receipt and grant rates of DSP, and significant increase in receipt of unemployment benefits - with a more rapid increase among people with mental ill-health (Collie, Sheehan, & Lane, 2021).

Other recent reforms to social security have included compulsory income management programs that restrict how and what people can spend their income support payments on (for example, through use of a cashless debit card) (Australian Council of Social Service, 2019). Compulsory income management programs have disproportionately impacted Aboriginal and Torres Strait Islander people, particularly in the Northern Territory (Bray, Gray, Hand & Katz, 2015). Income management policy specifically aims to reduce spending on things like alcohol and gambling, and encourage prioritisation of meeting basic needs, “pro-social behaviours” and “building financial capabilities” (Bray, Gray, Hand & Katz, 2015, p.373). These goals suggest an underlying assumption that people accessing income support need to have their spending controlled in alignment with specific societal values. Restricting people’s spending through income management ignores the fact that unemployment payments are below the poverty line by all commonly recognised measures (The Senate Community Affairs References Committee, 2020), and that people accessing income support often exercise a range of strategies to manage expenses on very limited income (Bourova, Ramsay and Ali, 2019; Person accessing DSP, personal communication, 24 July 2021).

The evidence is clear that low income support payment rates contribute to financial hardship and people being unable to meet their basic needs, despite careful budgeting (The Senate Community Affairs References Committee, 2020; Bourova, Ramsay and Ali, 2019). Recurrent evaluations of income management found that it was largely ineffective, and social service peak bodies and social security advocacy organisations have also opposed these measures as stigmatising and harmful to people’s dignity, impractical, and expensive (ACOSS, 2019). The stigmatising elements of this in relation to economic dignity are highlighted and discussed further in Chapter 8.
5.2 Impacts of COVID-19

The COVID-19 pandemic is having significant impacts on mental health, but effects differ according to the social and economic resources people have access to. Economic insecurity has been increasing since the 1980s, along with living costs and household debt (Bourova, Ramsay, & Ali, 2019). People who are already experiencing socio-economic disadvantage are most at risk of further financial hardship, and evidence supports the ‘K’ shaped recovery theory whereby during COVID those with high incomes have increased their wealth, and those with low incomes live more precariously (Bourova et al., 2019). Research on the mental health impacts of COVID-19 has found that protective factors include having a large amount of savings and being a homeowner (Rossell et al., 2021). Financial stability can provide a buffer against economic shocks, while those who do not have this buffer - such as people who are underemployed or insecurely employed (Kaleveld, Bock, & Maycock-Sayce, 2020) - can be more adversely affected. A recent review on reductions to social security benefits in high-income countries showed negative effects on population mental health, particularly among groups who were also disproportionately affected by the COVID-19 pandemic (Simpson et al., 2021).

Within Australia, rapid policy changes were made to respond to the impacts of COVID-19 on mental health and access to income. These responses included the introduction of the JobKeeper payment, which provided payments through employers for eligible businesses demonstrating financial loss; and a Coronavirus Supplement payment that approximately doubled the amount of income support for people receiving JobSeeker Allowance. A survey conducted by seven Australian mental health organisations of 738 people accessing mental health services found that - while the impacts of COVID-19 and restrictions negatively impacted people’s mental health - almost all respondents who had received increased financial assistance reported positive impacts on their wellbeing (Flourish Australia et al., 2020). However, another survey of 600 people who were receiving income support found that even with the increased payments, people still had trouble affording mental healthcare (ACOSS, 2020). Moreover, while some financial supports were boosted, the Disability Support Pension and Carer Payment were not (even though costs increased as a result of COVID, e.g. personal protective gear for at-risk individuals).

Modelling from the University of Sydney found that extending the JobKeeper payment (alongside doubling growth in community-based mental health services) was one of the most effective actions that could be taken to prevent suicides in the wake of COVID-19’s widespread social and economic impacts (Atkinson, Skinner, Lawson, Song & Hickie, 2020). Previous modelling by Deloitte Access Economics has found raising the rate of income support would have positive flow-on effects to communities - such as boosting the economy and employment figures – as well as providing direct financial support for the lowest income households in Australia (Deloitte Access Economics, 2018).

Story 1 illustrates some of the ways in which recent policy reforms and issues with the current social security system impact people with mental ill-health. These issues are discussed in further detail in Chapter 6.
Story 1: Having an Invisible Illness – George

George is a person who has been diagnosed with depression who is currently receiving JobSeeker Allowance. George applied for the Disability Support Pension but was unsuccessful. George has had multiple negative experiences related to his illness with previous employers, and feels uncomfortable with disclosing his illness to people he does not have a strong established relationship with. For this reason, George has not disclosed his mental illness to his Employment Services Provider. Throughout the pandemic, George’s symptoms have gotten worse, and he has found it difficult to find the energy to undertake any tasks. When mutual obligations requirements were reintroduced, it impacted George’s access to the JobSeeker payment, as George’s depression was significantly impacting his ability to complete a sufficient number of applications to meet the requirements outlined in his Job Plan. Because George does not meet the required number of applications, his payment is suspended.

George’s experience is harmful in multiple ways. George experiences a financial harm because he is placed on the JobSeeker payment instead of the DSP. George’s previous negative experiences with employers around his mental illness mean that he finds disclosing details of his illness difficult, and stigmatising employer attitudes contribute to difficulty obtaining suitable employment that aligns with his needs. The pressure that George feels to disclose his illness to people he does not have a strong relationship with negatively impacts his overall mental wellbeing, as it produces stress and anxiety. Further to this, because George’s application for the DSP was unsuccessful, he feels like his illness will not be respected by the system, and worries that disclosing it will not provide any benefit even if he does. George also feels like the system is not designed to meet the needs of people like himself, where the rules about applying for jobs are not well set up for people who have specific employment or accommodation needs and therefore a smaller set of jobs that it would be sensible to apply for.

George experienced structural stigma in multiple ways. After being deemed ineligible for access to the DSP, George experienced structural stigma because the payment that he was placed on was poorly designed to allow for flexibility around the challenges that George faced related to his illness. If the mutual obligations conditions were not a component of the social security system, George would not face the same pressures to disclose his illness to the Employment Services Provider. George’s experience exhibits the added structural issues faced by many people with mental illness, where their illness does not conform to the ‘ideal’ type of disability that is visible and therefore easier to recognise (McAllister, 2020). The expectation of George to disclose his illness to the Employment Services Provider (after having negative experiences related to his previous employer’s knowledge of his illness) also places structural pressure on George related to the invisible nature of his illness.

George’s experiences reflect common encounters with the social security system for people with an invisible illness. The invisible nature of George’s depression means that it does not align with the ‘ideal’ model of impairment which the social security system is more adequately suited to recognising and supporting (McAllister, 2017; 2019; 2020; McAllister et al., 2021). The episodic nature of George’s condition influences the way that he thinks about his employment options, which is also a common experience of people with mental ill-health, as they can be concerned about how entering the labour market might impact their access to supports when they have an episodic incident in the future (Gewurtz et al., 2018, p.217). The negative financial consequences George experiences - which are associated with the differences related to receiving JobSeeker Allowance (previously Newstart allowance) as opposed to the DSP - are outlined in Collie et al. (2021, p.18).
5.3 Chapter summary

This chapter has provided an overview of Australia’s social security system and other types of income protection, as well as some current statistics on income support payments, a brief overview of recent social security reforms, and changes arising from COVID-19. This chapter identifies the following examples of factors that contribute to structural stigma and discrimination against people with mental ill-health, or harm people’s mental health, some of which are also illustrated in Story 1.

- People with psychosocial disability experience higher rates of employment exclusion than people with other disabilities (Australian Bureau of Statistics, 2020), which limits access to employer-funded income support provisions such as paid leave.
- WorkCover claims relating to mental ill-health are less frequently granted due to challenges in attributing injury to an employer (Collie, Iles & Di Donato, 2018).
- The vast majority of people with mental ill-health face exclusions or higher premiums when they seek income protection insurance (Productivity Commission, 2020).
- Decisions about work capacity and payment eligibility are made by people with inconsistent (and potentially very limited) knowledge of mental ill-health and its impacts (McAllister, 2019).
- Stigma against mental ill-health influences decisions by health professionals regarding whether someone should be eligible for a disability pension (McAllister et al., 2021).
- Policy reforms have been explicitly designed to reduce costs by limiting the number of people accessing the DSP, and have made it harder for people with mental ill-health to qualify for DSP (Collie, Sheehan & Lane 2021).
- Income management programs that restrict people’s agency and choice are ineffective, stigmatising, and harmful to people’s dignity (ACOSS, 2019).
- The impacts of COVID-19 differ according to the financial and social resources people have access to – increased financial support improves the wellbeing of people with mental ill-health (Flourish Australia et al., 2020), but the Coronavirus Supplement payments were not available to people receiving DSP or Carer Payment.
- Mental healthcare remains unaffordable for many people whose primary income is social security payments (ACOSS 2020).

The impacts of social security reforms and the way the current social security system works will be discussed further in the following two chapters, which focus on the experiences of people with mental ill-health, and carers of people with mental ill-health.
6. EXPERIENCES OF THE SOCIAL SECURITY SYSTEM FOR PEOPLE WITH MENTAL ILL-HEALTH

6.1 Chapter introduction

This chapter explores findings from the literature review about how the current social security system does or does not support people who are unable to work (or unable to secure adequate income through work) due to their experience of mental ill-health. The following research questions will be addressed in this chapter:

1. How does Australia’s social security system currently support people who are unable to work (or unable to secure adequate income through work) due to their experience of mental ill-health?
2. How do people become aware of the available income supports?
3. To what degree are the existing income supports taken up?
4. Where they are not taken up, what is the evidence of why this is the case?
5. Are the current available income supports adequate?
6. How responsive are the existing income supports to the episodic nature of some experiences of mental ill-health?

