Chapter 5. Social protection measures and employment services in New Zealand

This chapter evaluates policies and programmes aimed at improving the responsiveness of New Zealand's social protection system and employment services to people with mental health conditions. It considers how this system ensures secure income in periods of inactivity, how it recognises and responds to people with mental health conditions and how the system helps people out of work to return to the labour market. The analysis uses the OECD's (2015) Council Recommendation on Integrated Mental Health, Skills and Work Policy *as the primary benchmark for informing best practice policies in this field.*

Introduction

Across OECD countries, mental health conditions account for the bulk of new and existing claims for health and disability benefits. These claims are different from most of the claims for people with physical complaints. The reason lies in the very nature of mental health conditions – onset at an earlier age, high recurrence, fluctuating course, as well as frequent comorbidities with other health issues. The consequence is a much greater labour market distance, with frequent periods of unemployment and inactivity. Compounding this is poor knowledge in the unemployment system of how to recognise and respond to mental health issues and frequently an underestimation of peoples' capacity to work. In OECD countries, this is reflected in limited benefit outflows and high disability claims because of incorrect allocation to the right intensity of employment assistance at the right time.

It is important to identify mental health symptoms and resulting labour market barriers as early as possible – ideally, on a jobseeker's first contact with the welfare system, or soon after. The longer a person is out of work the harder and costlier it is to support them to return to work. Periods out of work should be as short as possible. Where a mental health issue is identified or suspected, case management support should involve health expertise to facilitate swift access to appropriate health treatment, as necessary, in parallel with an effective return-to-work strategy.

Mental health competence and psychological expertise in the employment sector, however, are generally underdeveloped and not commensurate with the high prevalence of mental health conditions among jobseekers and welfare clients. These competencies have to be strengthened to make early identification and quick intervention possible in all systems. Efforts in that direction should come in the unemployment system especially because better job retention and reintegration at this early stage can prevent people with poor mental health from slipping into longer-term welfare dependence and disability.

The main challenges for the social protection and employment services system

The OECD *Recommendation of the Council on Integrated Mental Health, Skills and Work Policy* calls upon its member countries to: "seek to improve the responsiveness of social protection systems and employment services to the needs of people living with mental health conditions", detailing key priorities for action policy makers should consider. Table 2.1 gives an assessment of New Zealand's performance against the OECD Council Recommendations, and suggested actions. In summary:

The structural reforms to the welfare system have been unsuccessful in reducing the number of people with mental health conditions claiming health and disability benefits, and these claims continue to rise, particularly amongst Māori and Pacific people. Māori people are overrepresented in claims for all main benefits, making up 31% of all people on benefits, 25% of Supported Living Payment claimants for mental health reasons and 23% of Job Seekers Allowance claimants for mental health reasons. The numbers and rise of Māori people with mental health problems on benefit is a major concern and addressing this should be a priority. Welfare reforms have not helped in reducing ethnic inequities.

Table 5.1. New Zealand's performance regarding the OECD Council Recommendations around improving the social protection system's response to mental health conditions

	OECD Council Recommendation	New Zealand's performance	Suggested actions
A	Reduce preventable disability benefit claims for mental health conditions through **recognition of the work capacity of those potentially claiming a benefit**, and through a focus on early identification and early provision of medical and/or vocational support as necessary.	People with mental health conditions make up the majority of claims for health and disability benefits. Māori are overrepresented in health and disability benefits. Little focus on early intervention, with current assessment processes not necessarily picking up mental health issues.	Comprehensive allocation and navigation process for quicker and effective matching to right psychological and employment support. Assessment and case management need to be inclusive of Māori models of practice based on a practice philosophy of Whānau Ora. Employment services need to better support people whilst they are working. Evaluate the experience of people with mental health conditions in the employment system.
B	Help jobseekers living with mental health conditions into work through **appropriate outreach tools** as well as services that address the labour market barriers associated with a jobseeker's mental health condition.	The system underestimates the numbers of people with mental health conditions on benefits. Case management and support is not offered actively to all MSD clients or matched to their need. There is a lack of access to psychological support. The distinction between JS-WR, JS-HCD and SLP is unhelpful.	The benefits system needs simplifying. Evaluate the assessment processes to inform a new process with timely and appropriate follow up psychological and employment support offered to all MSD clients. Remove access restrictions for employment support services i.e. diagnosis, benefits status. Increase access to psychological therapies for people claiming benefits. Access to therapies should include Māori health practitioners.
C	Invest in **mental health competences for those administering the social protection system** by providing training for staff by ensuring co-operation of benefit and employment services with psychological services.	Mental health training is available to MSD staff. There is too little involvement of allied health professionals. There is little communication from Work & Income back to primary care practitioners.	Make mental health competency training mandatory for all MSD staff and integrate cultural responses to mental health within this, including Māori models of practice. Expand training, focus on the interrelationship between mental health and work. MSD staff needs earlier and greater access to health advisors with mental health expertise.
D	Encourage the **integration of mental health treatment into employment service delivery** by stimulating cooperation with the health sector and the development of evidence-based vocational interventions for jobseekers with common mental health conditions	Promising pilots but these have been going for six years. Funding of employment services for people with mental health conditions is fragmented, insufficient and short term. Move to outcomes payments is a positive step, but contract design needs to reward the provision of evidence-based practices. Individual Placement & Support (IPS) services are available only in some regions.	Implement a national mental health and employment strategy. Coordinate service procurement between MOH and MSD, and within MSD. Scale up vocational interventions that integrate psychological support and incorporate Māori models of practice. Increase the availability of IPS services. Monitor adherence to the national guidelines for employment support providers. Extend contract duration and provide financial incentives for evidence-based practices and the provision of post-placement support.

Source: Authors' own assessment based on all of the evidence collected in this chapter.

Better assessment and support systems are needed which quickly identify mental health issues across all people claiming benefits regardless of primary reason for claim, and support people to access integrated psychological and employment support services. The pathway to early and appropriate employment assistance and psychological support is unclear, inconsistent and inequitable.

Employment support services need expanding to people with mental health issues who are not claiming benefits to prevent hardship and higher societal costs later on.

The mental health competencies of staff working in the welfare system need further strengthening, building on the already available mental health training. Training should be mandatory, comprehensive and culturally informed. Case managers also need to increase their understanding of psychological techniques and have quick and easy access to psychological coaching and support services.

The employment sector needs strengthening. The non-government employment sector is underfunded, characterised by short-term pilots and as a result service provision is fragmented and access inequitable. Within the public employment service there is a significant mismatch between individual employment assistance needs and the intensity of case management support people actually receive.

A national mental health and employment strategy that addresses policy and funding barriers and helps to build national coverage of evidence-based employment services integrated with mental health treatment should be developed and implemented.

Overview of New Zealand's social protection system

New Zealand established the Welfare State with the enactment of the Social Security Act in 1938. Social welfare is mostly funded through general taxation and, since the 1980s, income support has been provided based on need, except for universal superannuation (state pension for people from the age of 65).

Work and Income New Zealand (Work and Income) provides employment services and income support throughout the country on behalf of the Ministry of Social Development. Work and Income administers the payment of social benefits, supports jobseekers into employment and contracts with non-government employment-service providers (see Box 5.1 for more details on the New Zealand social protection system).

In 2012, under the previous government and led by the Treasury and the State Services Commission, *Better Public Services* a cross-government initiative was introduced (Public Services Advisory Group, 2011[1]). *Better Public Services* consisted of ten high-level targets with specific results-oriented goals for the government to attain over time. Relevant targets contained within the strategy were around reducing long-term welfare dependence (Result 1) and setting strong foundations for work and life – primarily focusing on skills development (Results 5 and 6).

As part of the drive to reduce future welfare liability, from 2010, the former government set in place a series of welfare reforms including in 2013 specific health and disability reforms, recognising that most people can and do want to work (Work and Income, 2013[2]). The reforms included a change to obligations and to the income support benefits. In 2010, obligations were introduced to some people on Sickness Benefit. In 2013, Sickness Benefit was brought into a new benefit, Jobseekers Support, which is for all jobseekers, and contains sub-categories: Jobseekers with a Health Condition or Disability (JS-HCD), and Jobseekers who are Work Ready (JS-WR). At the same time, Invalid's Benefit was replaced with the Supported Living Payment (SLP). People claiming Invalid's Benefit had no obligations attached, but after the welfare reforms, some people on SLP now also have work-preparation obligations (see Box 5.2 for more details on the 2013 Health and Disability Welfare Reforms).

Box 5.1. About the New Zealand social protection system

The initial point of contact for anyone who is seeking financial assistance and employment services is through Work & Income New Zealand (Work and Income), Te Hiranga Tangata. Work and Income is a public one-stop shop and a business unit within the Ministry of Social Development, Te Manatū Whakahiato Ora. Work and Income services include skills development, work-search support, income support and in-work support, and helping people to secure childcare. Work and Income is divided into 11 regions, with 160 service centres across the country, serving around 294 000 each week, and paying out more than NZD 8 billion annually in financial support. Work and Income employs around 2 500 staff.

The New Zealand social protection and employment service system is predominantly provided by government, through Work and Income, with around 17% of the operational budget contracted to non-government providers. As part of the recent welfare reforms, Work and Income adopted a case management approach to provide a range of general and work-focused services according to client need. The primary role of case management is to reduce long-term welfare dependence by increasing labour market participation. In 2014 there were 1 780 full-time equivalent case managers.

Over recent years, the welfare system has adopted an investment approach aligned with that used in the insurance industry. The investment approach predicts the likely long-term benefits costs of a person based on what has happened in the past to other people with similar background and circumstances. It works out what interventions and services work best and for whom, and it uses this information to set priorities for investment (and disinvestment) and direct services to those people most likely to achieve positive change. The current government is reconsidering this approach.

There are three main benefits for people out of work: Jobseeker Support, Supported Living Payment and Sole Parent Support. The rates of payment vary according to individuals' marital status, age and number of dependents (Table 5.2). Eligibility for income support depends on partner's employment status, other income sources and assets.

