Assessment and recommendations

Poor mental health costs the New Zealand economy some 4-5% of GDP every year through lost labour productivity, increased health care expenditure and social spending on people temporarily or permanently out of work. It is also costly in terms of individual wellbeing as, at any given moment, one in five New Zealanders have a mental health condition. The prevalence of mental health conditions in New Zealand is higher for women than for men, higher for young people than for those of working age, and highest for those with low educational attainment and for Māori and Pacific populations.

Mental health has considerable implications on people's economic and labour market situation. People who have a mental health condition face lower rates of employment than those without such conditions and twice their rate of unemployment. The employment and unemployment gap is especially large for those with a severe mental health condition. Partly because all benefits in New Zealand are means-tested, the share of persons with a mental health condition who receive a social benefit is lower in New Zealand than it is in other OECD countries. However, roughly half of those who do receive a social benefit have an identifiable mental health condition. Because of the large employment and income gap, the poverty risk is high in New Zealand for people with a mental health condition: depending on the severity of their condition, some 35-45% will live in a low-income household, defined as households with a per-person income below 60% of the median. Multiple disadvantages often come together: Māori people have the highest mental health prevalence and face the largest income and employment disparities.

Moving from policy thinking to policy implementation

It is increasingly well understood in New Zealand that the prevalence of mental health conditions is very high and that they have significant effects on people's employment opportunities and their wellbeing, thereby affecting many other aspects of the economy as well, including public spending and economic growth.

New Zealand is in a good position to address these problems because the awareness of the issue is high. Influenced by an effective and repeatedly evaluated anti-stigma and discrimination campaign run on a continuous and evolving basis over a period of over 20 years, mental health and arising problems, in the most part, are discussed openly. More recently, influenced by research and policy developments in the United Kingdom, discussions increasingly also draw upon the strong evidence base around the health benefits of work. This is a promising starting position for the development of effective mental health and work policies. Added to this, cultural issues and multiple disadvantages faced by Māori as well as Pacific people, including a higher prevalence of mental health conditions and poorer associated outcomes, are also discussed in an open manner.

Policy thinking in New Zealand around mental health and work, however, has not yet translated sufficiently into better policies and, consequently, better social and labour

market outcomes for the affected populations or, if so, not to a sufficient extent. There are several reasons attributable to this situation.

- New Zealand is running a large number of interesting social policy pilots, trials and experiments, just like Australia and the United Kingdom, for example. But these initiatives rarely translate into lasting or structural reform. Much could be done to improve the evaluation and rollout of successful trials. Many of the ongoing trials have considerable potential as they successfully integrate health and employment funding or deliver integrated health and employment service, and some are being designed by the communities who are most affected.
- Health and employment services in New Zealand are highly fragmented with numerous programmes and initiatives running in parallel. As a result, service providers tend to receive their highly uncertain funding from a number of different institutions and authorities. There are also many stakeholders involved, with limited cross-country and cross-government leadership. National-level initiatives are also poorly coordinated with regional ones; regional actors have considerable authority over their actions.
- Policies tend to have a focus on diagnosed severe mental health conditions with limited attention given and services provided to people with common mental health conditions including most mood and anxiety disorders that are frequently unrecognised, or undiagnosed, but can also have a significant impact on a person. This is visible in services directed at youth (access to which generally requires a diagnosis); in welfare services (which also generally require a diagnosis); and health services (which are tilted towards costly inpatient service while primary and mental health care is relatively under-resourced).
- Certain fundamental features of the various systems operating in this space make better employment outcomes for people with mental health conditions and effective structural reform quite difficult to achieve. Among those are:
    - A strict and adverse distinction between injuries (covered by an effective and well-resourced social insurance system) and illnesses (covered by an under-resourced general health and a means-tested welfare system), with mental health problems virtually always falling into the latter group.
    - A health system that combines general practitioners who operate on a private business model with considerable co-payments for users on the one hand with a fully tax-financed secondary and tertiary health system with a relatively complex funding structure on the other. This creates a situation where many people lack access to primary health care while, maybe unnecessarily, accessing costly specialist services instead.
    - A general absence of early intervention in the welfare system as reflected in the lack of a sickness and return-to-work policy, including special payments to people who are off sick from work more than four weeks. Whilst the social investment approach offered a mechanism to promote early intervention, the way it was focused initially in the welfare system was to get people off benefits rather than preventing benefit claims and securing sustainable employment outcomes. Interpreted in this way, this approach contributed to poor work outcomes for many jobseekers with mental health conditions.