6.1.1 Overview

Our findings on how people with mental ill-health experience Australia’s social security system identify several connected issues that suggest structural discrimination exists within the social security system, and significantly impacts people’s lives. This finding is consistent with recent research showing that mental health stigma and discrimination are pervasive and impact all domains of people’s lives, including welfare support, insurance and employment (Groot et al., 2020). Many of the key issues identified relate to information and support, access and equity, payment adequacy, and responsiveness and flexibility within the system. Identified issues include:

- Policies and practices that are underpinned by the goal of reducing costs.
- Information on applications and eligibility requirements being lacking or unclear.
- Inadequate support available to assist people to navigate the system and access appropriate payments.
- High proportions of people with mental ill-health receiving unemployment payments that place inappropriate compliance-focused obligations on them, and provide inadequate income to meet essential needs.
- Evidence of systematic disadvantage to people with mental ill-health in applying for/being granted the Disability Support Pension; and in being able to comply with obligations related to unemployment payments.
- Inadequate responsiveness and flexibility of the system to the needs of people with mental ill-health, and flow-on impacts to people’s financial wellbeing, mental health, and capacity to meaningfully participate in life.
- Many of the issues highlighted within the reviewed evidence are interconnected – for example, issues of equity underpin the information and support that people have, which influences their
access to payments, and impacts payment adequacy. All these processes are connected because equity informs the responsiveness and flexibility of the system.

These findings indicate that previous recommendations to reduce system complexity, increase fairness and payment adequacy, protect mental health, and better support people’s capacity for meaningful participation in life have not been fully realised (McClure et al., 2015; National Mental Health Carer and Consumer Forum and Mental Health Council of Australia, 2014; The Senate Community Affairs References Committee, 2020). Illustrative examples of these key findings are discussed below.

6.1.2 The impacts of policy and practice reforms targeting cost reduction

People receiving income supports experience high rates of distress and mental ill-health, and mental health problems are associated with increased likelihood of accessing income support (Butterworth, Crosier & Rodgers, 2004; Kiely & Butterworth, 2014). Given that people experiencing mental ill-health represent a high proportion of income support recipients, policies that restrict the resources and opportunities of people accessing income support are also disproportionately impacting people with mental ill-health (Collie, Sheehan & McAllister, 2019). Research findings over the last two decades have consistently recommended considering mental health in the design of social and economic policies, and increasing support to improve people’s health, and facilitate social and economic participation (Butterworth & Berry, 2004; Collie, Sheehan & McAllister, 2019; Kiely & Butterworth, 2014). However, following reforms to income support eligibility criteria, there is evidence that rates of receiving DSP have decreased, and receipt of (lower) unemployment income support payments have increased, particularly among people with primary mental health conditions (Collie, Sheehan & Lane, 2021). Policies that restrict the rights and opportunities of stigmatised groups; and policy inaction on issues that disproportionately affect stigmatised groups are both examples of structural stigma (Link & Hatzenbeuhler 2016).

Evidence suggests that these reforms to government income supports have impacted people’s financial circumstances and stress levels (Collie, Sheehan & Lane, 2021; Goldie, 2016). A recent systematic review of international research in high-income countries (such as Australia) has shown that increased restrictions to social security programs are associated with decreased mental health, while more generous social security measures are associated with improved mental health (Simpson et al., 2021). Recent reforms to the Disability Support Pension (DSP) have the explicit aim of reducing costs by tapering DSP growth and reducing new grants (Australian Government, 2016). While these reforms affect anyone attempting to access the DSP, the evidence suggests that people with mental ill-health are particularly impacted by these changes, which limit people’s financial resources and opportunities for meaningful participation and recovery (Collie, Sheehan & Lane 2021). Further, recent reforms have removed the mechanisms by which people with experience of mental ill-health provided input into social security design (Mental Health Australia, 2019).

Targeting programs that support people with mental ill-health for budget cuts is described by Holley, Stromwall & Bashor (2012) as a form of overt oppression, as is excluding people with mental ill-health from budget and program decisions. Policy targeting is also linked to stigma, as it singles out groups ‘in need’, drawing attention to their perceived higher reliance on the public purse (Carey & Crammond 2017; Soldatic & Morgan 2017) and reinforcing divisive labelling of “us” and “them” (Link & Hatzenbeuhler, 2016). Work on policy targeting shows that the more we target, the more inequitable and stigmatising systems become (Carey & McLoughlin 2016).
6.1.3 Information and support

One of the impacts of recent reforms is a shift in the burden of information provision away from the social security system, and onto people seeking support (Collie, Sheehan & Lane, 2021). This is problematic, as people with mental ill-health and carers may not always explicitly identify their situation when seeking support – in some cases due to self-stigma, or concerns about being stigmatised by others (Groot et al., 2020; Mental Health Council of Australia, 2009). The evidence demonstrates that this change in administrative burden has created additional pressure and costs for people in proving their eligibility for support (Collie, Sheehan & Lane, 2021), and this can disproportionately disadvantage some community members – including people with mental ill-health (Collie, Sheehan & McAllister, 2019), as well as Aboriginal and Torres Strait Islander people, and people living remotely (Soldatic & Fitts, 2021).

People experience the social security system as complicated, and navigating the system successfully is challenging for people who are experiencing distress or mental ill-health (Economic Justice Australia, 2021; McClure, Aird & Sinclair, 2015; Soldatic & Fitts, 2021), particularly where people have limited support networks to draw on (Person accessing DSP, personal communication, 24 July 2021). Administrative burden and the personal financial and psychological costs associated with application processes and compliance obligations is high, particularly for people with mental ill-health who are required to obtain a psychiatrist or clinical psychologist assessment at their own cost (often hundreds of dollars and up to a few months’ wait) to support their application, even if they have a history of receiving treatment for the same condition with other healthcare professionals (Mental Health Australia, 2019; Soldatic & Fitts, 2018).

One of the recent reforms to the DSP is the removal of the Treating Doctor’s Report, which previously enabled a health professional who knew the person’s history and impact of their health condition to provide evidence for their application for Disability Support Pension, and to bill this item under Medicare (National Social Security Rights Network, 2018). The removal of the Treating Doctor’s Report shifted assessments of people’s applications for DSP to government-contracted medical professionals and Job Capacity Assessors, who have varying degrees of mental health knowledge (McAllister, 2019). This change also removed the option for doctors to receive payment through Medicare for the time spent supporting their patients with income support applications (Economic Justice Australia, 2021).

The current processes have contributed to:

- People having to seek additional assessment from an unfamiliar health practitioner (without an existing relationship of trust and rapport) to establish eligibility for the DSP. This process is often impacted by healthcare cost and accessibility barriers, disadvantaging those with the least resources to draw on (Soldatic & Fitts, 2021; State of Victoria, 2021a).
- People having to rely on voluntary help from healthcare professionals, other services or social support to assist them through the application process (Soldatic & Fitts, 2018).
- Less clarity for both DSP applicants and health professionals around the level and kind of information required for an applicant to prove eligibility for DSP (Economic Justice Australia, 2021). Unclear information has been found to increase fear, distress and distrust for people with mental ill-health who are accessing income support (Gewurtz et al., 2018).
- Capacity and claims being assessed based on limited information, by people with varying degrees of knowledge regarding the impacts of mental ill-health (McAllister, 2019).
- Increased difficulty for people with mental ill-health to demonstrate eligibility for DSP (Collie, Sheehan & Lane, 2021).
Reduced rates of DSP being granted across all types of disability, but a larger increase in people with mental ill-health being placed on unemployment payments (Collie, Sheehan & Lane, 2021).

The lack of information provided to people about their social security entitlements and the evidence required of them results in people struggling to navigate the application process, and (for those who can access it) needing to seek additional support from medical professionals, social services, and advocacy organisations (Economic Justice Australia, 2021; Soldatic & Fitts, 2021). Information about income support is complex, and not well-adapted for people with mental ill-health (Economic Justice Australia, 2021). Evidence from the UK shows that having support from a welfare rights worker can increase income support access for people with mental ill-health and carers (Minogue, 2006).

Recent figures from Australia’s Administrative Appeals Tribunal (which reviews social security appeal claims) show that between 20-25% of all DSP appeal claims are approved, and the main reason for this is provision of additional information to support the person’s claim (National Social Security Rights Network, 2018). While these figures include both people with psychosocial, and other disability, this indicates there are people who are eligible for DSP who are missing out when they first apply, and that appropriate support and assistance in understanding or gathering the required information makes a difference to payment access (National Social Security Rights Network, 2018).

The claim and appeals process can be both psychologically and financially stressful for people with mental ill-health and their family members or carers (Social Security Rights Victoria, 2019). People may wait anywhere from two to six months for an initial DSP claim decision, and commonly around 10-11 months between the initial claim and an Administrative Appeals Tribunal decision (National Social Security Rights Network, 2018).

Story 2 illustrates some of the ways in which inadequate information and support relating to the current social security system impacts people with mental ill-health, by delaying access to the DSP.
**Story 2: Delayed Access to the Disability Support Pension – Helen**

Helen has been diagnosed with chronic paranoid schizophrenia. After Helen’s illness made it difficult for her to participate in the labour market in July 2017, she applied for the Disability Support Pension with the support of multiple medical professionals. Helen was ruled as ineligible to receive the DSP, and was instead placed onto Newstart Allowance. Helen challenged the outcome of her application through the Administrative Appeals Tribunal Social Security and Child Support Division (AAT) in August 2017 when she was notified of her initial unsuccessful outcome. As part of the appeals process Helen had to attend a hearing which was a traumatic experience for her, as she finds it difficult to leave the house because of her condition. In February 2018 Helen’s appeal was ruled as successful and she moved onto the DSP.

