Mental Health Foundation
mauri tū, mauri ora
OF NEW ZEALAND

Social Unemployment Insurance Tripartite Working Group
Ministry of Business, Innovation and Employment
PO Box 1473
Wellington 6145

incomeinsurance@mbie.govt.nz

21 April 2022

Tēnā koe

New Zealand Income Protection Insurance Scheme

Tuia te rangi e tū nei
Tuia te papa e takoto nei
Tuia i te here tangata
Tihei mauri ora
He hōnore, he korōria ki te atua ki te runga rawa
He whakaaro maha ki a rātou kua haere ki te wāhi ngaro
Rau rangatira mā, ānei ngā whakaaro me ngā kōrero nā Te Tūāpapa Hauora Hinengaro

Introduction

Thank you for the opportunity to be provide feedback on the New Zealand Income Insurance Scheme discussion document.

The Mental Health Foundation of New Zealand (MHF) works to improve the mental health and wellbeing of all New Zealanders with a focus on positive mental health; workplace wellbeing; eliminating bullying, prejudice and discrimination; increasing social inclusion; suicide prevention; providing information; and advocating for positive change and social justice. Our workplace wellbeing work provides resources and training programmes to give workplaces the confidence and tools to develop healthy cultures and support the mental wellbeing of their staff.

Phone: 09 623 4810 | www.mentalhealth.org.nz

Units 109-110, Zone 23, 23 Edwin Street, Mt Eden, Auckland
PO Box 10051, Dominion Road, Auckland 1446

The MHF supports the intended outcomes of the proposal, but considers more discussion is needed about whether a social insurance scheme is the best approach. Regardless of whether or not a social insurance scheme is introduced, we endorse wider reforms to support employment (including job loss) such as centralised and intensive employment support and promoting mentally healthy workplaces to promote wellbeing, prevent mental distress and respond appropriately to employees experiencing mental distress. We strongly recommend faster progress to embed evidence-based integrated employment support in health and mental health and addiction services, and to eliminate discrimination and prejudice against people with experience of mental distress in the workplace to help them gain and maintain employment given that discrimination[1] is one of the most significant barriers to employment for people with experience of mental distress.

If a social insurance scheme is implemented by government, the MHF fully supports the coverage for health conditions and disability, including mental distress or 'illness'. We make a number of recommendations in response to the 'health conditions and disability-related' questions (questions 49-66). We are pleased to hear assurances from MBIE officials during a consultation meeting on 29 March that psychiatric diagnosis will not be used as eligibility criteria for access to the scheme.

1. **The MHF supports the intended outcomes of the scheme but considers more discussion is needed about whether a social insurance scheme is the best approach.**

The MHF supports the intended outcomes of the scheme – to:

- Reduce hardship and associated mental distress caused by the loss of employment and income - unemployment (and job loss) is associated with a greater risk of developing a mental illness.[2]

- Help people to find or prepare for 'good' work – work is a significant driver of positive mental health and wellbeing.

- Support people with experience of mental distress or 'illness' to gain/return and maintain employment through financial and non-financial supports – we know work, including voluntary and part-time work, is vital to recovery.

[1] Discrimination is unfair treatment which results in social exclusion (e.g. reduced access to housing, healthcare, and employment)
[2] He Ara Oranga, Report of the Government Inquiry to Mental Health and Addiction (2018). https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf

However, there are a range of options to achieve these outcomes, and there are consequences of the social insurance scheme that have not been fully discussed in the discussion document. Our main concerns, as shared by the Welfare Expert Advisory Group, are:

- it will perpetuate the two-tiered system whereby the newly unemployed received a tax-free high-rate weekly payment (or an ACC payment if an injury) and those who are otherwise unable to work or have reduced capacity to work on a long-term basis received a much lower welfare payment. This will intrench existing inequities.

