MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

05 JAN 2021

On 16 October 2020, you emailed the Ministry of Social Development (the Ministry) requesting, under the Official Information Act 1982 (the Act), the following information:

1) *Any information on how the rollout of the work to improve outcomes for those with physical and mental health issues went with its implementation between 2014-19: www.msd.govt.nz/about-msd-and-our-work/publications-resources/ research/welfare-reform-health-disability/working-differently-with-people-with-health-conditions.html.*
2) *What ongoing screening or surveying does the Ministry currently undertake with clients?*

On 23 October 2020, you refined your request to the following:

1) *Any reviews/feedback on changes to working with those with physical/mental health challenges (implemented in the mid-2010s).*
2) *What screening and mental health monitoring for clients is currently used?*

On 10 November you further clarified your request to the following:

- Regarding question one, you are seeking information regarding the years 2014, 2015 and 2016.

On 23 November 2020, the Ministry advised you that the Ministry requires more time to respond to your request.

For clarity, I will respond to your questions in turn.

1) *Any reviews/feedback on changes to working with those with physical/mental health challenges (implemented in 2014, 2015 and 2016).*

Please find enclosed the following documents relevant to this aspect of your request:

- Draft Summary report – *2012 Welfare Reform – what happened and what was the impact?* (no date)
- Evaluation Report – *Work Focused Case Management for clients with a health condition or disability (WFCM: HCD)*, dated March 2014

- Evaluation Report – *Young SLP Opt-In Trial*, dated October 2015
- Evaluation Report – *Young SLP Opt-In Trial*, dated December 2016
- Report – *Outcomes after Project 300*, dated March 2017
- Memo – *Work to Wellness evaluation*, dated 8 May 2018
- Evaluation Report – *Work to Wellness – Qualitative evaluation 2018* (no date)

You may also be interested in the Individual Placement and Support (IPS) trial, which supports people with severe mental illness into employment. The Ministry implemented a trial of the IPS model from 2018 onwards. The IPS model seeks to provide integrated, long-term employment and mental health support. This model differs from the Work to Wellness service and seeks to address some of the challenges that were found in the Work to Wellness evaluation. It also aligns with the recommendations in the OECD (2018) Mental Health and Work report, available at: www.oecd.org/newzealand/mental-health-and-work-new-zealand-9789264307315-en.htm and the Welfare Expert Advisory Group Report (see reference below). Please note, data about the effectiveness of Work to Wellness has not yet been analysed but will be available in the Ministry's upcoming Employment Assistance Effectiveness report.

Note that the Ministry has endeavoured to locate all documentation relevant to your request but accepts that some documents may be missing.

You will note that the names of some individuals are withheld under section 9(2)(a) of the Act in order to protect the privacy of natural persons. The need to protect the privacy of these individuals outweighs any public interest in this information.

The following documents relevant to your request have been published and are, therefore, not provided under section 18(d) of the Act as they are publicly available. Please find a list of these documents below. The documents can be accessed via the links provided:

- Evaluation Report – *Effectiveness of contracted case management services*, dated December 2016, available here: www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/evaluation/effectiveness-of-contracted-case-management-services-mhes-and-spes-trial-evaluation-report-july-2018.pdf.
- Evaluation Report – *Return to Work Programme for stroke survivors*, dated August 2018, available here: www.msd.govt.nz/about-msd-and-our-work/publications-resources/evaluation/return-to-work-stroke-survivors/the-return-to-work-programme-for-stroke-survivors.html.
- Report of the Government Inquiry into Mental Health and Addiction – *He Ara Oranga*, dated November 2018, available here: www.mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf.
- Report – *What happened to people who left the benefit system during the year ended 30 June 2014*, dated December 2018, available here: www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/research/benefit-system/people-leaving-benefit-system-print.pdf.
- Welfare Expert Advisory Group Report – *Whakamana Tāngata – Restoring Dignity to Social Security in New Zealand*, dated February 2019, available

here: www.weag.govt.nz/assets/documents/WEAG-report/aed960c3ce/WEAG-Report.pdf

- Report – *What happened to people who left the benefit system during the year ended 30 June 2016*, dated February 2020, available here: www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/research/benefit-system/what-happened-to-peopole-leaving-the-benefit-system-2016.pdf.
- Action Plan – *Working Matters*, dated July 2020, available here: www.msd.govt.nz/documents/what-we-can-do/disability-services/disability-employment-action-plan/working-matters-2020-spreads.pdf

I will now respond to your second question.