Helen’s experience was harmful in multiple ways. Having to prove the negative experience of her illness, and highlight the impacts it had on her was harmful to Helen’s mental health and overall wellbeing. Helen had multiple negative experiences related to discussing her illness with Centrelink staff who were dismissive of the impacts of her illness, and this negatively impacted her mental wellbeing. Because Helen’s condition makes it difficult to leave the house, she found the appeals process particularly stressful, and this also had a significant negative impact on her mental wellbeing. For the duration of the appeals process Helen was placed on Newstart Allowance, which provided a lower level of financial support that was not sufficient to meet the costs of Helen’s essential needs, including the costs associated with accessing her medication. As a consequence, Helen also experienced significant stress and anxiety about her financial situation.

Helen experienced structural stigma in multiple ways. The first instance that Helen experienced harm from structural stigma was in the way that her application for the DSP was initially denied. Her original application was denied because her schizophrenia was assessed as not permanent since it was not fully treated and stabilised. This aligns with the structural stigma that people with mental ill-health can face where their disability is viewed as less clearly eligible for support because the impacts can vary over time. Helen experienced a second harm related to structural stigma where she had to perform her illness. Many people with mental ill-health must do additional work in demonstrating the impacts of their illness, and the performative nature of this can have negative mental health consequences as it aligns with a deficit model of illness. Helen experienced a third harm from structural stigma, where the appeals process negatively impacted her mental wellbeing. A process more receptive to the challenges that she faced could have ensured that she did not need to attend the appeal hearing in person if this would cause her distress. Helen experienced a fourth harm associated with structural stigma through her interactions with Centrelink staff who devalued the impact of her illness. This experience was degrading to Helen and negatively impacted her mental wellbeing and overall sense of self-worth.

Helen’s experience of increased difficulty accessing the DSP because her primary condition is mental rather than physical is highlighted by work from Economic Justice Australia (2021, p.1), who find that “for people whose primary condition is a psychiatric impairment, our member community legal centre experience is that the eligibility criteria and application requirements make it more difficult for them to access the Disability Support Pension.” This aligns with the work of McAllister and others which outlines how mental illness is often not seen as an ‘ideal’ form of impairment when trying to access the DSP (McAllister, 2017, 2019, 2020; McAllister et al., 2021). Helen’s experience as a person with chronic paranoid schizophrenia is similar to one outlined by Social Security Rights Victoria (2019), including issues related to the appeals process. The negative financial consequences associated with delays in DSP applications and appeals are outlined in Soldatic (2018).
6.1.4 Improving employment supports

Another common theme related to support is suggested improvements to Australia’s employment services system. Several papers recommend more person-specific support, reduction in disincentives to work (such as fear of losing income support), and better collaboration between the different systems that support people (Collie, Iles & Di Donato, 2018; National Social Security Rights Network, 2019; Orygen Youth Health Research Centre, 2014; Roulstone, Harrington, & Hwang, 2014). Efforts to support employment should recognise that both the nature of employment (e.g. casualisation) and unemployment benefits have changed over time. Unemployment benefits that were originally designed to provide temporary support are now being utilised for extended periods of time – averaging 2.5 years in 2015-16 - in cases where people either cannot access work, or are underemployed (Collie, Iles & Di Donato 2018).

Compliance obligations are widely viewed as punitive and unhelpful for supporting people to access work (Black, 2009; Humpage, 2007; Mental Health Australia, 2019). Compliance measures such as suspensions and cancellations of payment can result in significant stress, deterioration of mental health, loss of income and housing, and increased need to access other community and social services (National Social Security Rights Network, 2019). Providing support to improve people’s health and increase their economic security are recommended as ways to support participation (Collie, Sheehan & McAllister, 2019; Humpage, 2007).

Suggested improvements to employment supports for people with mental ill-health include:

- Employment supports being co-designed with people who access them – including people with mental ill-health (National Social Security Rights Network, 2019).
- Basing employment supports on a person’s self-determined goals (Mental Health Council of Australia, 2009), and enabling people to exercise choice and flexibility in accessing employment support and work as they are able (Gewurtz et al., 2018; National Social Security Rights Network, 2019).
- Abandoning compulsory compliance measures (Black, 2009; Humpage, 2007; Mental Health Australia, 2019).
- Providing supports that address health and other factors (Collie, Sheehan & McAllister, 2019).
- Increasing access to Individual Placement and Support models of employment assistance (Productivity Commission, 2020).
- Providing access to employment support within mental health services (Orygen, 2014).
- Increasing regulation of the employment services industry (National Social Security Rights Network, 2019).

6.1.5 Equity and access

Many of the identified issues relate to equity and access for people with mental ill-health, and these often tie back to the policies that underpin and inform Australia’s social security system and its administration. The complexity of legislation and assessment processes for disability income support have created systemic barriers that have reduced access to DSP (Forbes, 2021), and systematically disadvantage people with mental ill-health (Economic Justice Australia, 2021). These systemic barriers include the influence of ideology, politics and public perceptions on decisions about DSP eligibility; and evidence that decision makers favour disabilities that are visible, permanent, fully recognised as a medical illness, with clear proof of disability and with an external cause (McAllister, 2019). Mental illness is less likely to meet these criteria of being ‘ideal’ for granting of the DSP, and evidence shows that medical professionals (who are pivotal in supporting people’s applications) are also influenced by their own perceptions about who should be granted DSP (McAllister et al, 2021). This and other research on Australia and the UK (McAllister,
identifies the impacts of social attitudes (or perceived attitudes) among the media, public and taxpayers (stigmatising and devaluing people with mental ill-health, people with disability, and income support recipients) on policy and claim decision-making.

An example of inequities in payment access is that people with some types of disability are not required to undergo additional eligibility assessments, because their eligibility is considered (under existing social security policy) to be manifestly evident – this includes people with permanent blindness, and people with intellectual disability (where evidence indicates an IQ under 70) (Services Australia 2020). Due to the sometimes episodic nature of mental ill-health, assessments based on a single time-point (for example, an appointment with a Job Capacity Assessor) may not adequately demonstrate the impact of mental ill-health on a person’s life (Brophy et al., 2014). In addition, people who experience fluctuating conditions can find it more difficult to respond to assessment questions that are time-limited (Brophy et al., 2014).

In addition to the equity issues identified for people with mental ill-health, Aboriginal and Torres Strait Islander people also face specific forms of structural discrimination. These additional system issues include lack of understanding and flexibility for cultural commitments, inaccessibility of information, lack of cultural competency in medical assessments, and the fact that people may be fearful of engaging with systems (e.g. medical and government) that have systematically harmed and discriminated against them (Dudgeon, Bray, D’Costa & Walker, 2020; Soldatic & Fitts, 2018). For Aboriginal and Torres Strait Islander people who may also be supporting family members while applying for the DSP, this can impact availability to complete administrative processes, and limited financial resources from lower payments such as JobSeeker Allowance may be stretched further across family and kin networks (Soldatic & Fitts, 2021). Currently, the costs and burden of applying for DSP are creating barriers to access and shifting risk to individuals and other social services (or in some cases, towards high-risk commercial financial products) (Soldatic & Fitts, 2021). Aboriginal people in regional and remote areas experience disproportionately high suspension and penalty rates for non-compliance with activity obligations; and disproportionately low rates of DSP grants or successful appeals (Economic Justice Australia, 2021). These structural inequities can compound experiences of stigma for Aboriginal and Torres Strait Islander people, and negatively impact people’s social and emotional wellbeing (Dudgeon, Bray, D’Costa & Walker, 2020).

The recent Royal Commission into Victoria’s Mental Health System identifies the need to reform policies that result in structural discrimination, and increase information, advocacy and legal support to resolve systemic discrimination, rather than placing this burden on individuals with mental illness and their family members or carers (State of Victoria, 2021b).

6.1.6 Adequacy

The available literature (both academic and grey literature sources) is extremely consistent in stating that the current rate of unemployment income support (JobSeeker Allowance) is inadequate, and results in people being unable to meet their basic needs for decent housing, food, heating, healthcare, and social participation (The Senate Community Affairs References Committee, 2020). This harms people’s economic dignity and is counter to the human rights frameworks to which Australia is a signatory, and to several major government strategies and programs (for example the National Disability Strategy and the National Disability Insurance Scheme) (Humpage, 2007; Productivity Commission, 2011). There is also some evidence that Disability Support Pension and Carer Payment may not be adequate to cover the increased costs associated with healthcare needs, or supporting someone with mental ill-health (e.g. if needing to assist loved ones with bills, or travel to multiple appointments to accompany them) (Li et al., 2019; Morrison & Stomski, 2019). There is evidence that austerity policies that reduce social welfare
spending (including income benefits for people with disability) contribute to worse mental health and additional loss of life or increase in illness (Collie, Sheehan & Lane, 2021; Simpson et al., 2021). In addition, punitive bureaucratic assessment processes can contribute to increased suicide rates, particularly among men (Cummins, 2018). These reductions in levels of support and the resultant adequacy of support received - as well as increased difficulty in accessing support - are linked to issues around economic dignity as manner or bearing, which are explained further in Chapter 8.

Recommendations include an increased minimum rate of payment for everyone who is not able to work or obtain adequate income through work (Boyd-Cain, 2015; The Senate Community Affairs References Committee, 2020). Given that mental ill-health can contribute to substantial costs to individuals and their families, some research suggests that income supports need to be at least 50% higher to raise the standard of living for people with mental ill-health to a similar level as people without mental ill-health (Nghiem et al., 2020). This finding aligns with advocacy reports identifying that the low rate of current unemployment payments prevents people with mental ill-health from accessing adequate healthcare (ACOSS 2020). The adequacy of support is an important issue from an economic dignity perspective, as inadequate support can lead to harms to dignity as manner or bearing through the difficult choices that it brings about. This is discussed in more depth in Chapter 8.