- Those who will need to access the scheme are the least likely to be able to contribute to it. People on low incomes or part time, unstable or precarious employment may struggle to contribute to the scheme via a levy and this will most likely impact Māori, Pasifika, women and people with disabilities. Such an outcome would not be compliant with the Crown's Te Tiriti o Waitangi obligations. If the scheme progresses, we recommend consideration be given to increasing the employer and state contributions to the scheme for low-income earners or implementing a progressive levy policy.

We recommend further engagement with the health, disability and social sector to explore in full the implications of the scheme and how it compares to other options.

2. The MHF supports wider system reform to support employment and job loss, regardless of whether or not a social insurance scheme is introduced.

Regardless of whether or not a social insurance scheme is implemented, we support wider reforms to help all New Zealanders gain and maintain good work as outlined by the Welfare Expert Advisory Group report and the 2018 OECD report *Mental Health and Work: New Zealand*. These include:

a) **Providing adequate financial support** for all people who are unable to work, whether that be newly unemployed or long-term unemployment.

b) **Providing adequate non-financial support.** We note the proposal includes a case worker to facilitate return to work, but support needs to be accessible to a wider group than for those who can access the scheme. WEAG recommended rebuilding the core employment service functions and active labour market programmes within MSD and to place greater emphasis on early intervention, ongoing pastoral and mentoring support where needed. Both WEAG and the OECD report endorse the scale-up of **integrated health**

and employment supports and services, in particular Individualised Placement and Support for people who access mental health and addiction services.

c) **Promoting mentally healthy workplaces to retain and support staff.** Poor mental health and distress can develop due to workplaces cultures and processes. This includes, for example, lack of job clarity, unrealistic expectations, poor communication, and lack of regular feedback. The MHF's Working Well programmes, resources and campaigns already help employers take a proactive approach to create flourishing workplaces that enhances and protects people's mental health. Similarly, our Culturally Responsive Workplaces resources provide practical tools to help workplaces become more culturally responsive as evidence shows that culturally-inclusive workplaces have a positive influence on mental wellbeing for Māori employees, which can bring economic and social benefits to organisations such as retaining staff, building connections and improving overall wellbeing. Programs such as Open Minds and No Worries, which create inclusive and supportive work environments for people with mental distress, also help to achieve a wellbeing enhancing workplace. We are pleased to see an increased focus on mentally healthy workplaces within WorkSafe and are available to meet with officials to explore how to further embed this work across communities.

d) **Stop people from falling out of work due to mental distress by encouraging workplaces to take a preventive approach**, such as ensuring policies are set up to retain workers with mental distress and there are good structures around return-to-work planning.

e) **End discrimination of mental distress in the workplace to help people gain and maintain employment.** Discrimination is the most significant barrier to employment for people with experience of mental distress[3], whether this be by employers or colleagues, or the structures and cultures within workplaces, that either directly or subtly disadvantage people with experience of mental distress. A 2010 Ministry of Health survey found 33 percent of those surveyed did not apply for jobs because of anticipated discrimination.[4] People with experience of mental illness also ranked 'finding a job' as the biggest single

[3] Mental Health Foundation. 2007. The employment experiences of people with experience of mental illness: Literature review. Auckland, New Zealand.
[4] Wyllie A., & Brown, R. 2010. Discrimination reported by users of mental health services: 2010 survey. Research report for the Ministry of Health. Auckland: Phoenix Research.

area of discrimination. Another 2010 survey of people who had recently used mental health services in New Zealand found people assessed/treated under the Mental Health Act more often reported discrimination in relation to getting a job (and contact with the police).[5] Even during employment, a 2007 New Zealand review found employers and colleagues sometimes responded positively to people becoming unwell, but the majority of those who became unwell at work were treated with hostility and unfairness.[6]

There is good work being undertaken to provide anti-discrimination workplace education and we recommend this be built upon. For example, *No Worries* offers education opportunities for employers and work colleagues designed, coordinated and delivered by people with their own personal experience of mental distress, and *Open Minds* equips managers with the confidence and skills to talk about mental health in the workplace with videos, managers guide, tips, factsheets, posters and FAQs.