Table 5.2. Benefits rates and obligations, for single adults, no children, as at April 2018

Benefit type	Net weekly rate after tax	Obligations
Jobseekers support (work-ready)	NZD 215.34[a]	Full-time work obligations: To find or prepare for work of at least 30 hours per week, take part in work-ability assessments, interviews, meetings and assessments if the person has been referred to a Contracted service provider
Jobseeker support (HC-D)	NZD 215.34[a]	Part-time work obligations: To find or prepare for work of at least 15 hours per week. Some people claiming JS (HC-D) will be exempt from work obligations and may only have work preparation obligations.
Supported Living Payment	NZD 269.15[b]	Work preparation obligations: To attend - interviews to determine capacity to engage in work preparation; work ability assessments; participate in interviews and activities with Contracted Service Providers when this has been agreed.
Sole Parent Support	NZD 334.05	Part-time work obligations when your youngest child is aged 3-13 (unless you have a health condition or disability); Work preparation obligations when your youngest child is under 3. Take part in work ability assessments and activities with Contracted Service Providers.

a) Single 25 years or older no children, b) Single 18 years or older, without children.
Source: (MSD, 2018[3]).

Box 5.2. The 2013 Health and Disability Welfare Reforms

In seeking to reduce future welfare liabilities, the Government focused the most recent reforms on people not participating in the labour market. This was because between June 2004 and June 2014, the number of people not available for work had increased by nearly 64 100 to just more than 1.1 million, almost one-third of the working-age population.

There were three stages to the 2011 to 2013 reforms. In 2012, support for young people changed to encourage young people back into education or training. The second reforms focused on sole parents, widows and other women alone. In 2013, the biggest changes took place. The 2013 Health and Disability Welfare Reforms collapsed all previous main benefits into three categories, extended work-focused interventions to a wider range of people and introduced additional obligations for some people to meet.

There are two main benefit types for people with identified health conditions and disabilities, including people with mental health conditions: **Jobseeker Support on the grounds of health condition or disability** (JS-HCD) and **Supported Living Payment** (SLP). Access to these benefits is granted on the basis of the impact the health condition or disability has on the person's ability to work, not the existence of the health condition or disability itself. SLP is a slightly higher weekly benefit than JS-HCD. For example for a single adult 25 years or older, they would receive a payment of NZD 265.54 per week on SLP, and NZD 212.45 per week on JS-HCD. There is no difference in payment for a person claiming JS-HCD and a person claiming JS (work ready).

To receive **Jobseeker Support** on the ground of a health condition, injury or disability, a person must be limited in their capacity or unable to work full-time due to a health condition, injury or disability; or in employment but because of a health condition, injury or disability unable to work or only at a reduced level.

JS-HCD is a temporary benefit, with the impact of a health condition on work capacity expected to last less than two years. People whose capacity to work is permanently but only partially restricted to having a capacity for between 15 and 29 hours of work per week can also receive JS.

People in receipt of JS-HCD may have their work obligations deferred. When a client is applying for (or transfers to) JC-HCD they need to provide a current medical certificate, based on a medical review. The first certificate covers up to a maximum of four weeks. After the first four weeks, a second review is needed, again covering up to a maximum of four weeks. After eight weeks, a third review is required covering a maximum of 13 weeks. A medical certificate is required thereafter every 13 weeks, and a person must reapply for JS after 52 weeks, since this is a temporary, work-focused payment.

Abatement rates apply when a person reaches a certain level of income, including through earnings, resulting in reduced benefit payment (partial). People can work up to 30 hours per week (depending on abatement levels) before they are no longer considered eligible for JS.

Supported Living Payment (SLP) is for people not able to work because they are permanently and severely restricted in their capacity for work because of a health condition, injury, or disability, or fully blind. Permanent means the health condition, injury or disability a person has is expected to continue for at least two years, or the claimant has been diagnosed with a terminal illness. Severely means a client cannot regularly work 15 hours or more per week in open employment. Work preparation obligations are legislated but not used in practice for people receiving SLP. Abatement rates apply when a person reaches a certain level of income, including through earnings, resulting in reduced benefit payment.

Disability Allowance

The Disability Allowance provides non-taxable assistance to people who have on-going, additional costs because of a disability, including mental health. This assistance is available to people on benefit and non-beneficiaries with low income (provided they meet the income thresholds). The amount payable is based on the additional costs of disability up to a maximum amount per week.

Assessment process

The Health and Disability Welfare Reforms include a new staged assessment process for people with a health condition or a disability to identify their ability to work. This includes:

- Enabling people with very little or no work capacity, or whose condition is deteriorating or will not improve, or who are terminally ill, to receive benefit without any requirement for additional assessments of their ability to work.
- A self-assessment questionnaire to collect the person's view on their ability to work and the supports and services they need to prepare for, or find and stay in, work.
- A medical certification process with focus on what a person can do at work with appropriate services and supports. People are required to submit a medical certificate at four weeks, eight weeks and then every 13 weeks.
- An assessment of work ability (including on-going assessment through structured interviews during case management services), and, if earlier less intensive approaches (i.e. the self-assessment and structured interview) have not given clarity about what someone can do or the help they need to work, an independent Work Ability Assessment (WAA).

People may also be required to attend an appointment with a designated doctor as part of a second-opinion process. MSD does not track outcomes as such but from a qualitative view, it knows that there are opportunities to improve on this, which is part of the work under the Health and Disability work programme.

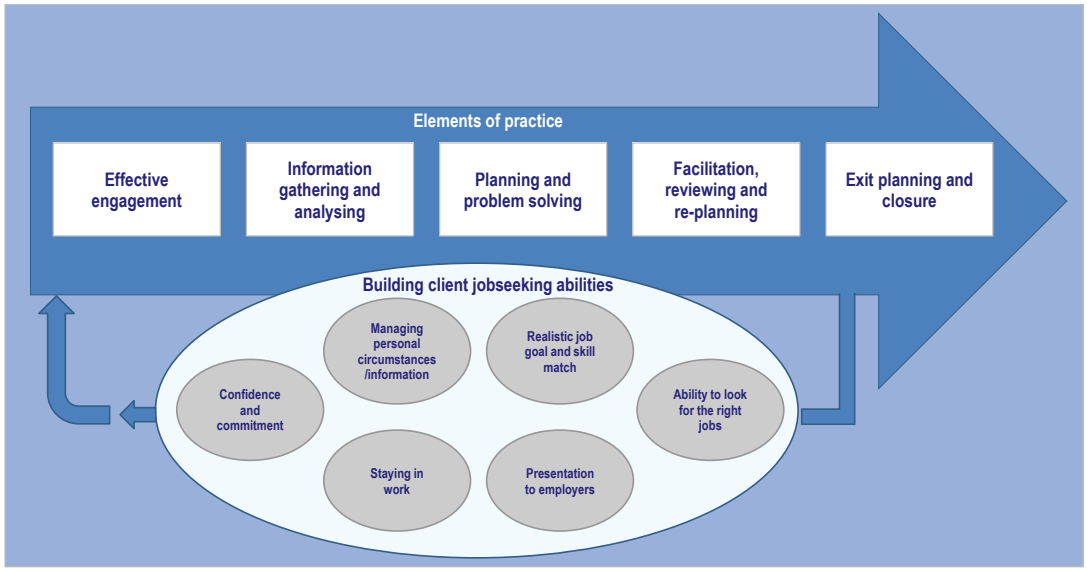
Source: Authors own compilation using OAG (2014[3]) and Productivity Commission (2015[4]).

The welfare reforms also saw Work and Income set in place a case management approach, employing three types of case managers: general, work-focused and work-search support case managers (Figure 5.1). General and work-focused case managers both check and process clients' benefit entitlements, make referrals to other social support and apply sanctions if clients do not meet their obligations. Work-focused and work-search support case managers also help clients to search a job, refer to training as required and work with clients to find solutions to issues preventing them from working. Work-search support case managers deliver seminars and provide other types of training to help job seekers. Case manager consistency allows building a relationship; this can be critical for the outcome.

Accordingly, work-focused case managers have multiple, potentially conflicting roles: supporting financial assistance, providing employment support, and imposing sanctions when clients do not meet their obligations. In other countries, the decision to impose sanctions comes from a higher level, to remove any conflicting roles for frontline workers. New Zealand could consider this.[1]

Clients are matched to case management services based on client information (such as the type of benefit, age, location, previous benefit history), analytics (predictive modelling) and agreed business rules (certain conditions may exclude a person from service) that prioritises clients to services based on eligibility and availability in each Work and Income service centre. This also includes a case management service for clients with health conditions or disabilities.

Figure 5.1. An illustration of Work and Income's case management approach



Source: Adapted from: OAG (2014), Ministry of Social Development: using a case management approach to service delivery, Wellington: Office of the Auditor General.

In May 2018, MSD launched a trial in four sites where clients are given the choice to opt in. Clients are provided with information about the services Work and Income can offer and can select the one they believe is right for them. Clients can discuss the alternative options with their case managers but the decision rests firmly with the client. The aim of

the trial is for clients to feel more empowered and engaged and having greater choice is a core part of that. The trial will be evaluated through feedback from the service centres and the clients involved.

In 2014, an audit of the case management approach found that although overall the system was working well, MSD was not working in a co-ordinated way with other sectors to address the multiple needs of people with the highest barriers to employment (OAG, 2014[3]). This audit found that their needs to be a greater focus on supporting the development of case managers' soft skills, such as effective client engagement, alongside their technical skills, and the need to focus on compliance.

A follow up review three years later found that progress had been made to strengthen the capacity of case managers, including training in active listening, communication and empathy, however, accuracy in their processing skills still strongly influenced case managers' performance ratings. The report also found that MSD had not progressed the sector response required to better support working-age adults with higher or complex needs, even though it had progressed its own initiatives in this area (OAG, 2017[5]). Building the mental health and cultural competency of case managers, and increasing access to mental health practitioners, could go some way to address this recommendation.