### 6.1.7 Responsiveness and flexibility

Social security requirements (such as assessments for DSP and Carer Payment) are not adequately responsive to the impacts of mental ill-health, its sometimes episodic nature, and the nature of caring needs associated with this (McAllister, 2017; National Mental Health Carer and Consumer Forum and Mental Health Council of Australia, 2014). Legislative requirements and policies that focus on biomedical evidence (Collie, Sheehan & Lane, 2021) and require that conditions be “fully diagnosed, treated and stabilised” can create structural disadvantage for people with mental health conditions, as diagnoses rely on the judgements of health providers, and people’s symptoms and diagnosis may change over time (Economic Justice Australia, 2021; National Mental Health Carer and Consumer Forum and Mental Health Council of Australia, 2014). Following reforms to the DSP, receipt of unemployment benefits (JobSeeker Allowance) have grown rapidly among people with mental ill-health – increasing from 43,709 (35.6% of total NewStart Allowance recipients) in 2012 (pre-reforms), to 108,771 (40.1% of total NewStart Allowance recipients) by 2018 (post-reforms) (Collie, Sheehan & Lane, 2021). This change represents a 148.9% increase in the number of people with mental ill-health receiving unemployment benefits since the DSP policy reforms (Collie, Sheehan & Lane, 2021).

People receiving JobSeeker Allowance are required to comply with job-seeking activities unless they have a medical exemption. However, the current exemption system does not adequately support people with mental ill-health whose conditions are ongoing or episodic (Economic Justice Australia, 2021; Mental Health Australia, 2019). Evidence suggests that people are required to continually seek medical certificates to substantiate the same (ongoing or episodic) health condition, and that certificates for a condition that is characterised as permanent are not accepted for obligation exemptions (Services Australia, 2021). However, if people provide evidence stating that a condition is temporary and then later apply for DSP, this can disadvantage their application (Economic Justice Australia, 2021; National Social Security Rights Network, 2019). Evidence suggests more effective and responsive processes are needed for people with episodic conditions such as mental ill-health (Mental Health Council of Australia, 2009).

People with mental ill-health currently experience structural disadvantages arising from policies, information, eligibility assessments, payment amounts, and processes that do not adequately respond to
their needs. Story 3 illustrates some of the ways in which the inadequate responsiveness and flexibility of the current social security system impacts people with mental ill-health.
Story 3: Episodic Illness – John

John has a generalized anxiety disorder that at times can manifest in panic attacks. John was assessed as ineligible to receive the Disability Support Pension and was instead placed onto JobSeeker Allowance. John experiences an episodic incident of anxiety on the day that he is scheduled to attend an Employment Services Provider appointment. John has strong negative feelings about the appointments, feeling that they provide no meaningful help to him, and are largely a tick-box exercise. John has a panic attack, induced by the stress of his payment being withdrawn if he does not attend and have a successful outcome at his upcoming appointment. John tries to call the JobSeeker Employment Services line to say that he will be unable to attend his appointment and request a temporary exemption, however the phone line is busy, and John is unsuccessful at getting through. John has his payment suspended because he misses his appointment, resulting in a delay in his payment being received.

John’s experience is harmful in multiple ways. The stress associated with having to meet various obligations negatively impacts John’s mental health and wellbeing. Because John is unable to attend his appointment, his payment is suspended, and he does not receive his fortnightly income at the usual time. This delays John paying his rent and phone bill, and John must pay late fees associated with the delays on both payments. As John is already living with a wage below the poverty line, this results in John deciding not to access a mental health support service that he regularly uses (his psychiatrist) as he is unable to afford this expense after paying the additional costs incurred from his late fees. John would be better able to meet these costs if he was on the DSP, and would also not have to meet the mutual obligations requirements that are the reason his payment is suspended and then paid later than his usual payment cycle.

John experienced structural stigma in multiple ways. In the first instance, the episodic nature of John’s illness meant that he found it harder to obtain access to the DSP, and his application was unsuccessful. After being deemed ineligible for access to the DSP, John experienced a second form of structural stigma, where the payment that he was placed on was poorly designed to allow for flexibility around the episodic illness that John has. The structural stigma experienced by John is both harmful to his mental and financial wellbeing. John defers accessing his psychiatrist, which negatively impacts his mental wellbeing, and he is also obliged to pay late fees which negatively impact his financial wellbeing. John’s experience exhibits the added structural issues faced by many people with mental ill-health, where their illness does not conform to the expected or ‘ideal’ type of disability that is both visible and encountered consistently (McAllister, 2020). Instead, the variability and relative invisibility of his illness makes its impacts on his life complicated in ways that the system is not adequately structured to account for.

John’s experience of finding the Employment Services Provider appointments unhelpful is identified as common in a recent Productivity Commission report (2020, page 934). John’s experience of finding it challenging to comply with his mutual obligations, and to receive an exemption is also a common one - for example, see Soldatic & Fitts (2021). This reflects an issue that has been documented for some time, where people impacted by greater levels of structural disadvantage find it more challenging to comply with welfare-related requirements, and are thus penalised and lose access to support at higher rates (Butterworth, 2003). John’s experience of being in financial hardship reflects the evidence related to payment adequacy for current rates of social security support. The financial consequences related to the differences in receiving JobSeeker Allowance (previously Newstart allowance) as opposed to the DSP are outlined in Collie et al. (2021, p.18).
6.2 Chapter summary

This chapter discussed some of the key findings in relation to how the current social security system supports people with mental ill-health. The available evidence suggests that structural discrimination exists within the social security system, and significantly impacts people’s lives. This chapter identifies the following examples of factors that contribute to structural stigma and discrimination against people with mental ill-health, or harm people’s mental health:

- Recent reforms to the Disability Support Pension (DSP) have the explicit aim of reducing costs by tapering DSP growth and reducing new grants (Australian Government, 2016).
- While these reforms affect anyone attempting to access the DSP, the evidence suggests that people with mental ill-health are particularly impacted by these changes, which limit people’s financial resources and opportunities for meaningful participation and recovery (Collie, Sheehan & Lane 2021).
- Given that people experiencing mental ill-health represent a high proportion of income support recipients, policies that restrict the resources and opportunities of people accessing income support are also disproportionately impacting people with mental ill-health (Collie, Sheehan & McAllister, 2019).
- Recent reforms have removed the mechanisms by which people with experience of mental ill-health provided input into social security design (Mental Health Australia, 2019).
- Targeting programs that support people with mental ill-health for budget cuts is described by Holley, Stromwall & Bashor (2012) as a form of overt oppression, as is excluding people with mental ill-health from budget and program decisions.
- Information about income support is complex, and not well-adapted for people with mental ill-health (Economic Justice Australia, 2021; Person accessing DSP, personal communication, 24 July 2021).
- Limited information and support are influencing the ability of people with mental ill-health to access the DSP (National Social Security Rights Network, 2018). While better access to information and support would likely benefit people with any disability, this is particularly important for people with mental ill-health (Person accessing DSP, personal communication, 24 July 2021), as they are not considered eligible on manifest medical grounds and are required to demonstrate the impact of their condition to assessors who may have limited understanding of mental illness (McAllister, 2019).
- Employment supports are currently compliance-focused, with obligations and exemption processes that do not adequately respond to the needs of people with episodic conditions such as mental ill-health (Economic Justice Australia, 2021).
- Compliance measures such as suspensions and cancellations of payment are commonly experienced by people with mental ill-health, and can result in significant stress, deterioration of mental health, loss of income and housing, and increased need to access other community and social services (National Social Security Rights Network, 2019).
- Examples of structural discrimination are present in assessment guidelines (and decision-maker interpretations) that do not view mental ill-health as the ‘ideal’ type of disability for access to DSP (McAllister, 2020).
- Due to the sometimes episodic nature of mental ill-health, assessments based on a single time-point (for example, an appointment with a Job Capacity Assessor) may not adequately demonstrate the impact of mental ill-health on a person’s life (Brophy et al., 2014).
• Additional structural inequities can compound experiences of stigma for Aboriginal and Torres Strait Islander people, and negatively impact people’s social and emotional wellbeing (Dudgeon, Bray, D’Costa & Walker, 2020).

• Given that mental ill-health can contribute to substantial costs to individuals and their families, some research suggests that income supports need to be at least 50% higher to raise the standard of living for people with mental ill-health to a similar level as people without mental ill-health (Nghiem et al., 2020).

• These findings indicate that previous recommendations to reduce system complexity, increase fairness and payment adequacy, protect mental health, and better support people’s capacity for meaningful participation in life have not been fully realised (McClure, Aird & Sinclair, 2015; National Mental Health Carer and Consumer Forum and Mental Health Council of Australia, 2014; The Senate Community Affairs References Committee, 2020).

• Policies and practices that systematically disadvantage or harm stigmatised groups such as people with mental ill-health (whether this is intended or not) are a form of structural discrimination, as is policy inaction (Link & Hatzenbeuhler, 2016; Corrigan, Markowitz & Watson, 2004).
7. EXPERIENCES OF THE SOCIAL SECURITY SYSTEM FOR CARERS OF PEOPLE WITH MENTAL ILL-HEALTH

7.1 Chapter introduction

This chapter is about how the current social security system does or does not support people who are unable to work due to their experience of caring for someone with mental ill-health. The following research questions will be addressed in this chapter:

1. How does Australia’s social security system currently support people who are unable to work (or unable to secure adequate income through work) due to their experience of caring for someone with mental ill-health?
2. How do people become aware of the available income supports?
3. To what degree are the existing income supports taken up?
4. Are the current available income supports adequate?
5. How responsive are the existing income supports to the episodic nature of some experiences of mental ill-health (and therefore potential changes in care needs)?