Establishing employment as a key target for mental health care

Twenty years ago, a paper by New Zealand's Mental Health Commission on issues and opportunities in employment and mental health called for an "integrated public policy response" across mental health, employment and income support policies. The report identified a lack of information about the "needs, numbers and trends" of people with mental health conditions seeking employment; a lack of "coordination between mental health and employment services"; and a need for "better skills among the mental health and employment service workforce". This was a very accurate state-of-the-art assessment and many of the conclusions are still valid. Today, more New Zealanders with a mental health condition receive treatment but the significant issues around service coordination and service integration, with a few local exceptions, remain.

This is likely to be explained by the relative complexity and fragmentation of the system, coupled with an underinvestment in mental health services and primary care-based services over many years. Despite a series of health care reforms, New Zealand still has a health system strongly orientated towards, and invested in, the provision of clinical services, with pharmacology the dominant model of treatment for mental health conditions. Where non-pharmacological treatments are available, access is inconsistent and inequitable.

Primary care has a particularly important role in improving the labour force participation of people who experience mental health conditions. It is also the gatekeeper to specialist care where later access to care is less cost effective. Building the capacity of primary care to respond effectively to people presenting with mental health conditions is essential, preferably while they are still working, but also quickly when they are not. For this, a shift of resources across general health into mental health services is required, coupled with a rebalance of the funding from specialist to primary and community services.

The other main challenge for New Zealand is to strengthen the employment focus of the health system. This needs to include employment guidance and access to employment support as a routine part of health services, and the inclusion of information on managing mental health and getting and keeping work as part of clinical guidance and on-line clinical pathways for the management of mental health conditions. Policy action is necessary as it can help to build structures that integrate mental health and employment support services at a delivery and workforce level, and across specialist and primary care.

Primary and community health practitioners in New Zealand are innovating new models of care, with culturally informed and culturally led programmes and support services. As these are grown, and the mental health capacity of primary care strengthened, this is the ideal time to build in training and guidelines around mental health and work, particularly on managing sickness absence and supporting return to work. Similarly, with a focus on increasing access to psychological treatments, including e-therapies, the scale-up of these programmes provides an opportunity to integrate them with employment support services and strengthen the links between mental health care and work from the outset.

Institutionally, an integrated whole-of-government policy framework promoting the interrelationship between health care and the workplace is required. Leadership roles and responsibilities of the Ministries need to be clarified, particularly across the Ministry of Health and the Ministry of Social Development but also the Accident Compensation Cooperation (ACC). The inequitable divide in New Zealand's system between injury and illness has created a two-tier health care system where integrated health services and

vocational rehabilitation support is prioritised for injury, through ACC, and not illness. This is particularly significant for people with mental health conditions.

In this context, conducting a national mental health survey is also a priority. This survey needs to gather data on labour force participation and other work and income outcomes by severity of illness and diagnosis. To inform policy making in this space, there is also an urgent need for accurate data on the number of people receiving primary mental health services and the share transferred to secondary care; the number of people receiving psychological therapies and the waiting times for such therapies; and the employment status before and after treatment.

Helping vulnerable youth to succeed in education and employment

One of the main characteristics of mental health conditions is their very early onset, most often in teenage and childhood. Accordingly, strategies to help people with mental health conditions enter the labour market must include youth and education policies. This is even more critical because of the long time lag of typically 10-15 years from the onset of a mental health problem to its first treatment. Early non-stigmatising support for youth is thus critical. Problems are potentially even more pressing in New Zealand as shown by a high risk of depression, self-harm and suicide attempts among youth. The youth suicide rate in New Zealand is more than twice the OECD average rate.

Well aware of the challenges, in 2012 the New Zealand government launched the Youth Mental Health Project, primarily targeting the age group 12-19 and financing 26 different initiatives across several government departments. These initiatives, most of which are still ongoing, include expansions in mental health services, attempts to improve access to services for disadvantaged groups, and a number of school-based programmes.