Benefit claims due to mental health conditions are increasing

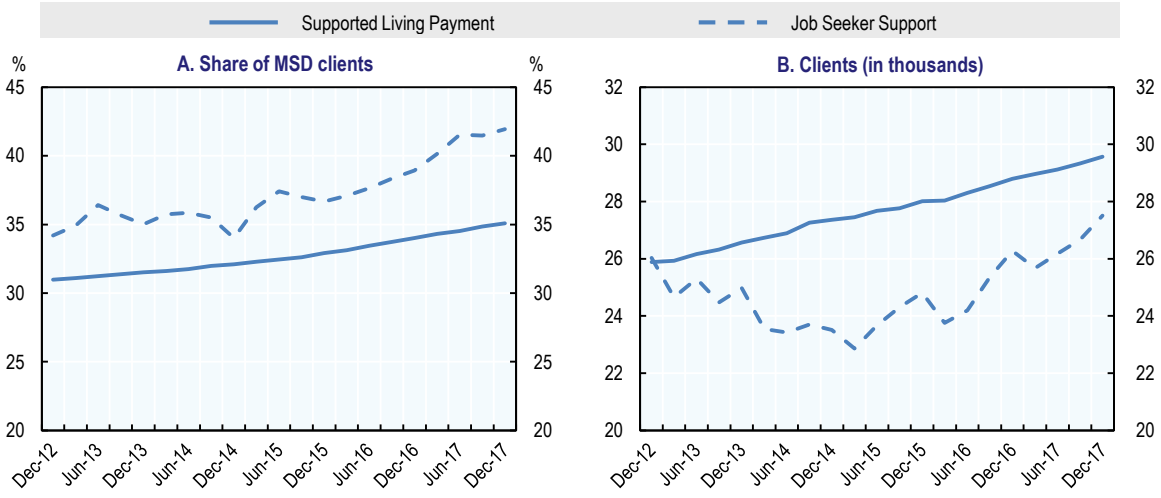
Since the welfare reforms, MSD has commissioned annual valuation reports on the benefits system. The 2016 evaluation had a specific section on people with mental health conditions. This identified that the average future lifetime liability of this client group is significantly higher than of the average client with a health condition or disability, NZD 33 000 higher for clients on JS-HCD and NZD 52 000 for clients on SLP (Greenfield, Miller and Mcguire, 2016[6]). The report argued that this difference was due mainly to the younger age of people who claim for mental health conditions compared to other clients claiming for health conditions and disabilities.

Whilst the reforms have reduced the overall numbers of people of working age claiming welfare benefits (Greenfield, Miller and Mcguire, 2016[6]), the numbers of people claiming benefits whose primary reason for claiming is a mental health condition, has continued to rise. Of SLP claimants, in December 2012 mental health claims made up 31% of claims, and by December 2017 this had risen to 35% (a rise from 25 883 to 29 567 people). Similarly, claims for mental health conditions within people claiming JS-HCD grew from 42.5% in December 2012 to 47.9% in December 2017 (an increase from 26 026 to 27 512 people), (Figure 5.2) (MSD, 2018[7]; MSD, 2017[8]).

The increase in the proportion of people claiming due to mental health conditions is in part related to the fact that the overall numbers of claimants on JS-HCD has reduced (from 61 245 in 2012 to 57 428 in 2017). The increase in numbers may in part be due to an increasing prevalence of mental health conditions in the population (Potter et al., 2017). However, more likely it is an indication that the reforms have not been as successful in supporting clients with mental health conditions – who face multiple barriers to employment – off benefit and into work, especially when compared to people with other health conditions or disabilities. Data shows that with the exception of cancer and congenital conditions, claims for mental health reasons is the only health and disability client group to have increased in numbers in the past five years (MSD, 2017[8]).

Figure 5.2. Welfare benefits claims for mental health reasons continue to increase

Share of MSD clients with a mental health condition as the primary reason for claiming



Source: Ministry of Social Development (2017) *Quarterly benefits Tables December 2017*.

StatLink http://dx.doi.org/10.1787/888933845643

Figure 5.2 (Panel B) further shows that there are as many people claiming JS-HCD for mental health reasons as are people claiming SLP for mental health reasons, with some systematic differences in the composition of the two groups.

Claims due to mental health conditions cover a range of issues. Claims coded as stress and depression make up a significant proportion, 41%, of mental health claims for JS-HCD. People diagnosed with bipolar disorder and schizophrenia represent a larger proportion of claims for mental health reasons for SLP, at 47% (Greenfield, Miller and Mcguire, 2016[6]).

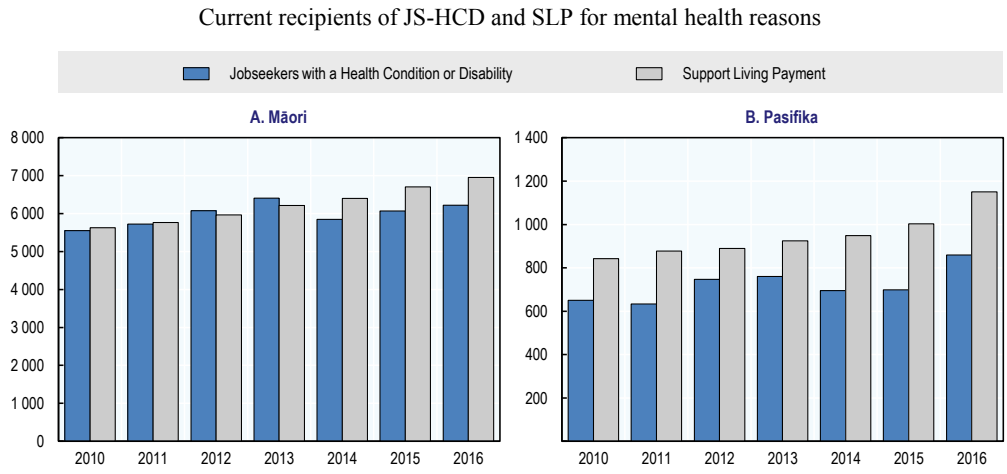
People claiming benefits for mental health reasons are also younger than the average person claiming a government payment. For instance, the average age of people claiming JS-HCD for mental health reasons is 7.6 years younger than for other JS-HCD clients; the corresponding figure is 4.4 years for SLP clients. Claims for mental health conditions are uneven across age groups. For example, as at October 2017, mental health claims made up 48% of claims for SLP for people aged under 25 and 70% for clients under 25 claiming JS-HCD (Greenfield, Miller and Mcguire, 2016[6]).

Ethnic inequities among mental health related claims are large and growing

Māori people are overrepresented in claims for all benefits. They comprise 31% of all benefits claims, but only 15% of the working-age population. In 2016, Māori people made up 25% of people claiming SLP for mental health reasons and 23% of people claiming JS-HCD for mental health reasons. They also stay on benefits longer regardless of the type of benefit and service they receive (MSD, 2018[7]). The numbers of Māori people claiming JS-HCD and SLP for mental health reasons is also increasing (Figure 5.3, Panel A).

Pacific people make up 5% of all people on SLP; 7% of those on JS-HCD; 4% of people claiming SLP for mental health reasons and 3% of people claiming JS-HCD for mental health reasons. This compares with a share in the total working-age population, in 2017, corresponding to 7%. The numbers of Pacific people claiming benefits for mental health reasons is also increasing (Figure 5.3, Panel B).

Figure 5.3. Gradual increase in the number of Māori and Pacific people claiming benefits for mental health reasons



Source: Administrative data supplied by the Ministry of Social Development.

StatLink http://dx.doi.org/10.1787/888933845662

Analysis of mental health claims by ethnicity further highlights the ethnic disparities, with the rates of increase over time much higher for Māori and Pacific people compared with New Zealand European (Table 5.3).

Table 5.3. Trends in mental health claim numbers vary remarkably by ethnicity

	2010	2016	Difference	Rate of change
JS-HCD mental health condition				
Māori	5 550	6 223	673	12%
Pacific	650	859	209	32%
NZ European	14 020	12 724	-1 296	-9%
Other	3 046	3 754	708	23%
Unspecified	665	632	-33	-5%
Total	**23 931**	**24 192**	**261**	**1%**
SLP mental health condition				
Māori	5 630	6 953	1 323	24%
Pacific	842	1 150	308	37%
NZ European	14 793	15 290	497	3%
Other	3 325	3 781	456	14%
Unspecified	378	335	-43	-11%
Total	**24 968**	**27 509**	**2 541**	**10%**

Source: Administrative data supplied by the Ministry of Social Development.

StatLink http://dx.doi.org/10.1787/888933845719

Changes over time indicate that whilst there is some reduction in numbers of NZ Europeans claiming JS-HCD for mental health reasons, the numbers of Māori and Pacific people claiming benefits for mental health reasons is continuing to rise.

A large share of clients have been on health and disability benefits over two years

A large proportion of people are also claiming benefits for more than two years: some 44% of people claiming JS-HCD and nearly all people claiming SLP. This data further highlights the importance of acting quickly to provide access to mental health treatment and employment assistance when people are not yet disconnected from the labour market (and thus receiving JS-WR) and the importance of supporting people into employment even earlier, prior to becoming MSD clients.

MSD clients with mental health conditions might desire to work but hesitate to seek it if it might jeopardise their current entitlements. Anecdotal evidence from people in receipt of benefits suggests that some see the system as opaque and do not understand whether they will be able to get back onto a benefit easily if they take a chance to look for work and therefore many of the poorest or most vulnerable simply do not take the risk. This concurs with the findings from an MSD survey of over 400 people and organisations working across the health and disability sector who commented when asked what could reduce the financial disincentives to working was "make the system easier to understand" (MSD, 2014[9]). MSD is currently in the process of trying to ensure people understand the benefit system, and that they receive the payment they are, in principle, eligible for.