7.1.1 Overview

Overall, there was less literature available on carers of people with mental ill-health and the social security system, but there were many strong similarities with the findings for people with mental ill-health. Key findings are summarised below, and again relate largely to issues with information and support, equity and access, adequacy, and responsiveness and flexibility within the social security system.

7.1.2 The impacts of current policy and practice

The recent reforms to the DSP were undertaken in response to concerns about continued growth in the number of people accessing disability income support, and the ongoing costs associated with this (Australian Government, 2016). There is evidence of concern among social security rights networks that the parallel growth in the population of people caring for someone should not be used to argue for policy reforms that curb access to Carer Payment, or limit the level of income support provided to carers (National Welfare Rights Network, 2015). Adult Carer payment design has not been reviewed since 1999, and there is some evidence that carers of people with mental ill-health are disadvantaged in accessing Carer Payment and Carer Allowance compared to other carers (Productivity Commission, 2020). "A high-level analysis of access to Carer Payment and Carer Allowance provides some evidence to support claims that mental health carers are less likely to receive these payments than carers of people with a physical condition" (Productivity Commission, 2020, p.914-5).

7.1.3 Information and support

Clear and accessible information about available supports and application requirements is lacking for both people with mental ill-health and carers (particularly for culturally and linguistically diverse people), and this contributes to people missing out on support (Diminic, Hielscher & Harris 2019; Diminic et al., 2017; Forbes, 2021; Kokanovic, Petersen, & Klimidis, 2006). Lack of information regarding mental distress and
support services for culturally diverse carers is common, due to language and cultural barriers between service providers and carers, people not seeking information due to the perception that caring is just what family do, social isolation, and not wanting to discuss mental illness due to stigma and fear of negative social consequences (Knifton, 2012; Kokanovic et al., 2006). However, lack of information is also common across the whole population of mental health carers. A study on mental health carers based on nationally representative data found that many had limited awareness of available services, and multiple unmet needs relating to both practical, and financial support (Diminic et al., 2019). This study suggested that more accessible income support would help to address these gaps (Diminic et al., 2019).

7.1.4 Improving employment supports
Caring for someone with mental ill-health has very similar impacts on employment to caring for someone with other disability - carers of any type are less likely to be employed, more likely to work less hours, and more likely to be employed in lower-skill/status jobs compared to non-carers (Diminic, Hielscher, & Harris, 2019). Improving employment service effectiveness would help enable people who are able to and wish to work to access employment opportunities (National Social Security Rights Network, 2019; Orygen Youth Health Research Centre, 2014; Roulstone et al., 2014). Employer willingness to employ people with mental ill-health or carers and provide mentally healthy and flexible work environments is also a factor in people’s access to employment (Productivity Commission, 2020). Specific examples of suggested improvements to employment supports for people with mental ill-health are covered in section 6.1.3, and many of these would also be relevant for carers – for example:

- Design of employment supports being informed by carers who access them.
- Increased choice and flexibility in accessing employment supports in ways that fit with episodic care provision.
- An increased focus on supporting carers with the range of services that might assist them (for example, including respite or other services that would facilitate access to employment).
- Removing compliance measures, which are not effective in supporting employment.

7.1.5 Equity and access
Carers of people with a mental health condition experience similar issues of structural disadvantage in terms of assessments focusing on provision of support with daily living activities that would be required to support someone with physical disability, and less on activities that mental health carers more commonly do (for example, providing emotional support and accompaniment) (Diminic et al., 2019; Productivity Commission, 2020). This appears to be reflected in data on income support among mental health carers, indicating that the majority were receiving no support, with only 24% receiving Carer Payment (Diminic et al., 2017). Given the findings on the difficulties and inequities people with mental ill-health encounter in attempting to access Disability Support Pension, it is not surprising that mental health carers experience similar structural disadvantages. There is evidence that carers of people with mental ill-health are disadvantaged in accessing Carer Payment and Carer Allowance compared to other carers (Productivity Commission, 2020). This may result from some of the same issues identified in chapter 6 and described above, around bias in assessments and decision makers towards other disabilities that are more physical, visible and non-episodic, with definitive “proof” (McAllister, 2019; 2020).

7.1.6 Adequacy
There is evidence suggesting that Carer Payment may not be adequate to cover the increased costs associated with supporting someone with mental ill-health (e.g. if needing to assist loved ones with bills, or
additional transport costs associated with travelling to appointments to accompany them) (Li et al., 2019; Morrison & Stomski, 2019; Productivity Commission, 2020). The inadequacy of JobSeeker Allowance is a contributor to carer financial burden (Davis, 2020) – and the rate of people with mental ill-health being placed on unemployment payments has increased since policy reforms to DSP (Collie, Sheehan & Lane, 2021). Given the consistent findings that unemployment payments are inadequate and do not enable people with mental ill-health to access needed healthcare (ACOSS 2020), it is unsurprising that family members and carers are often called on for support (Productivity Commission, 2020). A higher proportion of mental health carers (41% compared to 30% of other carers) report challenges in meeting their own living costs due to their caring responsibilities (Productivity Commission, 2020, p. 109).

7.1.7 Responsiveness and flexibility

Social security requirements (such as assessments for DSP and Carer Payment) are not adequately responsive to the impacts of mental ill-health, its sometimes episodic nature, and the nature of caring needs associated with this (McAllister, 2017; National Mental Health Carer and Consumer Forum and Mental Health Council of Australia, 2014). Evidence from a study of mental health carers suggests that carer supports (and assessment tools for eligibility) are not as well suited to people caring for someone with mental ill-health, and the different nature of support this entails (Diminic et al., 2019).

Supports and rules regarding paid work and income should maximise incentives to people with mental ill-health and carers to work when they can without fear of, or actual economic disadvantages from doing this (Productivity Commission, 2020). Some suggested changes identified within the literature include:

- Enabling carers to average hours worked over longer periods (e.g. 3 months) so that they don’t lose benefits from working more while the person they care for is well.
- Abolishing the 25-hour rule that limits the time that carers can be away from people receiving care to 25 hours per week (Brophy et al., 2014; Mind Australia, Neami National, Wellways, & SANE Australia, 2020; Orygen Youth Health Research Centre, 2014; Productivity Commission, 2020).

Current social security rules limit the ability of carers of people with episodic conditions to work more when they can, without losing access to needed financial support for periods when they need to provide more care (Productivity Commission, 2020).

Story 4 illustrates some of the ways in which mental health carers can experience stigma and structural discrimination in relation to the episodic nature of caring for someone with mental ill-health.
**Story 4: Being a Carer for a Person with an Episodic Illness – Petra and Ivan**

Petra is a carer for her partner Ivan who has Post Traumatic Stress Disorder (PTSD). As a relatively recent migrant to Australia, Petra has a low level of English proficiency, and only a small number of people who she can draw on for support in delivering care. Ivan was ruled ineligible for the DSP, and Petra was ruled ineligible for the Carer Payment, because Ivan’s PTSD is experienced irregularly, and Petra can work part-time when Ivan is more well. Currently, Petra has been unable to work for five weeks because of her responsibilities as a carer, and is currently receiving JobSeeker Allowance. On the day Petra is due to attend an Employment Services Provider appointment, Ivan experiences a trigger event and because no one else is available in their small support network, Petra needs to stay and care for Ivan, and misses her appointment. Petra has had a negative experience with her Employment Services Provider already, as the services are not culturally responsive or well-designed for people without high English proficiency.

Because Petra does not trust the service provider and is concerned about experiencing stigma associated with mental ill-health, she has not disclosed the severity of Ivan’s illness to her provider and so is unable to explain missing her appointment. Because Petra misses her appointment, she has her payment suspended.

Petra and Ivan’s experiences are harmful in multiple ways. Petra’s initial experience related to the lack of cultural responsiveness and accessibility for people without high English proficiency made her feel uncomfortable and stressed about the Employment Services Provider being able to understand her and Ivan’s situation. Because trust is an important component in disclosing mental health issues, this added an additional layer of difficulty to Petra explaining their specific situation. Because Petra is unable to attend her appointment, her payment is suspended, and she does not receive her fortnightly income at the usual time. Petra does not have someone to draw financial support from, so Petra and Ivan are forced to skip meals while they are awaiting the payment being released. Petra and Ivan would not be forced to skip meals if Ivan was on the DSP, and if Petra was on the Carer Payment, they would not have to meet the mutual obligations requirements that are the reason Petra’s payment is suspended and then delayed.

Petra and Ivan experienced structural stigma in multiple ways. Firstly, the episodic nature of Ivan’s illness meant he found it harder to obtain access to the DSP, and his application was unsuccessful. Petra and Ivan experienced a second form of structural stigma, where the payment Petra was placed on was poorly designed to allow for flexibility around the episodic care Petra provides to Ivan. The structural stigma experienced by Petra and Ivan is harmful to their wellbeing. Petra and Ivan skip meals because of their low amount of money, which negatively impacts their wellbeing. The requirement to disclose their situation to the Employment Services Provider to receive an exemption on the mutual obligations requirement is stressful for Petra, who must decide between two harmful things happening to them. Petra must either disclose her situation to an organisation she does not trust and hope the provider deems it sufficient grounds to grant a temporary exemption (which is harmful to her and Ivan’s dignity), or she must accept the payment being suspended, which has negative financial consequences. Petra and Ivan’s experience exhibits the added structural issues faced by many carers of people with mental ill-health. The variability and relative invisibility of Ivan’s illness makes his care needs and the impacts on Petra’s ability to work complicated in ways the system is not adequately structured to account for.