Together with the existing infrastructure, New Zealand now has an impressive array of services in place targeting schools and vulnerable youth. This includes:

- The Youth One Stop Shops, an accessible youth hub that combines low-threshold, integrated support with referral to specialist services;
- An effective Attendance Service to tackle and prevent early school leaving;
- Considerable resources in schools such as additional learning supports, managing behaviour programmes and school-based health services;
- Various alternative pathways to complete education e.g. through Activity Centres, Alternative Education, Teen Parents Units, or the Correspondence School; and
- Initiatives that promote the transition into work, especially through the Youth Guarantee (for those still in school) and through Work and Income's Youth Service (for NEETs and benefit recipients).

Many of these programmes and services are internationally of a very high standard. Actual outcomes, however, are not as impressive as the rich suite of services would seem to imply. Despite a great awareness of the need to help vulnerable students and although several initiatives have been shown to be effective, e.g. strengthening reengagement with education or increasing access to health care, considerable problems remain. First, the education system continues to produce noticeably unequal outcomes. Māori youth, the most disadvantaged of all groups, still have relatively poor education and employment outcomes: they are over-represented among all groups at risk – such as early school leavers and NEETs (= those not in education, employment or training) – and among users

of most services, while also being the group with the highest mental health prevalence. Most initiatives and supports, including some especially targeted for Māori youth, show poorer effectiveness for the target population. This is disappointing in view of the strong will of subsequent governments to ensure equal outcomes for all young people.

Secondly, many services and initiatives are insufficiently resourced and have to draw their resources from several government and non-government donors. Most initiatives are initially set-up as an experiment and many remain in a trial phase for years if not forever. Trials rarely cover the entire country and even if a service is rolled-out nationally, it appears that the accessibility and availability of supports varies considerably across the country. More national guidance and monitoring would be an important step to ensure all youth across New Zealand can benefit from the best available service.

Thirdly, it appears that the links and transitions between services and institutions in place are underdeveloped. This has multiple consequences, including duplication of service, lacking referrals to the appropriate service and unnecessary delays in getting the right service. For the youth population, it will not always be clear where (best) to go and the outcome may be highly entry and path-dependant. Improving this situation will require more of a nation-wide public policy and clearer political leadership.

Finally, many youth initiatives and services lack sufficient attention to mental health. This includes all non-medical youth services but also school-based health services and even the before-school health check done at age 4. This is unfortunate because children and adolescents with mental health conditions see much poorer outcomes later and benefit less from many of the rather comprehensive support programmes and structures.

Improving workplace mental health and return to work

The link between mental health and work and the key role of the workplace for people having or developing a mental health condition are well understood in New Zealand. It is a role model on mental health awareness campaigns, which, more recently, also started to target the workplace as a priority setting. This, together with a range of toolkits prepared by the Mental Health Foundation and the Health Promotion Agency, has helped New Zealand employers to understand and, possibly, address the issue. This is critical in a country in which workers can be dismissed relatively easily and at short notice.

Employer support tools, however, are not enough. Policies and legislation must follow which is only partially the case. Employment regulations in New Zealand are generally moderate, non-interventionist and often leniently enforced, similar to the United States. This is also reflected in policy and legislation targeting workplace health:

- Health and safety legislation has seen a major reform in 2013, slowly expanding its focus from workplace safety to work-related health but implementation of the new regulations is still weak and obligations for employers vague, and guidelines and supports for employers to live up to their new tasks are insufficient.
- Employer obligations for *sick* workers are minimal and employer-provided sick pay is meagre. Public policy on sickness matters is also underdeveloped, and the extent to which sick workers will receive support is highly variable and largely depending on whether they, or their employers, have any private insurance cover.
- Regulations on health problems caused by work are also problematic, as they put people with chronic stress and mental health conditions at a particular disadvantage. This is a consequence of ACC reform in the 1970s, cutting a big

divide between injury and illness and resulting in relatively poor care and support for everyone *not* eligible for ACC's injury compensation and services.