2) *What screening and mental health monitoring for clients is currently used?*

The Ministry does not screen or monitor clients' health conditions or mental health, as the Ministry's case managers are not clinical staff. Your request for this information is, therefore, refused under section 18(e) of the Act as this information does not exist.

However, the Ministry provides support services that staff can access for advice when dealing with a client with poor mental health. For example, staff can contact the Mental Health Advice Line. The Mental Health Advice Line is a phone line providing advice on a 24 hour, seven day basis to staff interacting with clients with possible mental health issues. Experienced and registered mental health nurses are available to talk over a client's situation and give advice on resources, services, tools and techniques that can be used when working with these clients.

Furthermore, the Ministry provides direct supports and services to clients with poor mental health. These services recognise the growing trend of people suffering from poor mental health and wellbeing. For example, Puāwaitanga is a phone and online based service provided by Homecare Medical, a social enterprise who run the national telehealth services which offer free health, mental health and addiction support across digital channels. Puāwaitanga support people to improve their emotional wellbeing, which in turn may be impacting on their ability to find or keep a job.

The Ministry have been working with Homecare Medical to test their Puāwaitanga service to see if it can support clients to improve their emotional wellbeing. This is part of a range of services the Ministry are testing and trialling to improve outcomes for clients in receipt of Jobseeker Support – Health Condition, Injury or Disability (JS-HCD).

The principles and purposes of the Official Information Act 1982 under which you made your request are:

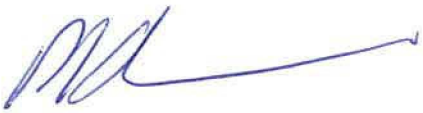
- to create greater openness and transparency about the plans, work and activities of the Government
- to increase the ability of the public to participate in the making and administration of our laws and policies
- to lead to greater accountability in the conduct of public affairs.

This Ministry fully supports those principles and purposes. The Ministry therefore intends to make the information contained in this letter and any attached documents available to the wider public. The Ministry will do this by publishing this letter and attachments on the Ministry of Social Development's website. Your personal details will be deleted and the Ministry will not publish any information that would identify you as the person who requested the information.

If you wish to discuss this response with us, please feel free to contact OIA_Requests@msd.govt.nz.

If you are not satisfied with this response regarding reviews or feedback on changes to working with those with physical or mental health challenges, you have the right to seek an investigation and review by the Ombudsman. Information about how to make a complaint is available at www.ombudsman.parliament.nz or 0800 802 602.

Yours sincerely



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Insights MSD

Draft Summary Report – 2012 Welfare Reform – what happened and what was the impact?

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Summary

The 2012 Welfare Reform Package

- Government was concerned about the social and economic costs of New Zealand's welfare system
- A welfare working group was established with a focus on reducing welfare dependency
- The welfare reform package was a mix of obligations and sanctions, changes in the way people on benefit were supported and changes to how MSD operated:
  - the Youth Service aimed to improve outcomes for young people not in employment, education or training.
  - a range of new obligations and sanctions aimed at improving the work focus of the welfare system
  - changes aimed at better determining and providing the right support to encourage people into work. These included a new service delivery model, trialling new approaches, simplifying the benefit categories, and changes to the assessment processes for those with health conditions or disabilities.
  - the use of social obligations to change the behaviour of parents on benefit to improve outcomes for them and their children
  - Welfare Reform introduced changes to the way MSD operated to help reduce welfare dependency. The investment approach and the annual actuarial valuation were to be used to guide decisions about where to invest resources to reduce long term liability. There was greater operational flexibility but it was also intended there would be greater accountability.