3. Te Tiriti of Waitangi

We are encouraged by statements committing to designing a scheme that works for and delivers equitable outcomes for Māori, and embedding a partnership approach to ensure Māori have real authority to develop and implement policies that address Māori needs and respect te ao Māori. We note the scheme will apply the principles of kāwanatanga, tino rangatiratanga and rite tahi. You may wish to consider also applying the principle of wairuatanga. Wairua is a manifestation of custom; an expression of spirituality and a descriptor of psychological wellbeing. Came[7] et al (2020), in their critical examination of health policy development against Te Tiriti o Waitangi, argue "demonstrated policy recognition of Māori custom and wairuatanga may reflect whether Māori have distinctively influenced its development. It may also indicate the exercise of rangatiratanga in the policy development process." We suggest this is a critical component given that good employment and conversely job loss/unemployment is a significant determinant of wellbeing, which in turn should be an important outcomes for the scheme.

---

[5] Wyllie, A., & Lauder, J. 2012. Impacts of national media campaign to counter stigma and discrimination associated with mental illness. Auckland: Phoenix Research.
[6] See Mental Health Foundation. 2007.
[7] Came, O'Sullivan & McCreanor. Introducing critical Tiriti policy analysis through a retrospective review of the New Zealand Primary Health Care Strategy. Ethnicities: Vol. 20(3) 434–456

4. Coverage for health conditions and disability in the scheme

If the proposal for an income protection scheme progresses, notwithstanding our concerns above, we absolutely support full coverage for health conditions or disabilities that cause a loss of work. We know the majority of people with experience of mental health conditions want to work.[8] Employment tends to be followed by greater wellbeing, reduced distress, lower relapse rates, better quality of life, and increased social contact and use of leisure time. Employment of people with experience of mental illness also removes cost from mental health services.

We note the inclusion of health conditions and disability in the scheme would appear to plug a current gap in our system by providing financial support for victims of workplace bullying who suffer from mental distress that reduces their capacity to work. This is helpful given that compensation and support for mental injures as a result of workplace bullying are explicitly excluded from ACC (because they do not relate to a one-off event), compensation through the employment relations pathway is draconian and not adjusted by inflation, and the few individuals who bring a private prosecution under the Health and Safety at Work Act face high costs and low compensation.

We recommend the definition of 'health conditions and disability' be explicit that it includes substance harm and addiction/s.

No restrictions on the types of conditions covered by the income insurance scheme

49. Do you agree there should be no restrictions on the types of health conditions covered by the scheme?

The MHF strongly supports no restrictions on the types of health conditions – pre-existing and newly acquired - covered by the scheme, in line with usual international practice. We agree this will avoid arbitrary distinctions between types of health conditions and will simplify assessment procedures.

It is vital the scheme is provided on the basis of incapacity to work and not based on medical models that define eligibility based on a medical deficit. Having a psychiatric diagnosis should not be required in order to meet eligibility criteria for accessing the scheme as this would generate an unfair burden (that only applies to a specific group). As such the MHF fully supports the application of the social model

---

[8] McLaren, K. 2005. Making employment work for people with experience of mental illness a review of research on the nature of effective employment support services. Mental Health Foundation of New

of disability[9] as a founding concept of the scheme, as recognised by the discussion document, to make clear that a person's eligibility for the scheme is based on their perception of barriers in society that are reducing their capacity for work and not a medical diagnosis. We suggest the social model of disability be incorporated into the definition of 'health conditions and disability.'

Applying a social model of disability suggests coverage of the scheme – and the definition of 'mental condition' – would apply to people experiencing broader experiences of psychological or mental 'distress'. We use the term 'mental distress' to describe people experiencing a far broader range of distress than is captured by the terms 'mental illness' or 'mental illness/es'. By using the term mental distress, it also demonstrates respect for the preferences of those with lived experience, and better reflects Māori and Pasifika views of health and wellbeing.[10] We encourage the Forum to consider the language used and to make clear that a 'mental condition' includes psychological or mental distress.