The lack of attention to sickness matters is particularly striking. This goes so far that New Zealand, contrary to all other OECD countries, does not even collect any data on sickness absence; the issue is largely ignored in both statistical and real terms. Since support by the government is variable and often low, support for workers and their employers is generally a function of whether or not they have private insurance covering their needs. For instance, some 17-20% of all workers have private income protection insurance that may provide unlimited income support in some cases and will provide return-to-work support in many cases. Stay-at-work support in New Zealand is offered predominantly by providers of Employee Assistance Programmes. About 80% of all larger firms contract such providers and some 30% of small and medium-sized enterprises. In addition to improvements in policy and legislation, therefore, it will be critical to raise coverage of private insurance and stay-at-work supports in smaller firms; tax deductions could be used to make these systems more accessible and affordable for small enterprises.

People with mental health conditions are amongst those disadvantaged most from the structural issues in New Zealand. Moving forward, much could be done to improve the situation. Special focus will have to be given on how to expand the strengths of ACC to a larger part of the population. Expanding ACC is not popular because of concerns on the financial sustainability of the system but the current situation is not acceptable. ACC intervention is often effective because support is flexible, in line with injured people's needs; it involves all relevant actors, i.e. people, their employers and health professionals including general practitioners; and it includes vocational services and return-to-work support. Essentially, there are three options for New Zealand for the future:

1. To expand the coverage of ACC to also include illness, as was always intended when the system was originally introduced;
2. To partially expand ACC to include at least some illnesses such as, for example, all chronic work-related health problems;
3. To learn from the successful features of ACC's approach and introduce as many of them as possible in other employment and income support systems, especially the support provided by Work and Income.

After all, it will be important for New Zealand to better support employers running small and medium-sized businesses; to better support workers on sick leave and with chronic (mental) health problems; and to strengthen monitoring and implementation of existing legislation to improve outcomes and identify needs for further reform. All of this will also require significantly improved data collection in a number of fields, such as on sickness absence, to make the developing Integrated Data Infrastructure more meaningful to support the labour force participation of people with mental health conditions.

Prioritising support for mental health in the employment and welfare system

Several years ago, in 2011, the Welfare Working Group rightly highlighted that "gaps in mental health, rehabilitation and managed care services create costs which inevitably show in the welfare system, not to mention the costs to individuals in terms of their own well-being"; and that "joblessness is particularly harmful to mental and physical health".

Structural and operational reforms to the welfare system in the past few years have been unsuccessful in reducing the number of people with mental health conditions coming off benefits and going into employment. The numbers of people with mental health conditions claiming benefits is gradually increasing, particularly amongst Māori and Pacific people. Some 30% of people on Supported Living Payment and 20% of those on Jobseeker Support have mental health conditions as their primary reason for claiming.

At the same time, there are also many people with mental health conditions claiming welfare benefits whose mental health issues are not recognised by the welfare system. Survey data suggest that between 45% and 55% of all recipients of Supported Living Payment, Jobseeker Support and Sole Parent Support have a mental health condition, almost irrespective of the type of payment. As a result, supports and services offered for many are not effectively matching their needs for employment assistance.

The strong emphasis in recent years on moving people off benefit, using an investment approach aimed at reducing welfare liabilities, does not seem to have helped this group, which has increased as a share of claimants as a result. The fact that services and support pathways are likely to differ depending on the type of benefit a person receives, adds to the problem; in turn, some claimants will see their needs better served than others.

Two problems stand out. First, there is no focus on early intervention for people with mental health conditions and for welfare claimants more generally. Better and non-stigmatising 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. The current pathway to appropriate employment assistance and psychological support is unclear, inconsistent and inequitable. Second, for people who are off from work because of sickness as well as those not employed but not claiming welfare benefits, there is virtually no employment assistance available. This issue must be addressed to prevent hardship and higher societal costs and to ensure better employment outcomes. The chances for people to return to the labour market fall quickly with the time they have been away from work.

Where supports are available, they lack a more integrated approach that combines employment assistance and psychological support or treatment. 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 pilots recognise the need to integrate health and employment services. Many of the pilots also have an urgently needed cultural foundation. This is a promising development, but services are available to only a small share of the population needing them. Integrated health and employment support services should be scaled up and the evaluation findings from promising pilots translated into lasting and structural reform.