The impact of the changes

- Overall welfare reform appears to have played a part in reducing numbers on benefit
- Some progress was made towards meeting BPS 1: Reducing long-term welfare dependency. While there were reductions in overall numbers on benefit, Māori were still overrepresented on benefit
- The Work Focused Service Delivery Model appears to have worked for some, especially sole parents. There were some groups that were less likely to benefit from intensive case management services (e.g. those close to the labour market and those furthest from the labour market). Further work is needed to understand the quality of the service that General Case Management clients receive and what improvements could be made. MSD needs to better understand case management within the New Zealand welfare context.
- Obligations and sanctions for clients under Welfare Reform were not evaluated
- Different ways of working with sole parents and clients with multiple barriers were trialled with mixed results
- The impact of welfare reform changes for people with health conditions or disabilities is unknown but likely to have been limited. MSD has a better understanding of people on benefit with disabilities or health conditions but there is more to learn.
- There was no evaluation of the implementation of the social obligations or their impact.
- There were small positive impacts for high and very high risk NEET[1] service participants but not for lower risk participants. Overall the Youth Service (NEET) was not effective in improving the outcomes of most participants over the 24 month follow-up period.
- Further work was needed to better understand the client experience of Welfare Reform and subsequent changes.
- MSD has not evaluated the impact of the changes to institutional arrangements (e.g. the investment approach, the MCA, research and evaluation). Several commentators have discussed the pros and cons of the Investment Approach. Several have stated the value in using large data sets to better understand the population on benefit to improve ultimately improve supports and services for them. However commentators have also outlined the limitations of the Investment Approach as it is currently implemented at Ministry of Social Development (MSD).

[1] Not in employment education or training.

- Other changes accompanied Welfare Reform which will have had an impact on benefit recipients (e.g. introduction of measures to reduce fraud in the welfare system, changes to social housing, a new approach to engagement with employers, a new approach to community investment, simplification).
- The OECD and others have identified best practice in implementing large scale reforms in the public sector. They may assist the design and implementation of future reforms in New Zealand.

Part A: the 2012 Welfare Reform Package

Background to the changes

Government was concerned about the social and economic costs of New Zealand's welfare system

At the time Welfare Reform was introduced the social and economic costs of New Zealand's welfare system were considered to be high:

- Over 12 per cent of the working age population received a benefit and 170,000 people had spent the majority of the last 10 years receiving a benefit. Unemployment was seen as detrimental to the economic and social wellbeing of individuals, families and the wider community.
- The social and intergenerational consequences of having 222,000 children growing up in benefit dependent households were deeply concerning (Welfare Working Group, 2010). Research indicated that children from poor households have worse outcomes than children from more advantaged households. Low levels of income are associated with negative impacts on child health.
- Welfare costs were high. In the year to June 2010, in total $7.78 billion was spent on the benefit system, which represents roughly 12.0 per cent of core Crown expenses and approximately 4.1 per cent of Gross Domestic Product (GDP) (Welfare Working Group, 2011: 39).

A welfare working group was established with a focus on reducing welfare dependency

The Welfare Working Group (WWG) was set up in April 2010. Its primary task was to identify how to reduce long-term welfare dependency. Their focus was on three groups: sole parents, sickness and invalid beneficiaries, and youth. WWG's mandate was to examine:

- Ways to reduce benefit dependence and get better work outcomes;
- How welfare should be funded, and whether there were things that could be learned from the insurance industry and ACC in terms of managing the Government's forward liability;
- How to promote opportunities and independence for disabled people and people with ill health;
- Whether the structure of the benefit system and hardship assistance in particular was contributing to long-term benefit dependency

When the group reported in February 2011, it presented 43 recommendations centred on eight key themes to improve lifetime outcomes for people at-risk of long-term welfare dependency (WWG, 2011). The themes were a stronger work focus for more people; reciprocal obligations; a long-term view; committing to targets; improving outcomes for Māori; a cross-Government approach; improving outcomes for children and more effective delivery.

In moving to a work-focused welfare system, the Welfare Working Group recommended:

- an increased emphasis on prevention, through access to appropriate and effective cross-sector services, including health and education;
- replacing existing benefit categories with a single payment called 'Jobseeker Support';
- reform of second and third tier assistance provisions that discourage recipients from moving into work or lead to poor outcomes;
- increased, clearer expectations for more people in the welfare system to look for paid work;

- low-cost assistance and clear expectations to help those that are work ready;
- more active delivery and up-front investment for those most at risk of avoidable long-term welfare dependence, in order to minimise the long-term costs of welfare;
- better support for people with no ability to work;
- focus on improved outcomes for children; and
- more effective delivery and expanded use of the private and community, not-for-profit sector agencies to deliver employment services.