Petra’s experience reflects one which is common for many mental health carers. Many carers have a relatively low level of knowledge about some of the existing supports that are available to them (Diminic et al., 2019). Carers face additional challenges around being in the labour market, and as a result, significantly more carers are not employed compared to non-carers (Diminic, Hielscher, & Harris, 2019). Payment inadequacy is an issue for carers as well, and the complicated nature of accessing higher levels of support impacts rates of payment for carers (Boyd-Cain, 2015). The issues Petra faced around lacking a sufficient support network is an experience identified across different migrant populations in Australia (Kokanovic, Petersen & Klimidis 2006). The issues related to the episodic nature of Ivan’s condition, and the subsequent variation in care needs are noted as a problem with the current structures around the Carer Payment (Productivity Commission, 2020, p.919). These reflect wider issues around the differences in the way the social security system handles ‘ideal’ and ‘non-ideal’ forms of impairment (McAllister, 2017, 2019, 2020; McAllister et al., 2021).
7.2 Chapter summary

This section has outlined the key issues identified from the literature review in relation to how the current social security system supports people who are caring for someone with mental ill-health. Very similar issues emerged regarding lack of clear information impacting access to support (particularly so for culturally and linguistically diverse carers), and some evidence of inequities and structural disadvantage in applying for support. Issues regarding payment adequacy, improving employment supports, and the need for greater responsiveness and flexibility were also identified for mental health carers. This chapter found the following examples of factors that contribute to structural stigma and discrimination against carers of people with mental ill-health:

- Carers of people with mental ill-health are disadvantaged in accessing Carer Payment and Carer Allowance compared to other carers (Productivity Commission, 2020).
- Clear and accessible information about available supports and application requirements is lacking for both people with mental ill-health and carers (particularly for culturally and linguistically diverse people), and this contributes to people missing out on support (Diminic et al., 2019; Diminic et al., 2017; Forbes, 2021; Kokanovic, Petersen, & Klimidis, 2006).
- Carers of people with mental ill-health are disadvantaged by income support assessments that focus more on provision of support with daily living activities that would be required to support someone with physical disability, and less on activities that mental health carers more commonly do (for example, providing emotional support and accompaniment) (Diminic et al., 2019; Productivity Commission, 2020).
- The inadequacy of JobSeeker Allowance is a contributor to carer financial burden (Davis, 2020) – and the rate of people with mental ill-health being placed on unemployment payments has increased since policy reforms to DSP (Collie, Sheehan & Lane, 2021).
- A higher proportion of mental health carers (41% compared to 30% of other carers) report challenges in meeting their own living costs due to their caring responsibilities (Productivity Commission, 2020, p. 109).
- Social security requirements (such as assessments for DSP and Carer Payment) are not adequately responsive to the impacts of mental ill-health, its sometimes episodic nature, and the nature of caring needs associated with this (McAllister, 2017; National Mental Health Carer and Consumer Forum and Mental Health Council of Australia, 2014).
- Current social security rules limit the ability of carers of people with episodic conditions to work more when they can, without losing access to needed financial support for periods when they need to provide more care (Productivity Commission, 2020). This restricts mental health carers’ economic participation and financial resources.
8. POTENTIAL PATHWAYS FOR IMPROVEMENT

8.1 Chapter introduction

This chapter explores potential pathways for improvement in Australia’s social security system, including international insights/models. This chapter addresses Research Question 8: Are there insights from other countries that could help restructure our income protection? Finally, the principles of economic dignity are used to inform a discussion of potential pathways to improving how the social security system works for people experiencing mental ill-health, or caring for someone with mental ill-health.

8.2 Potential pathways for improvement, drawing on international models

Within the preceding chapters, several key issues with the current social security system are identified, including system complexity and the need for cross-sector collaboration to better support people experiencing work incapacity, and improve health outcomes (Collie, Iles & Di Donato, 2018). The evidence suggests that many of the issues within Australia’s social security system are common in other countries including Canada, the US and the UK (Gewurtz et al., 2018; Hansen, Bourgois, & Drucker, 2014; Soldatic & Morgan, 2017). Several consistent arguments for improvement occur throughout the literature, including:

- Involving people with lived experience in the design of social security systems (Scottish Government, 2019).
- Improving information and access to support so that people with mental ill-health do not experience unnecessary uncertainty, mental or financial distress about feared or actual loss of their income support (Gewurtz et al., 2018).
- Addressing stigma at a structural level to ensure that social security policies and processes do not systematically disadvantage people with mental ill-health or carers of people with mental ill-health.
- Providing adequate and non-compliance focused support to ensure that people can:
  - participate in their community, caring role, or paid work as they are able, and
  - meet their essential needs (including access to mental healthcare as required).

Recommendations for improving the social security system include a focus on foundational principles of equity, dignity and autonomy, solidarity, adequacy, and accountability (Bowman, Thornton & Mallett, 2019). Some international examples of social security reviews and reforms in alignment with these principles include New Zealand’s “Whakamana Tāngata – Restoring dignity to social security in New Zealand” review, and recent reforms undertaken by the Scottish Government (The Senate Community Affairs References Committee, 2020). These international examples focus on improving social security in broad ways that are likely to benefit everyone, including people with mental ill-health.

8.2.1 New Zealand

In the recent (2020) Senate Community Affairs References Committee report on the adequacy of Australia’s unemployment benefits and alternative mechanisms to determine the level of income support
payments, several contributors recommended drawing on New Zealand’s review of its welfare system (The Senate Community Affairs References Committee, 2020). The main recommendations reflect those identified above, including making the income support system easier to access, ensuring income support is adequate to support meaningful community participation, improving the effectiveness of employment supports, and improving the health and wellbeing of people with disabilities and carers who engage with the social security system (New Zealand Government, 2019).

8.2.2 Scotland

The mechanisms and principles used by the Scottish Government to inform social security reforms have also been identified as a promising model (The Senate Community Affairs References Committee, 2020). These reforms are underpinned by a human rights framework that views social security as both a human right, and essential in upholding other human rights (Scottish Government, 2019). The Scottish reforms are based on principles of:

- Dignity and respect
- Poverty reduction
- Equality and non-discrimination
- Co-design with the people of Scotland (Scottish Government, 2019)

A charter based on these principles was collectively developed by people with experience of the social security system, advocacy groups and community organisations, government and social security staff - and an independent group of experts ensures accountability to the charter (Scottish Government, 2019). A similar model has consistently been recommended for Australia (National Mental Health Carer and Consumer Forum and Mental Health Council of Australia, 2014; The Senate Community Affairs References Committee, 2020).

8.3 Potential pathways for improvement based on economic dignity

This section draws on the reviewed literature discussed in the preceding chapters to outline, based on an economic dignity framework, how Australia’s social security system could be improved to better support people with mental ill-health and carers of people with mental ill-health. Each section discusses potential improvements that are relevant to one of the four elements of economic dignity – dignity as intrinsic, dignity as status, dignity as function, and dignity as manner or bearing.

8.3.1 Dignity as intrinsic

The first type of economic dignity, dignity as intrinsic, highlights the importance of respecting and supporting the agency of people, especially in relation to things that have important consequences for their lives. Currently, there are aspects of the social security system which demonstrate a lack of respect for the agency of individuals, especially in relation to some of the processes that influence their eligibility for access to support. This has occurred in three specific ways, which can be remedied through adjustments to current processes:

1. Improving the potential for individuals to have their voices directly contribute to the structures of the system.
2. Improving the receptivity of supports to better align with the needs raised by an individual presenting for support.
3. Changing compliance procedures which imply that individuals are incapable of identifying and
acting in their own best interests.
4. Removing restrictions on how social security recipients can exercise their economic agency.

As noted above, changes to the process around consultation have meant that there is significantly reduced scope for people with mental ill-health accessing the social security system to have their voices heard about how to best structure the system to support their needs.

Currently, there are challenges for individuals wishing to access support around having to demonstrate their needs, or having services structured in a way that is receptive to the episodic nature of the issues that they can experience. For example, carers who can participate in the labour market while not providing care could benefit from a system that was more responsive to the periods where they need to reduce their hours or exit the labour market to provide care. Arrangements that allowed for greater flexibility around the impact on support payments caused by variations in hours worked and income earned would better support people caring for those with episodic and variable care needs.

Compliance procedures related to accessing JobSeeker Allowance, the Disability Support Pension and other government social security supports construct the individual in a way that implies that they are incapable of determining the best options for themselves in terms of accessing the labour market. However, for some individuals, there may be a narrow pool of employment options that are suitable to their needs. Employers can be resistant to hiring people with mental ill-health (Reavley, Jorm & Morgan, 2017). Rather than increasing pressure on these individuals to find suitable employment, better supports could be offered to increase the number of roles that are available to them.

Restrictions on how social security support recipients can spend their income – through measures like the income management cashless debit card – explicitly position individuals in receipt of support as being incapable of exercising their agency. Evidence has shown that these income management cards have significant negative consequences for the emotional health of those who use them, causing both stress and feelings of embarrassment and humiliation. They can also explicitly mark the individual in the community, as they are visible when being used, and can thus also contribute to stigmatisation.

8.3.2 Dignity as status

The second type of economic dignity, dignity as status, highlights the importance of creating procedures and processes that do not stigmatise people accessing social security payments. In much the same way that compliance procedures and restrictions on how payments are spent can construct the person receiving support as an inferior agent (needing their choices restricted), they can also generate stigma for recipients. Further to this, compliance and punishment frameworks create a situation whereby recipients are positioned as either deserving or undeserving of support. This implies that support ought to be contingent upon the recipient being deemed worthy, and that some people who are receiving support might not be worthy (against a changing set of criteria, which can be explicit in terms of rules, or implicit whereby judgements are made by those administering systems). This contributes to stigma because any individual recipient of support might not be deemed one of the worthy or deserving ones.

As work on ‘ideal’ (or the ‘model minority’) and ‘non-ideal’ forms of disability highlights, there are also ways in which the system is currently structured that positions some experiences and conditions as more deserving of support than others. The episodic nature of some mental health conditions means that accessing support can lead to the experience of stigma, as the recipient seeking support must demonstrate their need for assistance (including the permanency of their condition, which may conflict with mental
health recovery frameworks that emphasise hope).