The benefits system itself therefore appears to create certain tangible disincentives for work. This is particularly problematic when people want to work and can with the right support. For example, JS-HCD incentivises fulltime work (30 hours or more) and therefore does not encourage a graduated return to work. SLP abates at a rate of 70 cents to the dollar after a beneficiary has earnt up to NZD 200 per week and this creates a disincentive to work more than 15 hours a week. Claimants with fluctuating conditions and support needs are likely to be fearful of moving off SLP in case employment does not work out. The current SLP Sustainable Employment Trial only allows people to try working 15 hours or more a week for 26 weeks (this period may be increased to two years in future trials). MSD is currently examining how to make changes to the benefit system to include smooth transitions in and out of benefits, and to improve awareness and take up of some of the existing incentives that are already available. Any changes need to consider the relevant differences between SLP and JS-HCD; and how these differences may create additional barriers, or encourage certain behaviours, among people working in the system, as well as those accessing it.

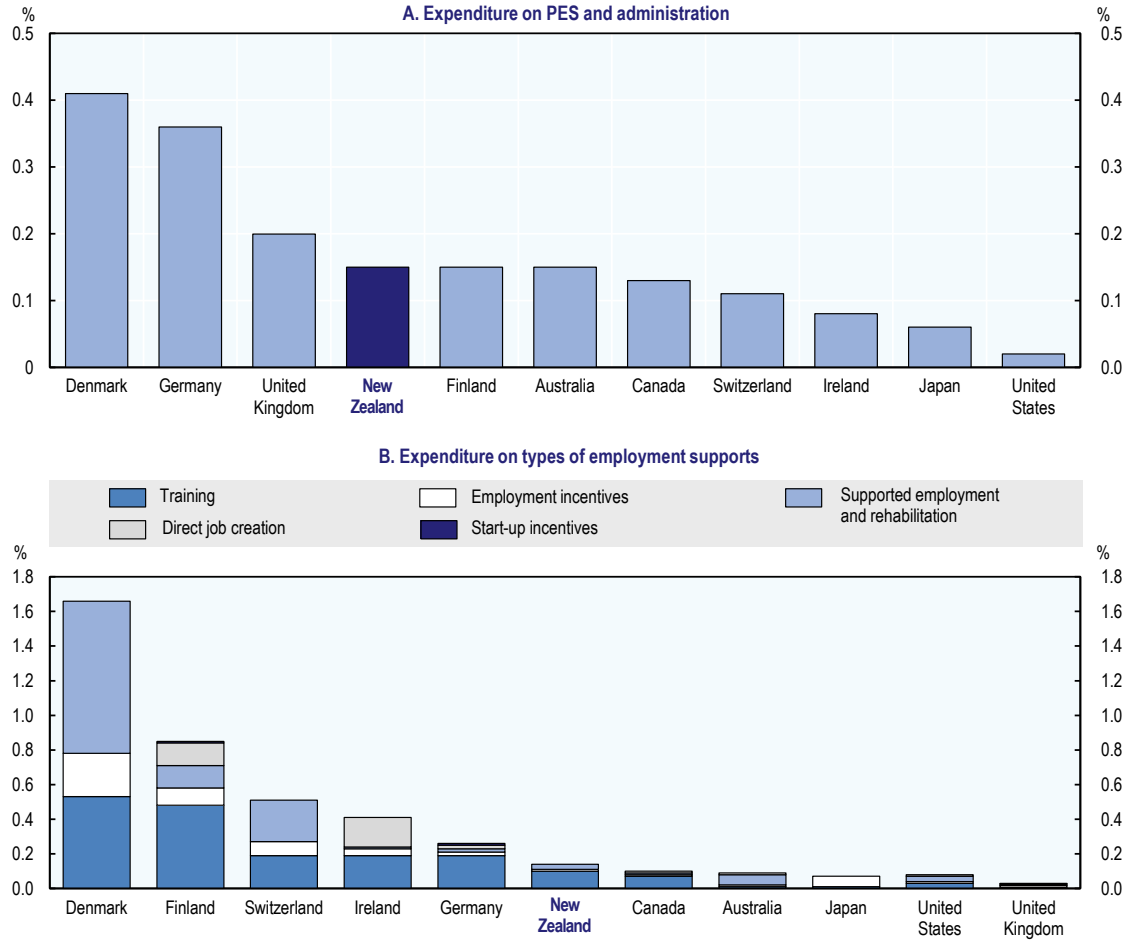
Organisations providing support services for people with disabilities, including people with mental health conditions, argue that what is needed is an employment strategy instead of the predominant benefit-reduction strategy (NZDSN, 2016[10]; NZDSN, 2015[11]).[2] This is an important point, as realigning the strategy to a genuine employment strategy would introduce a new way of thinking and working across the system. A mental health and employment strategy could include how to set up and support relapse prevention plans, working well plans and whānau ora plans, once people are in employment. The current New Zealand Disability Strategy reinforces this need to focus on employment outcomes over benefits reduction, for people with disabilities. An employment strategy is one of the eight key outcomes of the strategic plan (ODI, 2016[12]).

Furthermore, the New Zealand system appears as a highly unequal system, with higher benefits (in terms of income replacement) and faster access to health, employment and training services for people falling under ACC (see Chapters 1, 2 and 4 for more information on ACC). In contrast, people being out of work for health-related issues have to manage on savings and, once depleted, would start to claim the much lower income replacement from Work and Income.

Compared to other OECD countries, New Zealand is in the group of countries with lower expenditure on active labour market programmes. In 2016, New Zealand spent 0.15% of its GDP on administering its employment service (Figure 5.4, Panel A) and a similar amount on actual employment supports and labour market programmes (Panel B). Within the latter spending group, the largest share goes to training measures and very little is spent for supported employment and vocational rehabilitation (again, Panel B).

Figure 5.4. New Zealand belongs to the group of OECD countries with relatively low spending on active labour market programmes and training

Expenditure on active labour market programmes, selected OECD countries, 2016, percentage of GDP



PES = Public Employment Service.
Source: OECD Labour Market Programme Database, https://stats.oecd.org/Index.aspx?QueryId=49447.

StatLink http://dx.doi.org/10.1787/888933845681

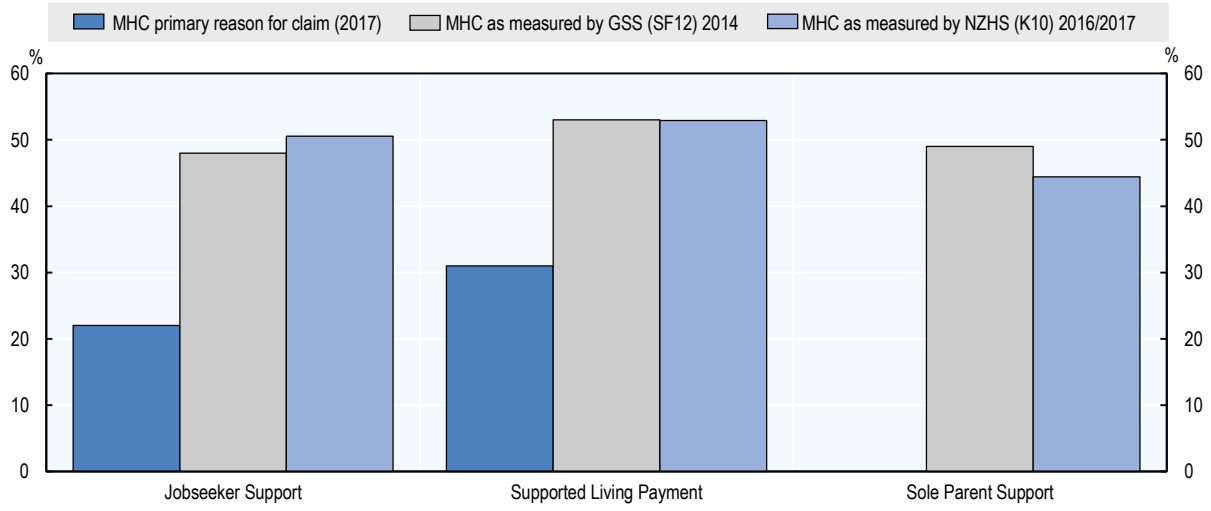
Benefit data underestimate the real number of people with mental health conditions

The figures on claims due to mental health conditions underestimate the *actual* number of people claiming benefits who have mental health conditions, as they only refer to people for whom a mental health condition is their primary reason for their claim. OECD analysis of 2014 data from the General Social Survey (GSS), found that 44% of people on JS-WR and 55% on JS-HCD met the criteria for a mental health condition.[3] This means that across the Jobseekers benefit population, the proportion of people meeting the criteria for a mental health condition is 48%, a much greater proportion than the 22% who are identified as claiming due to mental health conditions (Figure 5.5).

This data from the GSS also estimated that people with mental health conditions claiming SLP is higher, at 53% of all SLP claimants, while only 35% have a mental health condition as their primary reason for claiming (GSS, 2014). Furthermore, the GSS data identified that 49% of people claiming Sole Parent Support (SPS) met the criteria for a mental health condition. The same analysis was repeated using data from the New Zealand Health Survey 2016/2017, with similar results (Figure 5.5).[4]

Figure 5.5. Primary reason for benefits claims underestimates the proportion of people with mental health conditions on all main benefits

Share of people with a mental health condition on each type of income support



Note: MHC = Mental Health Condition.
Source: Secretariat estimates based on Ministry of Social Development, Benefits Tables, 2017; General Social Survey, 2014; and New Zealand Health Survey 2016/2017.

StatLink http://dx.doi.org/10.1787/888933845700

This underestimation of mental health need within the welfare population has significant implications for the provision of early and effective psychological and employment support (as discussed later in this chapter). It also highlights how important it is that some health information is collected on everyone claiming benefit, and that this is regularly reviewed, to ensure the right types and intensity of assistance can be provided.

One legislative obstacle in this is New Zealand's Privacy Act, which currently prohibits staff working within the social welfare system from accessing information on client

health conditions if this is not a reason for claiming benefit. Given this legislative barrier, routinely screening everyone for mental health issues who claims benefit, becomes even more important (again, see the discussion later in this chapter).