The Group also recommended that Government initiate a formal partnership with Māori leaders, with associated goals and strategies, designed to result in enduring increases in Māori employment

Key parts of the welfare system received no or limited attention from the WWG

The WWG did not look at superannuation, the tax/benefit interface and in particular Working for Families and benefit rates in its work. Benefit rates and benefit adequacy were specifically excluded from the scope of the work (O'Brien, 2017). This limited the nature of the policy issues under investigation and, therefore, the range of policy options that could be evaluated.

The focus was on people being in paid work. This has been criticised as devaluing the important role of unpaid work in the community (e.g. caring for children or people with health conditions or disabilities). Jackson (2011) argued that the focus on paid work paid to little attention other important aspects of wellbeing (e.g. social cohesion, personal self-worth and social identity).

The WWG was also criticised for not explicitly addressing the state of the labour market (e.g. availability and quality of jobs) or of the skills of beneficiaries despite a sustained period of significant unemployment. The focus placed on the lives, behaviours and circumstances of beneficiaries overlooked the root causes of the poverty they experienced (O'Brien; 2013). Jackson (2011: 29) stated *"much welfare dependency is generated by the economic system, not personal characteristics. Personal characteristics still matter, but they influence who needs welfare, not the total amount needed".*

The reforms were developed followed the WWG recommendations

Cabinet papers outlined the intended impacts of the reforms. The Welfare Reform changes were intended to result in a system that (Cab Paper A):

- reduced benefit dependency
- was work-focused and expected and rewarded independence
- was more flexible, and supported an investment approach, focusing resources where the returns are greatest
- was able to work with as many people as possible to support them into work
- reinforced social norms and improved outcomes through the introduction of social obligations for parents.

The changes were a mix of obligations and sanctions, changes in the way people on benefit were supported and changes to how MSD operated. Changes took place in three key implementation stages (July 2012, October 2012 and July 2013), the intention being that all stages would work together to make the benefit system more pro-active and work focused.

Some WWG recommendations were not followed. For example, the WWG had recommended the establishment of a delivery agency, Employment and

Support New Zealand to implement the new approach. This was not implemented.

Youth Service was the first component introduced

The Youth Service package, introduced in 2012, was an attempt to balance support and obligations in ways that would improve social outcomes for young welfare recipients. Such recipients were at high risk of long-term benefit dependency. The Youth Service was designed to encourage and assist disadvantaged youth to stay in education and achieve qualifications. Service providers were contracted to deliver the Youth Service while MSD continued to administer benefit entitlements for young people. It was available to all young people aged between 16 and 18 years who receive financial assistance from Work and Income (Youth Payment (YP) and Young Parent Payment (YPP)) as well as other young people who were not engaged in employment, education or training (NEET).

To improve outcomes for these young people the Youth Service provide intensive wraparound support to help young people achieve in education and transition into further study, or training or employment. Young people were required to engage with their youth coach, engage in full time education, and attend budgeting and parenting courses (where appropriate). Young people participating in the Youth Service could receive incentive payments for successfully meeting their obligations, or could be sanctioned if they did not comply.

In October 2016 the Youth Service was extended to 18 and 19 year old beneficiaries who were at risk of long term welfare dependency (Mackenzie, 2018). The rationale was that these young people had similar characteristics to their younger counterparts in the Youth Service and would therefore benefit from access to the service.

There was a range of new work focused obligations and sanctions

These new obligations and sanctions were aimed at increasing the work focus of the welfare system and included the following:

- A wider range of people were required to complete some activities before receiving a benefit (e.g. all people accessing work-tested benefits)
- The new work or work preparation obligations and rules varied for different people and at different times and depending on different situations. However, unless there was a good reason for clients not to meet their obligations, their benefit could reduce or be stopped. If they had dependent children, and were sanctioned their benefit would reduce by 50 per cent. This was a greater consequence than previously.
- Beneficiaries required to look for work were expected to accept suitable jobs unless they had a good reason, or their benefit may reduce or stop. They were expected to be able to pass pre-employment drug tests if referred to drug testable jobs. There were changes to overseas travel rules provided an opportunity to improve the work focus of the benefit system.