To support the status based economic dignity of people, the social security system needs to:

1. Ensure that the system treats recipients with respect.
2. Ensure that there is not a construction of deserving and undeserving poor.
3. Ensure that more episodic experiences of disability and mental ill-health are proactively accepted.

8.3.3 **Dignity as function**

The third type of economic dignity, dignity as function, highlights the importance of providing adequate support that allows people to participate and serve a function in the community that they have reason to value. People experiencing mental ill-health, and mental health carers may need support of various kinds to ensure that they are able to undertake a function that they have reason to value. The social security system plays an important role in this. To better support the function based economic dignity of people, the social security system needs to:

1. Ensure that there are adequate supports for people to participate in the community, and that there are roles that align with their needs.
2. Ensure that people are supported to undertake activities that they have reason to value, including the provision of care.
3. Ensure that people are not penalised or do not lose support for undertaking work when they are able.
4. Ensure that the system adequately supports people who experience episodic conditions to participate in the labour market and community.

Currently, people experiencing psychosocial disability participate in the labour market at a lower rate than those not experiencing disability related to mental ill-health. Some of this level of participation is linked to the challenges faced by those seeking to participate in the labour market (including stigma and discrimination), and the specific needs that individuals might have in order to be able to undertake work in a particular workplace environment (Reavley, Jorm & Morgan, 2017).

Undertaking a function that a person has reason to value extends beyond just participating in the labour market. It can include activities such as studying for the future, or providing care for a child or adult. As some studies included in the review have highlighted, the experience of acting as a carer of someone experiencing mental ill-health can be an isolating experience, and as such, there are times where increased support for carers is also needed.

The current social security system is suited to relatively uniform experiences within a defined scope of variation (i.e. income earned, and hours worked within a fortnight). For individuals with more volatility in their lives, such as people experiencing episodic mental ill-health, or caring for someone with episodic ill-health, this system can be unsuitable for meeting their needs. People with episodic mental ill-health may go through periods where they can participate in the labour market, and then need to take time out when they experience an episode of ill-health. The current system can discourage people in this position from engaging in the labour market above a certain level, as it can impact the level of support available to them during the period where they are unable to engage in the labour market, and this can leave them financially vulnerable.
8.3.4 Dignity as manner or bearing

The fourth type of economic dignity, dignity as manner or bearing, highlights the importance of providing support that is sufficient to meet the essential needs of individuals. This type of economic dignity can be harmed when there are inadequate resources for individuals to meet their essential needs, as this forces people to choose which need they will prioritise meeting, and which they will neglect. As highlighted above, the current rate of social security support in Australia is inadequate, and places extreme financial stress on many households. This extreme stress can exacerbate existing mental health conditions and impact the capacity of individuals to access the care or medication they may need.

To support the economic dignity of people related to manner or bearing, the social security system needs to:

1. Ensure that the levels of support provided sufficiently meet the essential needs of people.
2. Ensure that the increased costs associated with managing a mental health condition are covered in the support that is provided.
3. Ensure that application and appeals processes to access social security support are timely, and support is available to assist people.

When the level of support people receive is insufficient to meet their essential needs, they can experience a harm that is twofold. Firstly, they experience the harm of not having their essential needs met. In addition to this, they experience a second harm of having to actively participate in depriving themselves of meeting their essential needs by choosing which needs they will meet. This can have significant negative consequences on the person’s view that they might be entitled to these supports, and can negatively impact their sense of self-worth. For example, the harm of having to choose between skipping meals or skipping the usage of medication has been reported in multiple submissions included in this review that relate to the adequacy of current rates of social security support (ACOSS, 2020). Similarly, the increased costs that are experienced by people managing a mental health condition can lead to increased costs of living for both people with mental ill-health, and carers who may be providing financial support. In turn, people require increased levels of support to meet those costs and to ensure that they are properly able to manage their mental health or requirements of caring. Further to this, because applicants may need social security payments to meet their essential needs, the processing time for applications (and appeals when relevant) is important for protecting their economic dignity as manner or bearing.

8.4 Chapter summary

This chapter has summarised key recommendations for improvements to Australia’s social security system, with a focus on people with mental ill-health and carers of people with mental ill-health. Recommendations are drawn from the broader literature review, recent promising international examples from New Zealand and Scotland, and an economic dignity lens.

International examples from New Zealand and Scotland that are recommended as models for the Australian social security system to draw on align with several of the recommended ways to address structural stigma against people with mental ill-health, including:

- Making the income support system easier to access.
- Ensuring income support is adequate to support meaningful community participation.
- Improving the effectiveness of employment supports.
- Improving the health and wellbeing of people with disabilities and carers who engage with the social security system (New Zealand Government, 2019).
- Ensuring that the design of the social security system is informed by people who access it, and founded on principles of:
  - dignity and respect
  - poverty reduction
  - equality and non-discrimination (Scottish Government, 2019).

These recommendations are highly consistent with the general recommendations outlined in the economic dignity analysis above, as well as with specific recommendations to support people with mental ill-health and carers, including:

1. Ensuring that more episodic experiences of disability and mental ill-health are proactively accepted.
2. Ensuring that the increased costs associated with managing a mental health condition are covered in the support that is provided.
3. Ensuring that people are supported to undertake activities that they have reason to value, including the provision of care.
4. Ensuring that people are not penalised or do not lose support for undertaking work when they are able.
5. Ensuring that the system adequately supports people who experience episodic conditions to participate in the labour market and community.
9. CONCLUSION

This review of the evidence has identified several ways in which the current social security system does not serve people with mental ill-health, or mental health carers as well as it could. Issues around the impacts of policy reforms, lack of information and support impacting equity and access, and adequacy and responsiveness of the system were common. The analysis in chapter 8 provides insights into how the current system is harming people’s economic dignity in various ways.

Livingston’s (2013, p.11) structural stigma framework and the work of other stigma scholars Link & Hatzenbuehler (2016) and Corrigan, Markowitz & Watson (2004, p.658) identify that structural stigma and discrimination occur when cultural norms, societal conditions or policies limit people’s opportunities, resources or wellbeing – whether or not these effects are intended. Below, we identify the ways in which the current social security system (intentionally or unintentionally) perpetuates stigma and discrimination against people with mental ill-health, and mental health carers, according to these frameworks.

Does the institutional practice/policy contravene provisions of existing human rights statutes?
The evidence suggests that current policy and practice contravenes the human rights frameworks underpinning the Australian social security system - to provide income support to people who are unable to work, to alleviate poverty, and enable people to meet their essential needs (Australian Government, n.d.; Podger et al., 2014). Inadequate income support disproportionately affects people with mental ill-health (Collie, Sheehan & McAllister, 2019) and their family members or carers (Diminic et al., 2019), and compromises access to mental healthcare and recovery (State of Victoria, 2021a).

How broad/specifc is the criteria being used to restrict persons’ rights or opportunities?
The evidence suggests that assessments for access to DSP and Carer Payment are better targeted towards people with physical disability. This systematically disadvantages people with mental ill-health (Economic Justice Australia, 2021), and mental health carers (Productivity Commission, 2020) in accessing appropriate payments.

How broad/specifc is the domain that is being restricted?
Access to adequate income is a foundational social determinant of health and affects many aspects of people’s lives. The evidence strongly suggests that policy reforms restricting access to DSP, and the subsequent increase in people with mental ill-health accessing the (lower) JobSeeker Allowance have resulted in negative financial, social and health impacts for people with mental ill-health and their families and carers (Collie, Sheehan & Lane, 2021; Economic Justice Australia, 2021; Social Security Rights Victoria, 2019).

Are public and private institutions making reasonable efforts to assist individuals (e.g., providing services or supports) to enjoy access to the full range of rights and opportunities?
Recent reforms to the DSP resulted in changes to information and support access for people with mental ill-health and the health professionals that may assist them with income support claims (National Social Security Rights Network, 2018). Within the current system, people with mental ill-health have their work capacity assessed by someone who is unfamiliar to them, who may have little knowledge of mental ill-health and the impacts it has (McAllister, 2019). The evidence suggests that policy makers, assessors and other decision makers (such as health professionals, who are instrumental in facilitating access to income support) may be biased against viewing people with mental ill-health as eligible for disability income support (McAllister 2019; McAllister et al., 2021).
To what extent will the restriction remain in place when the impairment diminishes?
The evidence suggests that current social security rules are not adequately responsive to people with episodic conditions such as mental ill-health, and to carers of people with mental ill-health (Productivity Commission, 2020). Inflexibility in employment supports and opportunities, and fear of losing income support can create disincentives for people with mental ill-health (Gewurtz et al., 2018) and mental health carers (Productivity Commission, 2020) to seek work when they are able.

Do alternative methods (e.g., less restrictive or less onerous) exist that may be equally, or more, effective at achieving the same outcomes?
The evidence indicates that the current inequities in social security are creating harm and causing people to seek additional help through other community services or supports (ACOSS, 2019). The current system could be changed to better support people with mental ill-health and carers via a more flexible safety net that remains in place through periods where people may be able to work, without losing eligibility for income support should they need it (Productivity Commission, 2020). Reforms designed to save government funds could be targeted elsewhere - for example to those with the most resources (e.g. high income/high wealth individuals and corporations), instead of targeting people with mental ill-health and disability, who are more likely to have low household income and limited financial resources (Australian Institute of Health & Welfare, 2020; Morgan et al. 2017).

Would the stigmatising institutional practice/policy be rejected by those who may be affected?
Multiple recent inquiries and reports drawing on the experiences of people with mental ill-health and carers have found that people strongly object to the current policies and practices and the ways in which they create systematic disadvantage for people with mental ill-health, and mental health carers (Economic Justice Australia, 2021; Productivity Commission, 2020; Social Security Rights Victoria, 2019).