The effectiveness of work capacity and support needs assessments is unclear

To prevent health and disability claims it is essential to have effective tools in place, which identify the work capacity, potential barriers to employment, and likely support needs of individuals at an early stage, and to make available early provision of medical and employment support as necessary. In New Zealand, whilst there is no specific tool for claimants with mental health conditions, the intended approach for all claimants is to assess work capacity rather than working from a medical diagnosis.

The Welfare Reforms brought in a new staged assessment process to identify ability to work for people with health conditions and disabilities. (For more information, see Box 5.1). For clients with a health condition, this includes a self-assessment and a medical certification both of which have a focus on what a person can do at work with appropriate supports and services.

The Self-Assessment Questionnaire is a four-page form completed by the individual, which the person takes to their appointment to discuss with a case manager. The person completes the self-assessment if they are making a claim for benefit due to a health or disability, so this is not a questionnaire completed by all MSD clients.

The Self-Assessment Questionnaire was developed based on stakeholder feedback on what information would be useful to collect and takes a strengths-based approach. The questionnaire also asks about a person's hobbies and interests, with the aim to identify their interest and skills. It asks about what work the person has done, what they would like to do in the future and what work they think they would be good at. There are also questions asking the person when they expect to return to work, if at all, and if they got a job, the type of workplace support they think they need. The final section asks the person to identify what types of things will help them get a job and stop them from getting a job. Data on the completion rates and utility of the Self-Assessment Questionnaire is not available.[5]

It is unclear how many MSD clients complete a self-assessment and how effective this is at matching people to the right type and intensity of health and employment support. Depending on how effective the self-assessment is at helping people access the right supports in a timely manner, it could be used for all MSD clients, regardless of the reason for their claim, built into a new allocation and navigation process.

The Work Capacity Medical Certificate is completed by a registered medical practitioner (which includes psychiatrists), a nurse practitioner (Jobseeker Support clients only), a midwife (for clients who are pregnant), or a dentist (for dental-related conditions). Psychologists or chiropractors cannot complete the medical certificate. The medical certificate asks the health practitioner about barriers/limitations to work related to the health condition or disability and for a diagnosis. The health practitioner must assess whether the person's capacity is likely to improve and allow them to take up full-time or part-time work with appropriate accommodation and support. The certificate must include information on the treatment and support that will help the person improve or manage their condition; on accommodation and support that could assist the person into suitable employment; and on the likely date on which the person is expected to be able to return to

work. The information in the Work Capacity Medical Certificate is used, along with other information, to decide on a client's benefit entitlement and work obligations.

The critical role of the medical certificate highlights the importance of training and guidance to health professionals, particularly general practitioners, in understanding the interrelationship between mental health and work, managing the sickness certification consultation, and providing payment so that there is sufficient time for these consultations to be completed (see also the discussion in Chapter 2).

As with the self-assessment, it is important that the medical certifications provide information that can identify the right psychological and employment support a person would need in a timely manner. The effectiveness of the medical certificate in this regard should also be evaluated.

In cases where more information is needed than what has been provided by the self-assessment and the medical certificate, an independent Work Ability Assessment (WAA) is carried out to identify what work a client can do, and the support and services they need to gain and retain work. The assessment is undertaken by a suitably qualified health professional, such as a psychologist, occupational therapist or occupational nurse, who is experienced in assisting people into work.

The WAA covers all people claiming benefits due to a health condition and disability, inclusive of people with mental health conditions. Since its introduction and up to January 2018, of the 3 500 WAA conducted, about 1 000 were undertaken with people with mental health conditions. The numbers of people going through a WAA represents a very low proportion of MSD clients and an even lower proportion of people who are claiming for mental health reasons.

Whilst work capacity assessment is an important part of effective reform of the disability system, countries across the OECD have struggled to make the structural reforms to prevent increasing disability claims for people with mental health conditions (OECD, 2015[13]). It is clear that the same is the case for New Zealand.

The current system, whilst increasing support and resources to people with health conditions and disabilities, still has a much greater focus on other jobseekers.

Many not matched to the right type of case management and employment support

"Activation schemes need to start with an intake phase, where jobseekers are profiled to assign them to the appropriate target group" (OECD, 2015[13]). In New Zealand all jobseekers meet with Work and Income case managers to understand their individual circumstances. However, like many other OECD countries, New Zealand does not routinely screen for mental health issues. The first contact with the welfare system is an important opportunity for this to occur, so that prompt and early support can be offered. This is also the time to understand other potential barriers to employment and health and social care needs.

New Zealand needs to identify a more effective system to routinely screen for mental health issues. This can be based on validated instruments for all people claiming benefits and should be combined with appropriate follow-up supports and services (Liwowsky et al., 2009[14]). Any screening tool needs to be informed by cultural models of health and wellbeing, so that inequities of access to support and services do not increase.

The process of understanding an individuals' health status and circumstances, work capacity and barriers to re-employment could be a role carried out by a government or non-government provider. Identifying the right people and organisations to undertake this process is particularly important. For example, assessments for Māori claimants could be delivered by Māori assessors, using Māori models of practice and engagement, such as whānau ora. Inequities will continue if a universal approach is taken to assessment.

In Flanders, Belgium, at the moment of intake all job seekers are systematically assessed for issues which may be barriers to their employment. Information includes employment-specific competencies and qualifications as well as job-search behaviours, communication and social skills, disabilities and health conditions, including mental health problems. If a caseworker thinks there are more significant mental health issues, claimants can be referred to the public employment service's psychologist or an externally contracted employment centre specialising in in-depth multi-disciplinary screening. Where people are identified as having a need for greater assistance, they are referred to higher intensity employment support services. At any point, the guidance and support can be intensified depending on the needs of the person or the opinion of the case manager. At the latest, this would be after nine months of unemployment, and six months for people under age 26. At this point, an individual action plan is set up and intensive employment support started. People who have had mental health needs picked up through in-house or external screening receive specialised support in their job search, through government or contracted employment service providers (OECD, 2013[15]).

The OAG audit in 2014 identified that whilst the MSD had made good progress bringing in a case management approach, it does not yet serve people with high and complex needs well, and "greater collaboration with other agencies is needed" (OAG, 2014[3]).

At the same time as bringing in the new case management model, MSD brought in an actuarial model to evaluate the likelihood of long-term benefit dependency. The valuation is based on "what happened in the past to people with similar background, using 30 years of data on patterns of benefit receipt" (Productivity Commission, 2015[4]). This information informs the priorities for investment in case management and employment services. Clients likely to incur high and long-term costs have access to the most intensive front-line service. However, in practice it appears that the type of case management and employment assistance people are given predominantly depends on benefit they receive.

Jobseekers work-ready (JS-WR)

Within the current system people assessed as eligible for JS (work ready) would be allocated to work-search support case management (if they need additional support with job searching or work preparation activities) or general case management. Work-search support case managers have a caseload of 217 clients, and general case managers a caseload of 366 clients (OAG, 2014[3]). For the large numbers of people who have not had their mental health needs picked up, it is likely that these case management services will not be intensive enough to support them effectively. This group therefore faces a high risk of remaining unemployed or perhaps losing a new job again very quickly. During this time, they also face a greater risk of their mental health worsening.

Incorrect allocation to inappropriate employment assistance was found to be a problem in the Australian social protection system. Where people with mental health conditions had been triaged to more intensive employment assistance, the gap between their employment outcomes and people with no mental health condition was much smaller than for those who had been allocated to less intensive employment services. Jobseekers with mental

health conditions were triaged into less intensive employment services largely because their mental health issues had not been identified as a barrier to employment at assessment (OECD, 2015[16]). While comparable research for New Zealand is unavailable, the setup and mechanisms are similar to those in Australia.

Jobseekers health condition or disability (JS-HCD)

The pathway is different for people claiming JS-HCD who are allocated to work-focused case management, if there is availability. Where caseloads are full, clients receive general case management services until availability of active case management services. Work-focused case management has a caseload of between 100 and 120 clients per case manager. The exception is young people aged 18-24 where caseloads are between 80 and 100 (OAG, 2014[3]). The caseload ratios for external providers appear to be lower and are likely to vary across providers. Where people have full exemptions from work obligations, the take up of employment assistance is voluntary. It is also likely that external providers also carry out a process for determining a person's employment assistance needs, which may be leading to duplication of assessment.

A process evaluation conducted at the time of the Health and Disability welfare reforms, examined the working partnership between Work and Income, a general practice and an external contracted provider in relation to people with a diagnosed mental health condition. At that time, supporting people on sickness-related benefits through case management was a new area for Work and Income. The evaluation identified that the first thing Work and Income case managers would do is to assess entitlement for financial support, while a conversation about work may or may not happen, depending on the person's health issues. If such conversation about work did not happen straightaway, it might happen at some point down the track when the case manager thinks the person is ready for work. The decision to refer the client to an external employment provider seemed to depend on whether a person needed more support than a Work and Income case manager could offer (Te Pou, 2013[17]).

Supported Living Payment

All people claiming SLP are allocated general case management services, as the focus is on administering their income support. People claiming SLP are not subject to work test obligations, but some may have work preparation obligations. People claiming SLP can opt in for work-focused case management, but only 0.5% of all SLP claimants do so. Not being in active case management will often mean not to be referred to the right level of service. However, SLP clients can access supported employment service irrespective of the level of case management.