There were changes aimed at better determining and providing the right support

Introduction of a new Service Delivery Model

In September 2012 a new Service Delivery Model (SDM), including Work-Focused Case Management was implemented as a pilot in 24 MSD offices and introduced to all Work and Income Service Centres and Community Link sites across the country as part of the wider Welfare Reform changes in July 2013.

The SDM was intended to support the delivery of Welfare Reform by grouping clients into different services, enabling more resources to be targeted towards those clients with the highest risk of long-term benefit dependency (eg sole parents) and away from low liability clients (eg new job seekers). It also intended to test the cost-effectiveness of new interventions and services.

In line with the WWG recommendations[2], the model had different levels of intensity of support reflecting how MSD would work with clients based on their expected patterns of future benefit receipt. Clients with the highest risk of long-term benefit dependency were to receive the more intensive services (ie case managers would have fewer clients allocated to their caseload).

Under the new approach, beneficiaries with a higher risk of long-term benefit dependency were identified and provided within intensive one-to-one support. The intensity of service a beneficiary received depended on how much support they needed to find a job. The model had four components:

- **Work-focused case management (WFCM):** applied to beneficiaries with work obligations who had a high future liability (defined in terms of likelihood of long-term benefit receipt) or existing long-term dependency, the potential to become independent and significant barriers to employment. A case manager took a proactive role in addressing specific challenges and barriers to employment through regular 1:1 engagement and use of a range of products and services. Caseloads are capped at 121 clients for every case manager.
- **Work-search support (WSS):** Where it was evident that a client was likely to move into employment but requires a low level of support they would be managed through less intensive engagement such as group activities and phone calls. WSS involves a structured sequence of job search seminars with clients. Caseloads are capped at 215.
- **General case management (GCM):** applied to beneficiaries who did not have work obligations (e.g. IB recipients; DPB recipients with a child under the age of five years). In general case management, case managers supported beneficiaries who were required to prepare for work and assisted them in identifying and progressing with steps to get ready to do this. For those who are highly unlikely to achieve a work outcome, the service only involved the maintenance of income support payments. GCM has no caseload cap. Caseloads are generally higher than WSS and WFCM
- **Self-service:** a feature of the new model was the ability to transfer transactional tasks to an online environment where a client could self-manage their own account, releasing internal resources for more work focused interventions. The self-service model was implemented in July 2013.

It was intended that the new *Service Delivery Model* would be expanded across the country from July 2013, following the implementation of the next phase of reforms to the social security system.

MSD trialled new approaches to working with clients to move them into work

These included

- Service trials commissioned by the Work and Income board[3]
- Contracted out case management trials for sole parents and people with mental health conditions
- Work Focused Case Management- health conditions or disabilities (WFCM-HCD) trial. This was part of a phased approach to introduce

[2] The WWG (Rebstock, 2011) found most MSD employment assistance, including case management, went to those unlikely to remain on welfare long term. The WWG recommended that MSD better align the level of employment assistance to the expected future liability of the people receiving income support.

[3] These were Auckland - Domestic Purposes Benefit sole parents; Bay of Plenty - Sickness Benefit clients with a musculoskeletal condition; Wellington - Sickness Benefit clients with a mild to moderate mental health condition; Nelson - Sickness Benefit clients with a mild to moderate mental health condition

beneficiaries in receipt of health and disability-related benefits to the work-focused case management model.