No restrictions on the working arrangements covered by the scheme

50. Do you agree that all work arrangements should be covered (assuming other eligibility criteria are met)?

From a wellbeing point of view, we agree that all working arrangements should be covered by the scheme. All work, whether it be part time or full time, can contribute to wellbeing and is one of the main ways people participate in society.

Coverage for loss of at least 50 percent of capacity to work, for at least four weeks

51. Should the scheme cover partial loss of earnings due to a health condition or disability reducing work capacity?

Yes. Some individuals who experience mental distress are well enough to work to a certain level and capacity. It would also support people to maintain their social connections and general psychological benefits they may receive from their

[9] The social model of disability, as outlined by the UN Convention on the Rights of Persons with Disabilities (CRPD), asserts that people are disabled by barriers in society, not by their impairment or condition. The barriers can be physical (such as no ramp for a wheelchair user) or attitudinal (such as not offering someone a job because of their mental distress). Disabling barriers hinder people's equal participation in society.
[10] Flett, J. A. M., Lucas, N., Kingstone, S., & Stevenson, B. (2020). Mental distress and discrimination in Aotearoa New Zealand: Results from 2015-2018 Mental Health Monitor and 2018 Health and Lifestyles Survey. Wellington: Te Hiringa Hauora/Health Promotion Agency.

employment while also providing the space they may need in their recovery journey. It may also reduce the likelihood they will need to leave their employment due to any worsening of their health condition.

52. If partial loss is to be covered, do you agree claimants should have at least a 50 percent reduction of capacity to work caused by a health condition or disability and that reduction is expected to last for at least four working weeks?

This would appear to be reasonable for the majority of cases.

We note that a person experiencing mental distress may retain more than 50 percent capacity to work but nevertheless will still be dealing with significant emotional and mental distress and/or distressing circumstances. This is where the ability of employers to sufficiently support staff experiencing mental distress will be important. It is also unclear to us how well assessments will be able to draw accurate conclusions about whether a person's distress will result in at least a '50%' reduction of capacity (as opposed to 40% or 60%).

Some experience of mental distress may be short but very intensive. Some experiences of acute distress may be shorter than 4 weeks, so, if they are not covered by the scheme, it will be important that employers are sufficiently able to support staff through adequate sick leave policies and other appropriate entitlements such as flexible working where they do not meet the 4-week threshold but have reduced or no capacity to work.

Claimants' medical practitioners would assess work capacity, with final eligibility assessed by the scheme administrator

53. Do you agree that the claimants' health practitioner should be the main assessor of work capacity?

We are concerned about the ability for already stretched GP services to be able to train for and administer assessments for the scheme. We are also concerned the cost of visiting a GP for an assessment may be prohibitive for low incomes earners, and that not everyone is registered with a GP or has a GP they trust and have a good relationship with, who is able to fully understand their distress and circumstances. We recommend consideration be given to a range of people and providers that are able to provide assessments, including those in the mental health and addictions workforce.

We are also concerned the process to get and undertake an assessment might be distressing in and of itself, and consideration will need to be given to suitable support options and safeguards.

We recommend there are clear guidelines in place to ensure personal information, including sensitive and confidential information, provided to assessors by employees is not shared, without consent, with employers, and is handled and stored by the scheme administrators lawfully and ethically.

An alternative, and less administratively burdensome model, could be to restrict eligibility criteria to payment into the scheme over a period of time and then allow for self-assessment of the need for support. The outcome of the self-assessment would trigger a staggered set of flexible interventions delivered on the basis of perceived need to support people to return to work.

As a guiding principle, and in line with the proposed parity principle in the Pae Ora (Healthy Futures) legislation, we would not expect any requirements to be placed on those accessing the scheme due to mental distress that are not also reasonable requirements for those accessing the scheme for physical health conditions.

54. Do you agree that, where appropriate, employers could provide supporting information to inform the claimant's work capacity assessment process?