Non-beneficiaries with mental health conditions

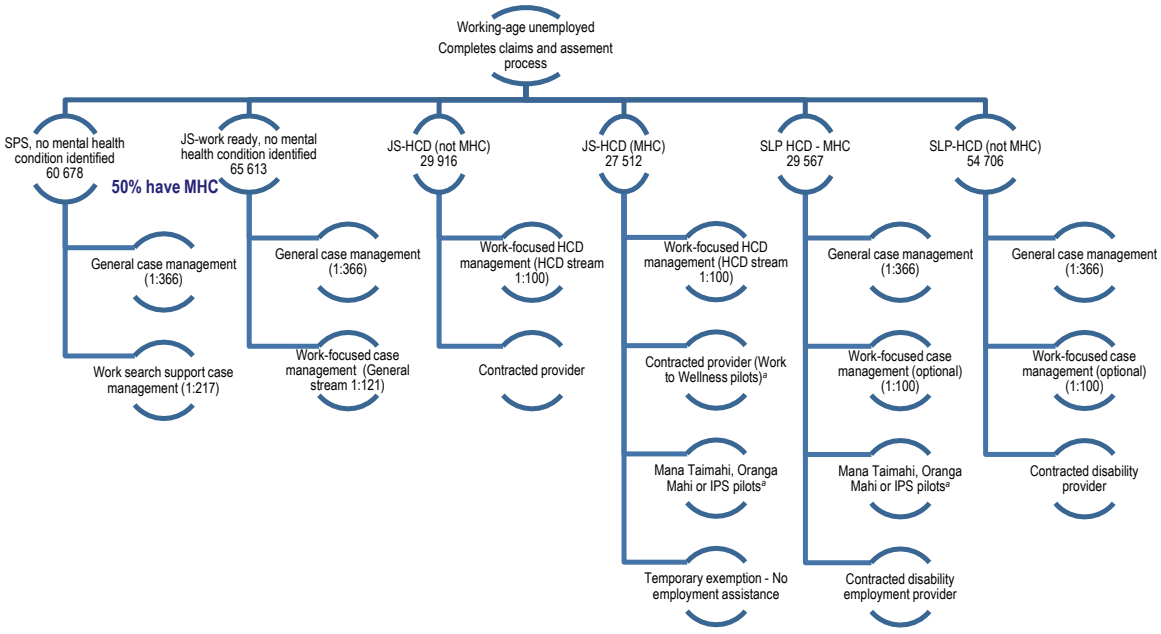
The allocation of employment services by benefit type also means that people who are not eligible for welfare benefits are not able to access Work and Income or contracted external provider employment support services. This would also include people at risk of losing their job due to mental health conditions. Non-beneficiaries appear only to be covered if Vote Health funding is paying for the employment support service, or if they are receiving vocational rehabilitation service through an ACC claim. There are examples of employment services funded through Vote Health within specialist mental health and addiction services (see Chapter 2). This is an area that needs to be prioritised and

addressed, particularly for people with mental health conditions, in order to reduce personal hardship and later societal costs.

The logic of MSD's approach is to match case management intensity to the identified needs of the client (OAG, 2014[3]). However, if mental health needs are not picked up through contact with a Work and Income case manager, the actuarial allocation process will not be effective in matching people to the right type and intensity of employment assistance.

Figure 5.6 shows the various routes to case management and employment assistance by benefit type. The largest number of people is those claiming Sole Parent Support and JS-WR, of whom 50% will have a mental health issue; they are receiving either general case management or work-focused case management. While there are more options for people receiving benefits for mental health reasons, these are not available across all regions, and people have to opt-in for additional support.

Figure 5.6. The routes to case management and employment assistance by benefit type



a) This initiative is currently a trial and is not available in every region/for all clients.
Source: Benefit claims figures taken from MSD Quarterly Benefits fact sheets, December, 2017.

It is also important to note that the logic of the actuarial allocation process is not applied in practice to people on SLP. In fact, the reverse seems to be the case in that people claiming SLP are allocated the least intensive general case management and can opt into more intensive work-focused case management. Even if a person opts-in, the assistance is unlikely to be intensive enough, although supported-employment programmes delivered by contracted providers may be available to offer more intense employment assistance.

It appears that a major issue effecting people with identified and unidentified mental health conditions is being allocated to inappropriate case management and employment support. This could lead to people going in and out of different advisors and providers (government and non-government) and through this process losing motivation and

potentially getting further away from the labour market. It is also likely that their mental health will be deteriorating if they are not accessing the appropriate health services either.

A process evaluation of clients' experiences within and across case management and employment services, in 2013, highlighted the multiple assessment processes clients may go through, especially if information is incomplete or not passed on. This could happen between different case managers or between the work-focused case manager and the external service provider (Te Pou, 2013[17]).

One indication of the lack of early access to appropriate supports and services for this group is that 55% of new claims for SLP come from people previously claiming JS-HCD (administrative data supplied by MSD). Transfers from JS-HCD to SLP-HCD are also much higher than reverse transfers from SLP-HCD back to JS-HCD: 1 266 transfers per quarter compared to only 196 reverse transfers (Taylor-Fry, 2016). This implies that a frequent and well-trodden pathway for a jobseeker with a health condition or disability on JS-HCD is a gradual move into a generally permanent disability benefit.

MSD should also be monitoring the transfer from JS-WR to JS-HCD and the corresponding reverse transfer, in general and for people with mental health issues in particular, to better understand the impact of case management and employment assistance services.

For Māori and Pacific people claiming JS-HCD and SLP for mental health reasons, the pathway to de facto permanent disability benefits appears to be even more likely. Whilst data on transitions could not be examined by ethnicity, data on claimants by ethnicity show that the number of Māori and Pacific people claiming SLP for mental health reasons is increasing at a faster rate than for other ethnic groups.

Ethnic inequities highlight how important it is that case management and employment assistance are informed and designed by Māori and Pacific communities; otherwise, inequities will likely continue to worsen. For example, whānau ora plans could describe the narrative, which then helps to understand the contributing factors to being out of work. Whānau Ora wrap-around support services would be case management approaches that are inclusive of whānau and describe a narrative of the presenting issues of concern, and the solutions. MSD has adopted one such model, Te Whare Tapa Wha in its Intensive Client Support trials (see Box 2.3 in Chapter 2).

Given these inequities, it is strongly recommended that future actuarial reports continue to monitor the experience of people claiming benefits for mental health reasons and that this is expanded to include an analysis of benefit inflows and off-flows as well as benefits transfers by ethnicity and other socio-demographic characteristics.

The welfare reforms also brought a greater focus on work obligations, with 80 000 more people now having such obligations (OAG, 2014[3]). At December 2017, 70% of all working-age adults on benefits had work obligations (201 874 people with work obligations out of 289 788 total recipients), with most people receiving either JS or Sole Parent Support. If people do not comply with their work obligations, sanctions can be imposed. About 15 000 sanctions are imposed each quarter, of which approximately 3 000 per quarter result in benefits suspension or cancellation. About two in three sanctions are for missed appointments (OAG, 2017[5]). Data from the December 2017 shows that 42% of imposed sanctions were for Māori and 11% for Pacific clients. The Auditor-General, in 2014, made a number of recommendations to MSD on how to reduce missed appointments, including reminding people through text messaging, and encouraging innovative practice to increase the percentage of appointments kept. Again,

ensuring the use of Māori-led models of care and support and involving whānau could potentially help to understand and reduce the number of missed appointments of Māori clients.[6]

In addition to varying across benefit type, the current case management procedure and corresponding outcomes appear to vary across the country as well. It is important for MSD to collect data on regional practices and performance in a systematic manner and to introduce appropriate feedback mechanisms to ensure that laggard regions can learn from vanguard regions and thus ensure better overall outcomes.

Early evaluation of the recent welfare reforms found that work-focused case management was effective at supporting sole parents into work. As a result, MSD added another 18 000 sole parents to the work-focused case management stream (OAG, 2014[3]). Given the reforms have not been as successful for people with mental health conditions, the expansion in case management for this group has not taken place in the same way. This is understandable and likely to be explained at least for some of the client group by a lack of well-integrated employment and health services. Any obstacles to better employment outcomes should be removed; this could include strengthening work-focused case management and building the capacity of both the employment and health sectors to be more aware of and responsive to the interrelationship between mental health and work.

The New Zealand social protection system needs to improve the approach it takes to the identification of individual employment assistance needs. Whilst some MSD clients appear to be receiving the appropriate level and intensity of employment support, the vast majority are not. The system is therefore missing the opportunity to provide the right support, at the right time, and reduce the flow of people onto health and disability benefits.

There is a lack of funding for and access to psychological support

OECD countries' social protection systems can address clients' health needs by either co-ordinating its services with the health care system or providing integrated health services as part of the social protection system. Sweden, for example has pooled resources between its national employment service, the regional health authority and welfare offices, and its national social insurance scheme (OECD, 2013[18]).

In New Zealand, psychological support is not routinely offered to MSD clients. A doctor, usually a GP, can however provide the necessary information to case managers to authorise the use of Disability Allowance payments for counselling, for some people. The allowance covers ten sessions initially, which must be provided through a counsellor with recognised qualifications. Health practitioners and members of the New Zealand Association of Counsellors or the Social Workers Registration Board can provide such counselling support. People can apply for additional sessions. At March 2018, 1 139 clients were accessing counselling using a Disability Allowance. The majority (92%) were people claiming benefits for mental health reasons; 16% of the total identified as Māori, 2% as Pacific, and 62% as NZ European. Counselling not related to a person's disability or health condition, such as relationship counselling, is not financially reimbursed.

Work and Income employs Health and Disability Advisors to provide advice to case managers, regional leadership teams and the national office. There are 39 such advisors working across New Zealand, nine in Auckland and three in each of the other ten Work and Income regions, plus one principal health adviser and one principal disability advisor

to support the regional health and disability advisors and ensure a nationally consistent approach is being taken. None of these advisors can provide psychological treatment.

Health and Disability Advisors have a variety of health and disability backgrounds. Some are trained psychologists, others have backgrounds as social workers, employment advisors, rehabilitation experts or mental health nurses. All advisors have completed Mental Health 101 (MH101).

Anecdotal reports suggest people outside the welfare system, particularly in the medical services, find it hard to get information from Work and Income, terming the system a black hole. A small-scale evaluation identified one-way communication between general practitioners and Work and Income staff, where health professionals will send a letter to Work and Income but will not get a response unless there is consent from the client or the GP has formal authority to act as an advocate for the client (Te Pou, 2013[17]).

The Social Security Act allows for limited communication around the purpose for which the external agency is involved. For example, when a doctor fills out a medical certificate and this information is sent to Work and Income, the latter can communicate directly with the doctor to seek clarification around the information provided. If additional information is required, such as a specialist report, separate specific client consent is needed. MSD advises to involve in such situations Health and Disability Advisors who usually have an established relationship with the health professional. The guidance for the case managers therefore is to seek advice from the Health and Disability Advisors rather than contact the doctor. If needed, Work and Income can have case conferences involving general practitioners and specialists.