Benefit categories were collapsed into three benefits

The creation of the three simplified main benefits – two with a strong work focus - was intended send a strong signal to the public, beneficiaries, and case managers that the benefit system is undergoing a fundamental change to focus on work for more people, while maintaining a clear distinction with those who were not expected to be available for work. The three categories were:

- *Jobseeker Support (JS):* this included Unemployment Benefit (UB), Sickness Benefit (SB), Domestic Purposes Benefit (DPB) - Women Alone, DPB - Sole Parent if the youngest child was aged 14 and over and Widow's Benefit – without children, or if the youngest child was aged 14 and over.
- *Sole Parent Support:* this included DPB if youngest child aged under 14 and Widow's Benefit – if the youngest child was aged under 14
- *Supported Living Payment:* this included Invalid's Benefit and DPB – Care of Sick or Infirm

Changes to the assessment processes for those with health conditions or disabilities (HCD)

The new work-focused JS benefit was to be supported by new assessment processes that identified the level of work expectation and support that was appropriate for sick and disabled beneficiaries. It was seen as particularly important to maintain the gateway to the benefit where there were no requirements to be available for work.

People on Job Seeker Support – Health Conditions or Disability (JS-HCD) were required to undergo a staged assessment to identify their ability to work and the support they needed to work. This included:

- *a self-assessment questionnaire* to collect the person's view on their ability to work and the supports and services they needed to prepare for or find and stay in work.
- a *medical certification process*, which focused on what people could do at work with appropriate services and supports. As with SB prior to Welfare Reform people on JS-HCD were required to submit a medical certificate at four and eight weeks after grant 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) did not give clarity about what someone could do or the help they needed to work, an *independent Work Ability Assessment (WAA)*.

People were then streamed into case management services. There were priority rules for clients to enter WFCM-HCD[4].

Social obligations and other steps to improve child welfare outcomes

To improve child outcomes, beneficiaries with dependent children were required to take all reasonable steps to make sure children get health checks and education. This included making sure children

[4] To be selected for WFCM-HCD, clients must: have a current benefit status, be aged less than 60 years, and be in receipt of JS-HCD with 'work preparation' work obligations. Clients are prioritised for service based on a model that predicts which clients are most likely to benefit most from WFCM-HCD. These insights are based on which clients have had the most benefit from WFCM-HCD in the past.

- participated in early childhood education for 15 hours a week from the age of three,
- were enrolled with a doctor,
- received their core Well Child/ Tamariki Ora checks and
- were in school if they were of school-age.

Also included were:

- measures to discourage people having additional children while on benefit
- measures to encourage sole parents to verify their relationship status
- providing access to Special Needs Grants for long acting contraceptives (LARCs)

Welfare Reform introduced changes to the way MSD operated to assist reducing welfare dependency

The measures were put in place to help direct spending to where it would make the largest difference to long term liability and to improve accountability.

Use of the Investment Approach

The essence of the investment approach was about *"getting better outcomes for clients from making better choices about what programmes and services are available, how they're designed and delivered, and for who"* (Ministry of Social Development, 2017; 23). It was expected that making investment decisions that improved client outcomes would lead to a reduction in the long-term costs to government.

In the context of MSD this meant targeting employment services and supports towards people at high risk of long term benefit receipt who were amenable to moving into work. The benefit population was segmented to give insight into different patterns of life time benefit receipt and risk factors and to enable a more systematic approach to service delivery. The focus was to be on supporting the right client at the right time to reduce long-term benefit dependency. The intention was for MSD to work with a wider range of clients, with a wide range of service requirements and potential barriers to employment.

Annual actuarial valuation of future liability which was publicly reported

The Cabinet Social Policy Committee agreed

> *"[The Ministry's] ... performance will be measured through increasing the impact that [the Ministry] has on future liability. This was to be achieved through increasing the number of people moving off benefit into employment and reducing the numbers moving onto benefit"* [SOC Min (11) 21/1 refers].

The actuarial Investment Approach was to be a key of measuring progress. Annual valuations, produced by independent actuaries, were to report on changes in the future liability of the benefit system based on new benefit categories and associated work obligations and identify the factors that drove annual changes in the liability. The changes in the annual liability and specifically the proportion of that change under 'management control' would provide an important accountability measure for MSD.

Prior to this, performance primarily focused on how well MSD worked with Unemployment Benefit (UB) clients. Under Welfare Reform resources were to be directed towards those areas that most contributed to reducing welfare dependency and the future liability. It was a first step in linking MSD's service

delivery and strategic direction to the key drivers of the long-term benefit valuation.