In most cases this would be a practicable approach. However, this arrangement could be compromised where there is a breakdown in the relationship between the employer and employee, for example where there is a complaint made about the employer.

Are the current requirements on employers to make workplace changes sufficient to allow health condition and disability claimants to return to their regular employment (or alternative work)?

We consider there is scope to improve employer perceptions and knowledge of their obligations to make changes to the work environment and return-to-work support to meet an employee's needs in relation to a disability. New Zealand research found most of the special arrangements made for employees in the workplace, due to their experience of mental illness, were around increased flexibility of working hours, work location and sick leave arrangements.[11] This research

[11] WEAG. 2019. Current state: the welfare system and people with health conditions and disabilities. Paper prepared for the Welfare Expert Advisory Group (WEAG), Wellington.

found these accommodations are generally no greater than the arrangements other employees have to accommodate various aspects of their lives (e.g. long-term physical conditions or impairments, children), are not onerous to implement and manage, and are not costly, but are the most effective accommodations for supporting people with experience of mental illness to work positively and successfully.

56. How could employers be supported to help workers with health conditions or disabilities to remain in or return to work?

We recommend better information and education for employers about how to integrate best practice support for people with experience of mental distress, as well as funding and access for employers to offer supervision, counselling and life coaching to their employees to remain or return to work.

In particular, as part of the return-to-work plan and reasonable accommodation (outlined above), employers need to be supported to provide long-term support options for workers. The lack of on-going mental health support when a person is in employment is a significant barrier for people with lived experience of mental distress. People with lived experience may need support to help manage practical challenges; such as managing mental illness (both symptoms and medication side-effects), accessing appointments with mental health and addiction services during work hours, managing workplace culture and navigating policies and practices, and managing workplace discrimination and stress.[12] Support during employment must be long-term and not just at the beginning of employment in order to help people sustain employment and reach long-term employment goals.

Employers would be expected to make reasonable efforts to keep a job open where a return to work within six months is likely

57. Where an employee must stop work entirely because of a health condition or disability, do you think employers should be expected to keep a job open and help with vocational rehabilitation where a reasonable prognosis is made of return to work within six months?

[12] Gladman, B., & Waghorn, G. 2016. Personal experiences of people with serious mental illness when seeking, obtaining and maintaining competitive employment in Queensland, Australia. Work (Reading, Mass.), 53(4), 835–843.

We think it is reasonable that employers should be expected to keep a job open for six months. This gives someone experiencing mental distress critical time to get well and stay well without pressure or expectation and knowing they have a job to come back to will support them on their recovery journey.

58. Should this be a statutory requirement placed on employers or an expectation?

We would support a statutory requirement that is backed up with appropriate training and support for employers to meet this obligation.

Specific obligations for claimants with a health condition or disability

65. Should claimants with health conditions or disabilities be subject to obligations to participate in rehabilitative programmes and other support, where appropriate?

Vocational rehabilitation is important, but a blanket obligation could create added stress and anxiety for someone recovering from a period of mental distress. Employees being cared for in inpatient or respite services may also have reduced ability to access vocational rehabilitation. We recommend vocational rehabilitation be provided as an option for employees. Again, we would not expect any requirements to be placed on those accessing the scheme due to mental distress that are not also reasonable requirements for those accessing the scheme for physical health conditions.

66. Should claimants with health conditions and disabilities be subject to obligations to search for work or undertaking training where they are able to?

As above. Most people with experience of mental distress want to work, but a blanket obligation will not be appropriate for everyone and could exacerbate symptoms of distress and impede recovery. It is imperative that appropriate supports and programmes are available as currently they are not - as outlined earlier, it is crucial there is increased access to integrated employment support for people with mental distress.

Summary

Thank you again for the opportunity to provide feedback on this proposal. If you have any questions, in the first instance please contact Olivia Stapleton, Policy and Advocacy Manager, by email at olivia.stapleton@mentalhealth.org.nz.

Mauri tū, mauri ora,

Shaun Robinson
Chief Executive Officer