Expand the current approach to building case workers' mental health competences

Across the OECD, mental health competencies and psychological expertise in the employment sector are underdeveloped and not commensurate with the high prevalence of mental health issues among jobseekers and welfare clients. Better mental health competencies need to be developed to make early identification and quick intervention possible in all systems. Efforts in that direction should come primarily in the unemployment system because better job retention and reintegration at this early stage can prevent people with poor mental health from slipping into welfare and disability.

It is important therefore that all front-line Work and Income staff receive training, which builds their mental health competence, cultural competency and psychological expertise. MSD currently invests in different training courses to build mental health competencies of staff (see Table 5.4). Immediate post-training evaluation of the available training shows that the courses are having the desired impact. However, evidence has shown that any training needs to be following up by practice and support in a person's everyday working context, in order for the learning to be sustained (Fixsen et al., 2005[19]).

Whilst awareness training and the recognition of signs of mental distress, are a crucial step, this should be built upon so that Work and Income staff not only develop the skills to identify mental health issues, but decide when to seek support from specialists, and where such support can be found. This is an area where improvement is needed for most OECD countries. Training should help Work and Income staff understand the interrelationship between mental health and work, and the impact of mental health conditions on work capacity. This is because staff working in the benefits system frequently underestimates the work capacity of people with mental health conditions (OECD, 2015[13]).

Table 5.4. There are a range of mental health competency training sessions for MSD staff

Course name	Duration	Aims	Reach	Evaluation
Lives Like Mine	2.5 hours	The importance of empathy to enhance positive outcomes for MSD clients.	4 692 staff trained Applies to all MSD staff	1 300 staff completed the post session evaluation. **96%** of respondents agreed with the statement "*I have a better understanding of how my actions and values can influence client outcomes."* **95%** of respondents agreed with the statement "*I have a greater level of self-awareness of what might be going on in the lives of others (i.e. my colleagues or clients)."* **99%** of respondents agreed with the statement "*I intend to continue to reflect on how my attitudes and behaviours may impact on what I do in my job."*
Mental Health 101	One day	To build confidence to recognise, relate and respond to people experiencing mental health issues.	3 419 staff trained	An evaluation of 13 MH101 workshops found that: A **56%** increase in confidence of recognising signs and symptoms of mental health conditions. A **65%** increase in confidence in knowing how to respond
Suicide Awareness	3.5 hours	How to recognise and respond to people at risk of suicide.	1 731 (of expected 4 000) trained	476 staff completed the pre-workshop evaluation and 807 have completed the post-workshop evaluation. Participants were asked "*what is your confidence level in being able to identify someone at risk of suicide?*" Prior to the workshop staff confidence levels were at **34**%, and this increased significantly to **85**% post workshop. Learners also expressed feeling more confident about holding an effective conversation with someone who is having suicidal thoughts – **39**% of staff were confident pre-workshop, which has risen to **84**% post-workshop.
Work to Wellness	90 minutes (online)	Supporting clients diagnosed with a mental health condition who have part-time, deferred or no work obligations.	502 staff trained Targeted at WFCMs	N/A
Lives Like Mine Outtakes	3 hours	An extension of Lives Like Mine, a focus on case studies and increasing self-awareness	N/A	Over 550 staff completed the post-session evaluation. **94%** of respondents agreed or were neutral with the statement "*I feel confident to apply my new knowledge and skills from the training to my role."* **93%** of respondents agreed or were neutral with the statement "*This training has helped me to further develop and improve what I do in my job."*
Rethinking Mental Health	5x one-hour modules	Explores the experiences people with mental health conditions may have had and encourages effective engagement from front line staff.	N/A	512 staff complete the post session evaluation **95%** of respondents agreed or were neutral with the statement "*I felt I understood why I was doing this learning programme before starting and how it would benefit me."* **98%** of respondents agreed or were neutral with the statement "*I feel confident to apply my new knowledge and skills from the training to my role."* **95%** of respondents agreed or were neutral with the statement "*This training has helped me to further develop and improve what I do in my job."*

Source: Data supplied from Ministry of Social Development, April 2018.

It is also not clear how much access case managers get to training in psychological techniques, like brief interventions. Whilst they can access advice from the Health and Disability Advisor, there are only 19 such advisors across the country.

MSD should ensure supervision builds on the training provided and helps staff to identify mental health issues, as well as other health barriers to work, including addiction and physical health issues. Case managers need to know how clients can access appropriate,

specialist support locally. It is also essential that all trainings integrate cultural competency with mental health competency. For example, Work and Income staff need to know how to facilitate whānau hui and engagement with Māori whānau and should also be supported to seek out cultural supervision to talk through case-specific situations.

It is also essential that Work and Income staff represent the cultural diversity of the communities with which they work. Given the overrepresentation of Māori people claiming welfare benefits, MSD should review the profile of Māori case managers and seek to recruit more Māori case managers as needed.

Mental health and employment services are in their fifth year of piloting

Employment and health needs are rarely addressed together. Even where jobseekers' mental health issues are recognised, people are often plainly exempted from job-search and availability requirements and expected to seek treatment until they return fit and healthy to seek work. This is evident in the New Zealand welfare system although it is an approach found not to be effective (OECD, 2015[13]).

Delivering co-ordinated, integrated health and employment services is challenging because of the lack of coherent incentives, obligations and guidelines for stakeholders and participating professionals. Integrating services requires public employment services to address clients' health and employment needs concurrently. Funding and policy mechanisms are needed which stimulate cooperation between employment services (government and non-government) and the health sector, especially primary and community-based mental health services.

In 2013, MSD started to examine this need for coordinated, integrated health and employment services. A tender process was run to select and contract with external providers to deliver employment support services to people in receipt of JS-HCD with a mental health diagnosis. These Mental Health and Employment Service (MHES) pilots were then run for three years, in four regions of the country.

In 2016, following an evaluation conducted by MSD, the MHES pilots were replaced by Work to Wellness (W2W) pilots and a new tender process announced. W2W pilots cover the same target group as MHES pilots, people on JS-HCD with a mental health diagnosis who are interested in finding work. Providers are contracted by MSD to deliver outcomes-based case management, placement and post-placement support. Providers are paid for full-time and part-time employment outcomes, as well as job retention milestones. W2W contracts aimed to improve on MHES by 1) improving the links to health services to help the integration of mental health treatment into employment services; 2) defining client outcomes in broader terms; and 3) decreasing the dropout rates. W2W services are available in the same four regions as MHES, plus a fifth region, and aim to provide employment support for 2 000 clients for two years. There are currently more than 200 clients enrolled. A formal evaluation of W2W is currently underway, and a report is expected later in 2018. Early findings suggest that W2W pilots are experiencing challenges getting the right type of employment service to the right person at the right time, in reducing early exits and in integrating employment services with health provision. Whilst W2W aimed to increase the integration with health services, it appears the contracts may not have encouraged or recognised this.

W2W contracts pay providers an initial enrolment fee for each person accepted into their service meeting the eligibility criteria, a monthly activity fee per client, and further on

payments based on job placements and successful job retention, at six and 12 months. Higher payments are received for clients with higher needs and for full-time employment.

If outcomes for these contracts are disappointing, it may be that payments to providers were too low, or the contract duration too short for the provider to make a real investment, or there may have been issues inherent in the contracting process, or the contract terms and conditions. Anecdotal evidence suggest that many of the external providers working with people on JS-HCD experience significant challenges getting referrals from Work and Income. All these potential issues should be investigated.

As at December 2017, MSD also funds 32 employment services that support people with disabilities and people with health conditions to gain and retain open employment, through contracting with external employment providers. Of these, six providers with a total service volume of approximately 680 people, specialise in supporting people with mental health conditions. These providers would predominantly be working with people whose mental health conditions is having a significant impact on their daily living, and likely to be claiming SLP. A new outcome-based payment system similar to that being used in W2W contracts, and a Service Level Intensity (SLI) rating system have recently been introduced under these National Supported Employment contracts. This is a step away from the old one-size-fits-all approach towards a more nuanced basis for aligning funding with the actual support needs of individuals. Anecdotal reports suggest that these contracted providers use whānau links, other community supports, health professionals, and other social services for their main referral pathways, rather than Work and Income case management. Although NZDSN are trialling a desk-based service profile tool, to provide information to case managers on their local disability providers.

New pilots aim at higher take up of case management and employment assistance

At the same time, MSD has set up a number of additional pilots for people with health conditions, including but not specifically for mental health conditions. These *Oranga Mahi* pilots are running across four district health boards. An investment of NZD 24 million supports these trials over three years. Evaluation of these trials is currently underway (OAG, 2017[5]).

One of these pilots is *Mana Taimahi*, an initiative co-designed and delivered with the National Hauora Coalition (NHC).[7] The main objective of Mana Taimahi is to support clients receiving Jobseeker Support with a health condition or disability into work, by testing new approaches to working with general practitioners. People on SLP are not eligible. The initial referral is made by GPs, who can promote *Mana Taimahi* to clients meeting the criteria at work-capacity medical certification consultations.

Mana Taimahi began as a Proof of Concept (POC) that ran between August 2016 and June 2017, involving two general practices and two community links in West Auckland. The POC was designed because in talking with GPs they found that:

- The limited interaction between GPs and case managers with mutual clients has resulted in misunderstandings about Work and Income services and processes and the work abilities of JS-HCD clients;
- Time pressures on GP appointments and limited information about how to support clients to return to work, mean that GPs struggle to offer work-focused support to patients who need it.

The *Mana Taimahi* POC confirmed that the apparent disconnect between Work and Income and GPs can contribute to sustained periods on benefit for mutual clients, which can also have a negative impact on health. The POC aimed to address these issues through education modules for GPs, networking meetings between GPs and Work and Income case managers, and free GP visits for clients on JS-HCD. Anecdotal reports have found that the feedback from the GPs has been very positive. They feel the trial has made a difference to their knowledge and perception of services and brought them in a much better space to support clients into work.