There was increased accountability

New expectations on MSDs performance (e.g. BPS targets)

In 2012 ten Better Public Services (BPS) result areas were set for the public sector to achieve over the following three to five years. MSD was responsible for co-ordinating the cross-agency response to the BPS target 1 – Reduce the number of people who have been on a working age benefit for more than 12 months. Welfare Reform was expected to reduce long-term welfare dependency but also influence other Government results areas (e.g. Increase the proportion of 18 year olds with NCEA level 2 or equivalent qualification; Increase infant immunisation rates and reduce the incidence of rheumatic fever; Increase participation in early childhood education)

It was intended that holding MSD accountable for BPS 1 would ensure that transfers of operational funding were made in a way that was consistent with their achievement and government priorities. It was anticipated that:

- external performance expectations would cascade down to regional and site level, providing a clear line of sight between core service delivery and high-level outcomes.
- there would be a critical shift in performance expectations for the frontline – client: case manager caseloads would be driven by the overall liability and amenability of specific client groups.

A Work and Income Board was appointed by Ministers but was short-lived

The Work and Income Board was to oversee the implementation of the investment approach to welfare. The Board was tasked with responsibility for ensuring accountability and overseeing the delivery of reforms that would see fewer people on welfare for long periods. They helped make decisions about which interventions worked best for individuals and oversaw trials to collect best evidence. The Work and Income Board advised and supported the Chief Executive of MSD on the implementation of welfare reforms and reported to the Minister for Social Development, Minister of Finance and Minister for State Services on the performance of MSD (Work and Income). The Board was dis-established in December 2015.

External monitoring of MSD with respect to its performance against the future liability from 1 July 2012

The Treasury was appointed as the External Monitor to comment to the Minister of Finance and the Minister for Social Development.

Monitoring and evaluation was seen as important

This was essential to assist in deciding whether to stop, continue or expand current interventions or trials.

More operational and financial flexibility and better data

Financial and operational flexibility to target funds (and service responses) to those groups with amenable risk profiles

In 2014 a new Multi-category Appropriation (MCA) was introduced for employment assistance. The MCA enabled greater financial flexibility by allowing MSD to refocus funding to investments that improved employment outcomes, while disinvesting in services that proved ineffective. A critical element of this flexibility was achieving understanding of what works for different groups of people through trialling different approaches. The MCA also required strong accountability measures and expected that the Ministry of Social Development would provide the evidence of what works best.

Agreement to improve access to information to support the investment approach and service delivery model

Greater use was to be made of information from across MSD and other agencies to accurately target interventions toward higher-risk clients.

Part B: Impact of Welfare Reform

Overall welfare reform appears to have played a part in reducing numbers on benefit

At the time the reforms were introduced it was estimated the overall programme of welfare reform could result in fiscal savings to the Government in the order of $1 billion over four years, and between 28,000 and 46,000 fewer people receiving benefits by 2015/16, depending upon economic conditions.[5]

The 2016 valuation reported that the welfare reform policy and operational changes have had a significant impact on benefit take-up over the past number of years, with flow on financial savings (Taylor Fry Ltd, 2016).

Compared to pre-reform baseline forecasts in the 2012 valuation, there has been a cumulative reduction in payments of $2.07 billion over four years. About 70% of these savings can be attributed to Welfare Reform policy and operational changes (Taylor Fry Ltd, 2016).

The 2016 valuation reported that numbers of beneficiaries and their expected duration on benefit (as at June 2015) are as follows:

- Since 2012, Jobseeker segment numbers have reduced by 14%, with a relatively larger reduction in the JS-WR segment. Expected number of future years on main benefits were slightly shorter; one fewer year for JS-HCD clients.