One of the problems in this regard is the relative underfunding of the non-government employment sector, in relation to the proportion of operational budget spent on public employment services. Service providers have to cumulate service contracts from different public authorities, with contracts being very different if not contradictory and always very short-term. This inhibits sufficient investment by providers in the right type of support. In the course of pilots, the biggest problem has been service access, due to funding or contractual restrictions – in turn limiting the success and learning from these pilots.

Within the public employment services there is a significant mismatch between individual employment assistance needs and the intensity of case management support they are

being allocated. The latter is often a function of the type of benefit people receive rather than their actual needs. The mental health competencies of staff working in the welfare system also need strengthening. Such training should be mandatory and culturally informed. Case managers also need to increase their understanding of psychological techniques and have easy access to psychological coaching and support services for people claiming benefits.

Ultimately, a national mental health and employment strategy should be developed and implemented addressing policy and funding barriers and helping to build national coverage of evidence-based employment services integrated with mental health treatment.

Conclusion

Policy makers in New Zealand are in a good starting position through a high level of awareness from all stakeholders of the need for action in the mental-health-and-work space and widespread agreement around the main barriers and most promising ways forward. Policy is also moving in the right direction if only, predominantly, through trials, pilots and experiments all over the country which have helped to improve the knowledge base around what can be achieved and how to do it. But assessing systems and policies in New Zealand against the OECD Council Recommendation shows that much remains to be done. Mutual understanding of what should be done has not translated sufficiently into real change. There are many good building blocks within the system but a number of systemic barriers hinder reform and the improvement of outcomes.

OECD's recommendations for New Zealand's policies on mental health and work

Key policy challenges	Policy recommendations
1. Establishing employment as a key target for mental health care	• Shift health spending from somatic to mental health care and from specialist to primary care, and provide more funding for talking therapies, including a scale-up of e-therapies, integrated with employment support. • Ensure equitable access to primary and mental health care for everyone and improve the mental health capacity and the employment focus of primary care. • Develop the primary care sectors' work and workplace competence, and provide guidelines for sickness certification to treating doctors. • Make employment a focus of the health system's quality and outcomes framework, and prioritise employment in national mental health policy e.g. by providing incentives for primary health services to connect with employment support.
2. Helping vulnerable youth to succeed in education and employment	• Step up teachers' mental health competence and address bullying at school more rigorously. • Ensure that comprehensive school-based mental health services are available for all students. • Ensure that adequately equipped and easily accessible Youth One Stop Shops operate in all regions, with comparable service quality. • Resource Youth Primary Mental Health Services adequately and enable them to provide common interventions (such as talking and e-therapies).

Key policy challenges	Policy recommendations
3. Improving workplace mental health and return to work	• Strengthen employer support and obligations to better enforce the health and safety at work act; and increase WorkSafe's mental health competence, its enforcement power and its resources. • Develop a sickness absence policy including collection of absence data; a longer sick-pay period; and an effective return-to-work strategy. • Provide financial incentives for smaller firms to get income protection insurance and to contract an Employee Assistance Programme provider. • Consider expanding ACC to cover illness, fully or partially, or replicate the comprehensive ACC approach in other parts of the (welfare) system.
4. Prioritising support for mental health in the employment and welfare system	• Assess claimants' (mental) health needs quickly irrespective of the type of benefit and primary reason for a claim to ensure effective matching of needs and services. • Provide access to fully integrated psychological and employment support and expand services to people with mental health conditions not claiming a benefit (be they off sick or inactive). • Further improve mental health and cultural competence of welfare staff and improve ease of case managers' access to mental health advisors. • Coordinate service procurement; elongate service contracts to ensure service quality investment; provide incentives for the provision of evidence-based and post-placement employment support.
5. Moving from policy thinking to policy implementation	• Set up a mental health and employment strategy with focus on evidence-based employment service integrated with mental health treatment. • Rigorously evaluate ongoing pilots and trials and their impact on education and employment outcomes and roll out successful pilots nationally to ensure comparable service is available in all regions. • Systematically collect evidence needed for good policy-making, through administrative data as well as regular health and mental health surveys. • Increase the focus on high-prevalence common mental health conditions, with an emphasis on non-stigmatising support rather than diagnosis.