The *Mana Taimahi* POC resulted in 57% of clients being referred to MSD related programmes and providers, while 20% have entered employment. This is a group of clients able to choose to opt into MSD programmes and support services; a step that many of them, however, would usually avoid.

The POC is currently scaled up to a prototype to test the concept on a larger scale. The prototype will run from November 2017 to November 2018 continuing the services established through the POC. In particular, it will aim to:

- help GPs to understand the negative health impacts of long-term unemployment, the health and social benefits of work, and the misconceptions about Work and Income services;
- provide up to three additional free GP consultations for clients to allow GPs to have in-depth discussions with clients about their wider circumstances, their employment goals and the appropriate steps needed for them to return to work;
- hold regular meetings between GPs and Work and Income staff to improve communication, create a stronger understanding of one another's services, and ensure consistency of support for clients.

The *Mana Taimahi* approach, working directly with primary care teams, is a similar approach adopted by a mental health non-government provider. Employment support services have been co-located with general practice primary care teams to support people with mental health conditions to get and keep employment. These small-scale pilots were self-funded or utilised existing funding contracts from the Ministry of Health or the Ministry of Social Development. They provided one full-time employment advisor to two to three general practice teams. Evaluation of these pilots have found that general practitioners value the service and it also increased the frequency of employment-focused consultations held by the general practice teams (Te Pou, 2013[17]; Te Pou, 2013[20]). On average, these embedded primary care pilots support about 50% of people accepted onto the programme into employment.

MSD has also recently initiated funding for two services to trial the Individual Placement and Support (IPS) approach (see Chapter 2). The pilots are for 18-35 year olds diagnosed with a severe mental health condition (Auckland) and youth aged 16-24 years with mild-to-moderate mental health condition (Christchurch). To date, IPS services in New Zealand have been funded exclusively by money from Vote Health.

Social bonds are used in other OECD countries to support the delivery of integrated health and employment services.[8] The first social bond in New Zealand commissioned in 2017 aims at improving employment outcomes for people with mental health conditions who are on a welfare payment. A financial incentive is offered to a consortium of providers and investors if they can achieve a result with a service, which is demonstrably better than what has been previously achieved with the old way of doing things. The aim

is to assist up to 1 700 people in South Auckland over the 60-month period of the bond. Under the contract terms, the employment service provider is allowed six months from referral to finding people a job. Therapeutic help is also delivered, where needed. Once a job has been found, people can be supported for up to two years to help them remain in work. Intermediate results from the social bonds contract, however, seem to be disappointing. Every effort will have to be made to understand the reasons to strengthen the contract and to ensure better outcomes in any future contract.

In conclusion, there are a range of promising programmes, pilots and experiments available, but these remain limited in scale and regions. Furthermore, most of these programmes and pilots are not available to people who are non-beneficiaries, with the exception of the health-funded IPS programmes. Rigorous independent evaluation is needed of all programmes and pilots so that findings can inform future contracting.

Annual appropriations for MSD to cover contracted-out services are around NZD 41 million. This compares with costs of in-house case management and work broker services worth around NZD 240 million. A further NZD 307 million covers the administration of income support (Productivity Commission, 2015[4]). Therefore, contracted-out services represent a very small proportion of MSD's total investments in the provision of case management and employment services.

Pilots that integrate health and employment services need scaling up

Easy and early access to employment support services appears to be a significant issue. Many specialist employment support services are only available to people with a diagnosed mental health conditions, or people on certain types of benefits, or only if the person is referred through the Work and Income case manager, or only in some parts of the country. Furthermore, all employment support services that specialise in working with people with mental health conditions are on time-limited service contracts, which makes recruiting and retaining an adequate workforce challenging.

The pilots working directly with general practice teams are bringing employment support much earlier, rather than waiting for a referral from a Work and Income case manager. They are also serving as a bridge between the client and Work and Income offering navigation support to apply for financial support and other social services.

There is an urgent need to have national access to evidence-based vocational interventions for jobseekers with mental health conditions, which combine psychological counselling with pre- and post-placement services, learning from successful pilots that have combined employment support with improved communication between Work and Income case managers and health practitioners.

Of note is that the audit-general's report from 2014 notes that "International evidence on successful outcomes for people with multiple barriers to employment is limited, and the Ministry might need to build its own evidence base to find out what work". This is a potentially misleading statement partly explaining the lack of scale-up of employment services since the science of vocational rehabilitation for people facing multiple barriers to employment is an area of psychosocial rehabilitation, which has advanced significantly over the past 30 years (Drake and Bond, 2017[21]).

It is important that pilots are informed by existing evidence, including Māori models of practice. The issue lies less in trying to work out "what works", as there is good evidence for that, but in ensuring the authorising system can enable good practice to be

implemented. Experience with MHES and W2W contracts is perhaps an illustration of this issue. The contracts were changed, but on the ground their appears still to be an issue of getting integrated health and employment services or reducing drop-out rates.

A recent policy analysis, which investigated the strengths and weaknesses of MOH and MSD contracts and the contracting process, concluded the current contracting environment is hindering not assisting the labour force participation of people with mental health conditions. There are many purchasers, each with different types of contracts, and an uncoordinated approach to contracting and purchasing across government agencies. The analysis recommended identifying a lead agency for coordinating health and welfare policy in relation to purchasing employment services for people with mental health conditions and starting a trial of pooled investment. The analysis also recommended amending the fee structures to reward job tenure over hours of employment, encouraging post-placement support and better specifying and rewarding closer integration between health and employment services and alignment with evidence-based practices (Lockett, Waghorn and Kydd, 2018[22]).

Whilst these issues were raised in the context of the labour force disadvantage of people experiencing mental health conditions, they echo the findings from the 2015 New Zealand Productivity Commission's more effective social services report. This review of New Zealand's social services also focused on improvements that need to be made to the authorising systems, particularly the purchasing and contracting environment (Productivity Commission, 2015[4]). The government has responsibility for good systems stewardship and the creation of an enabling environment for social services to operate effectively within and this is especially important for people who have higher or more complex needs, who are affected the most by the silo nature of much of the available service funding, purchasing and delivery.

New guidelines for providers of employment support services for people with disabilities have recently been launched (NZDSN, 2018[23]). These could provide a quality benchmark for (government and non-government) employment support providers, and adherence to these guidelines built into contracts and quality management processes, along with known evidence-based practices in employment support services, like the Individual Placement and Support fidelity scale. This could sit alongside contracts that reward providers for integrating with health services, providing early intervention, and providing post-placement support. Consideration should be given to the best contracting environment to enable what works, to be implemented in the New Zealand context, and to assist with scaling-up of successful pilots.

Conclusion

In 2011, a Welfare Working Group set out a set of practical recommendations to reduce long-term welfare dependency for people of working age, their families and the wider community. Within this report the Group highlighted the fact that "gaps in mental health, rehabilitation and managed-care services create costs which inevitably show in the welfare system, not to mention costs to individuals in terms of their well-being"; and that "joblessness is particularly harmful to mental and physical health". At that time, 41% of people receiving the then Sickness Benefit and 29% of people receiving the then Invalid's Benefit had mental health conditions as their primary reason for claiming. The Group called for specialist employment interventions to support people with mental health conditions to work, and a greater investment in psychological therapies.

The structural and operational reforms since the Welfare Working Group report have had minimal impact on people with mental health conditions. In fact, the numbers of people with mental health conditions claiming benefits is increasing, particularly for Māori and Pacific people. There are also many people claiming welfare benefits whose mental health issues are not formally recognised by the welfare system; conditions that may not be the assessed cause for the benefit claim but still pose a major barrier to re-employment. As a result, the supports and services offered for many are not effectively matching their needs for employment assistance. Even where mental health needs are recognised, there is limited access to timely and appropriate treatment and employment assistance.

There is no focus in the New Zealand welfare system on early intervention for people with mental health conditions, and more generally. For people who are off sick from work or not employed and not claiming welfare benefits, there is virtually no employment assistance available. Addressing this issue is of paramount importance and will need significant cross-government collaboration.

New pilots aim to support people with mental health conditions to access Work and Income case management and employment assistance, or employment assistance from a contracted provider. These new pilots recognise the need to integrate health and employment services. This is a promising development, but these are available to a tiny proportion of the population in need of these services. Well-integrated health and employment support services should be scaled up and the findings from promising pilots translated into lasting and structural reform.

Finally, there is a need for more effective assessment and more timely access to appropriate support including integrated psychological and employment support services. The current pathway to early and appropriate employment assistance and psychological support is unclear, inconsistent and inequitable.

Notes

[1] A recently established Welfare Expert Advisory Group will advise the government on changes to obligations and associated sanctions applied to beneficiaries to ensure alignment with the vision of the new government. In practice, sanctions are not often applied.

[2] NZDSN is the New Zealand Disability Support Network, a network of NGOs that provide support services for people with disabilities. The purpose of the Network is to lead and influence change that supports inclusive lives for people with disabilities.

[3] The General Social Survey uses the Short Form Health Survey 12 item scale (SF-12), which measures the impact of mental health on role functioning.

[4] The New Zealand Health Survey uses the Kessler Psychological Distress 10 item scale (K-10), to measure levels of psychological distress in the past 4 weeks.

[5] The Self-Assessment Questionnaire is not linked to a person's claims process; hence, it is not used to decide on benefit entitlements.

[6] A forthcoming report by the Welfare Expert Advisory Group will reconsider obligations in the welfare system and associated sanctions imposed.

[7] The National Hauora Coalition is a Māori-led and culturally driven Primary Health Organisation focused on improving outcomes for all whānau.

[8] Social Bonds are a method of providing health and social services, where upfront-funding is provided by private investors. If the agreed outcomes are reached, the government pays back the investor a pre-determined return on the investment. The following link provides an example: https://www.socialfinance.org.uk/projects/health-and-employment-partnerships-hep.

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