What is the nature and scope of harm (e.g., social isolation, health or economic inequalities) that will be produced by the institutional practice/policy in comparison to its expected benefits?
As outlined throughout this report, there is significant evidence indicating that the current policies and processes of the social security system involve structural stigma and discrimination against people with mental ill-health, and mental health carers. The effects of this are broad, and include negative impacts on access to adequate financial resources (Collie, Sheehan & Lane, 2021), mental health (Collie, Sheehan & McAllister, 2019; Social Security Rights Victoria, 2019), housing, mental healthcare (Economic Justice Australia, 2021), and social and economic participation (Productivity Commission, 2020).

Many of the areas for improvement identified here and throughout this report would align with efforts to address structural discrimination. These include:

- Ensuring that social security policy and practice is grounded in human rights and does not discriminate (directly or indirectly) against people with mental ill-health or mental health carers.
- Enabling people to have a voice and influence on systems that affect their lives.
- Changing current assessment processes, compliance and exemption rules that systematically disadvantage people with mental ill-health and mental health carers.
- Providing clear information and support that facilitates access to income support and responds to other identified needs for healthcare, employment support or advocacy.
- Making income support payments adequate to enable people’s meaningful participation in life, and to meet people’s essential needs (including the need for adequate mental healthcare or other supports as required).
10. REFERENCES


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doi:

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11. **APPENDIX**

11.1 **Appendix 1 – Detailed methodology**

11.1.1 **Search strategy**

We conducted a review of the literature by drawing upon systematic review methods. An initial list of search terms was compiled by the authors and further developed in consultation with the research team. The terms (see Table 1) are based on the *population* of people with mental ill-health and mental health carers, the *context* of social security in Australia, and the *concept* of stigma and discrimination.

**Table 1. Search terms**

<table>
<thead>
<tr>
<th>Key word</th>
<th>Search terms</th>
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<tbody>
<tr>
<td>Consumers and caregivers (population)</td>
<td>“mental illness” OR “mental ill*health” OR “psychosocial disability” OR “consumer” OR “carer” OR “user” OR “patient” OR “caregiver”</td>
</tr>
<tr>
<td>Social security in Australia (context)</td>
<td>“income support” OR “welfare” OR “social security” OR “centrelink” OR “services Australia” OR “disability support pension” OR “newstart” OR “Jobseeker” OR “carer payment” OR “sickness allowance”</td>
</tr>
<tr>
<td>Stigma and discrimination (concept)</td>
<td>“stigma” OR “discrimination” OR “right*” OR “equity” OR “equality” OR “dignity”</td>
</tr>
</tbody>
</table>

The academic search platforms Informit, EBSCOHost and ProQuest Central were selected based on the contextual and topical relevance of their databases to the research questions. One member of the research team tested the search terms to determine whether they would return useful and manageable results. Search strings were developed using a combination of the search terms and trialed in each platform between 1 July and 8 July 2021. The search strings were adapted for use for each platform and selected based on the number of results returned; the relevance of those results; and their manageability (see Appendix 1). For example, removing wider *conceptual* terms from the ProQuest Central search helped narrow its scope while retaining the relevance of the results.

In addition to the above databases, target websites were selected to search for relevant grey literature that may not be captured elsewhere. The target websites (see Appendix 2) were known to produce materials relating to Australia’s social security system and/or key issues affecting the lives of people with mental ill-health and carers. They were selected to yield a more representative sample of the literature available. One member of the research team hand-searched the websites by screening the publications section of each website for relevant texts, or if not available, conducting a search using the website’s built-in search function. Where the search function was inadequate or returned poor results (irrelevant or too wide), a Google search operator was used to search the entire website, using search terms in Table 1. For example: site: https://www.dss.gov.au/ "mental illness" AND "social security". Flow Chart 1 outlines the steps involved in the literature search, screening processes and review procedure.
Flowchart 1. Overview of the literature review process

11.1.2 Search and screening of results

The finalised database and target website search were conducted 8 July 2021. The database search yielded a total of 1755 records. One member of the research team extracted 169 relevant records from the databases based on an initial title screen. The target website search resulted in 116 records, and two duplicates were removed, leaving a combined total of 283 records eligible for abstract screening.

Two members of the research team reviewed the abstract of each source based on the criteria specified (see Table 2), and relevance to the research questions. A third team member adjudicated their decisions. At the abstract screening stage, a combined total of 139 records were excluded, leaving a total of 144 sources for full-text screening.

Given the large number of texts and the limitations imposed by project time-constraints, at the full-text screening stage the 144 sources were assessed on a priority scale of 0-3, with 0 being of no direct relevance; 1 being of direct relevance; 2 being of contextual relevance; and 3 of limited contextual relevance. A total of 76 texts were assessed as being of direct relevance (priority 1) and 68 full texts were excluded on the basis of being: of no direct relevance (n=5); of contextual relevance only (n=48); and of limited contextual relevance (n=15). An additional 27 hand-searched sources were screened at this stage, and 6 of these were included for review based on direct relevance and input from the research team and colleagues (21 excluded - of contextual relevance only). A final 82 sources were included in this literature review. This process is laid out in the PRISMA Flow Diagram (see Flowchart 2) on the following page.

Table 2. Inclusion and Exclusion criteria

<table>
<thead>
<tr>
<th>Inclusion criteria</th>
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<tbody>
<tr>
<td>• Published between the period 2000 to 2021 - to reflect a period of significant reforms (Australian Institute of Health and Welfare, 2019a)</td>
</tr>
<tr>
<td>• Accessible in English</td>
</tr>
<tr>
<td>• Peer reviewed empirical research or grey literature produced by relevant organisations or people with lived experience</td>
</tr>
<tr>
<td>• The publication relates to at least one of the research questions listed at section 4.1</td>
</tr>
<tr>
<td>• The publication is focused on the Australian context, or provides examples of promising international practice</td>
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<table>
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<tr>
<th>Exclusion criteria</th>
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<tbody>
<tr>
<td>• Not accessible in English</td>
</tr>
<tr>
<td>• Does not pertain to the research questions</td>
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<tr>
<td>• Is not published within the relevant period</td>
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**Flowchart 2. PRISMA Flow Diagram**


Records identified through database searching (n = 1755)

Records identified through other sources (n = 143)

Records after duplicates removed (n = 1897)

Records excluded (n = 1726)

Records screened (n = 1897)

Full-text articles assessed for eligibility (n = 171)

Full texts excluded (n = 89)
- Not of direct relevance to research questions (n = 5)
- Of contextual relevance only (n = 69)
- Of limited contextual relevance (n = 15)

Studies included in qualitative synthesis (n = 82)

Non-empirical articles included (n = 36)
11.1.3 Data extraction and analysis

The 82 sources were reviewed, and information was extracted. The information extracted included:

- The type of source
- Aims
- Jurisdiction
- Data collection methods, sample size, target group, intervention or program, measures and outcomes used (if applicable)
- Results
- Conclusions
- Recommendations
- Assessment of the strength of the evidence

11.1.4 Summary of the literature review sources

This review looked at 82 sources (46 empirical, 36 non empirical) published in the past 18 years (2003–2021). Sixty-five articles were focused on Australia, and 17 on other countries.

Search Strings and databases – academic platforms

**Informit**
Databases searched:
- Analysis and Policy Observatory (APO);
- Australian Public Affairs Information Service (APAIS);
- FAMILY (Australian Family and Society Abstracts Database);
- Aboriginal and Torres Strait Islander Health Bibliography (ATSIhealth);
- Multicultural Australia and Immigration Studies (MAIS)

Search string:

```
("mental illness" OR "mental ill*health" OR "psychosocial disability") AND ("income support" OR "welfare" OR "social security" OR "centrelink" OR "services Australia" OR "disability support pension" OR "newstart" OR "Jobseeker" OR "carer payment" OR "sickness allowance" OR "sickness benefit" AND "well*being" OR "dignity")
```

**EBSCOhost**
Databases searched:
- CINAHL; eBook academic collection; Humanities International Complete;
- Psychology and Behavioural Sciences; SocIndex

Search string:

```
("mental illness" OR "mental ill*health" OR "psychosocial disability") AND ("consumer" OR "carer" OR "user" OR "patient" OR "caregiver") AND ("income support" OR "welfare" OR "social security" OR "centrelink" OR "services Australia" OR "disability support pension" OR "newstart" OR "Jobseeker" OR "carer payment" OR "sickness allowance" OR "sickness benefit") AND ("stigma" OR "discrimination" OR "right*" OR "equity" OR "equality" OR "dignity")
```

**ProQuest Central**
Databases searched:
- Aus & NZ; consumer health; public health; social science; sociology

Search string:

```
("mental illness" OR "mental ill*health" OR "psychosocial disability") AND ("consumer" OR "carer") AND ("income support" OR "welfare" OR "social security" OR "centrelink" OR "services Australia" OR "disability support pension" OR "newstart" OR "Jobseeker" OR "carer payment" OR "sickness allowance" OR "sickness benefit") AND ("stigma" OR "discrimination")
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<table>
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<th>Target websites</th>
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<tr>
<td>(ACOSS)</td>
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<tr>
<td>(AIHW)</td>
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<tr>
<td>3. Australian Unemployed Workers’ Union</td>
<td><a href="https://unemployedworkersunion.com/">https://unemployedworkersunion.com/</a></td>
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<tr>
<td>11. Mental Health Australia</td>
<td><a href="https://mhaustralia.org/">https://mhaustralia.org/</a></td>
</tr>
<tr>
<td>17. Productivity Commission</td>
<td><a href="https://www.pc.gov.au">https://www.pc.gov.au</a></td>
</tr>
<tr>
<td>19. Sane Australia</td>
<td><a href="https://www.sane.org/">https://www.sane.org/</a></td>
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