[5] Paragraph 45, https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/regulatory-impact-statements/ris-welfare-reform-phase-one-social-security-amendment-bill-no1-.pdf

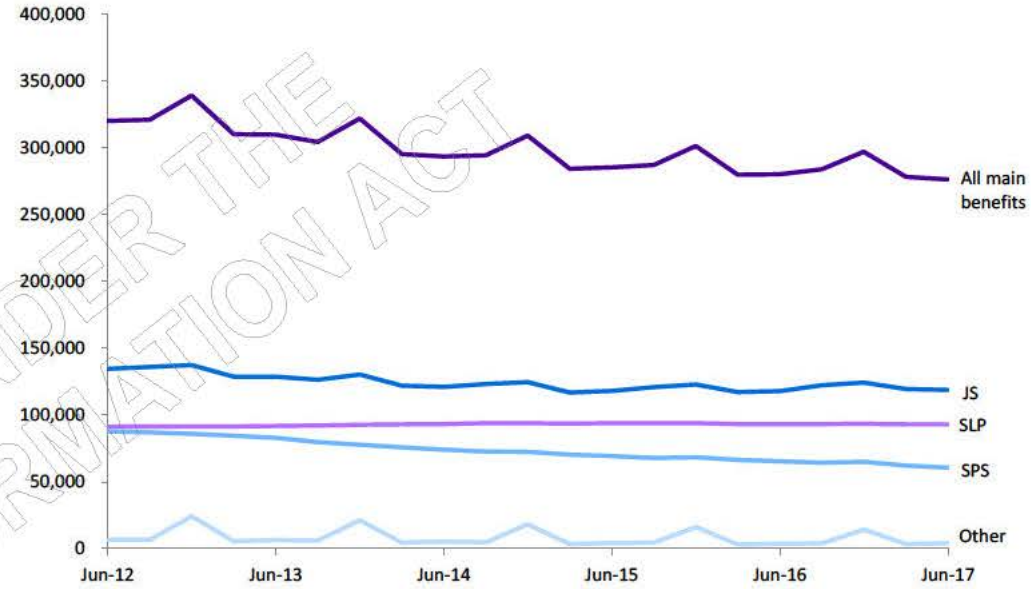
- Numbers in SPS 5-13 segments were down 25%, while numbers in other SPS segments were 24% lower. Current SPS clients were expected to spend over 2 years less on benefit.
- SLP numbers were 1% higher (Carers +13%), with small changes in duration.
- Youth segments had 7% fewer clients, with a large substitution from YPP to YP. Average future duration on benefits was 2.4 years less (3.5 for YPP).
- Future duration on main benefits for Supplementary only clients had reduced, by about a year. However, their expected time on Supplementary only benefits had increased by one-and-a-half years (Taylor Fry Ltd, 2016).

Some progress was made towards meeting BPS 1: Reducing long-term welfare dependency

Consistent with the valuation numbers of working-age people receiving main benefits in June 2017 were lower than in June 2012 (Figure 1). SPS recipients had experienced the largest decline.

Changes in benefit numbers over this period largely reflect changes in economic conditions, and an increased focus by Work and Income on moving job seekers into paid work. However it is important to note not everyone who moves off benefit moves into work (SUPERU, 2017). Moreover those in work are not necessarily in a good quality job.

Figure 1: Quarterly main benefit numbers, June 2012 to June 2017



Note 1: Working-age people are aged 18 to 64 years. This definition reflects the minimum age of eligibility for most main benefits and the age of qualification for New Zealand Superannuation.

Note 2: Jobseeker Support (JS), Supported Living Payment (SLP), Sole Parent Support (SPS).

Note 3: Other includes Youth Payment (YP), Young Parent Payment (YPP), Emergency Maintenance Allowance (EMA), Emergency Benefit (EB), Jobseeker Student Hardship (JSSH), Widow s Benefit Overseas (WBO), and Sole Parent Support Overseas (SPSO).

SOURCE: MSD https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/statistics/benefit/archive-2017.html#Allmainbenefits2

While there were reductions, Māori are still overrepresented on benefit

The WWG report stated that Māori in particular were over-represented on assistance and had low rates of employment and high rates of poverty. They argued that for welfare reform to work, it needed to work for Māori and expected a large and significant improvement in the outcomes for sub-groups

such as Māori, Pacific people, children and young people as a result of welfare reform (Welfare Working Group, 2010).

MSD data[6] indicates that between 2012 and 2017 there were reductions in the number of

- Māori on working age benefits (106,001 in June 2012 compared with 97,716 in June 2017)
- Pacific people on working age benefits (26,038 in June 2012 compared with 21,826 in June 2017)
- young people (aged 18-24 years) on working age benefits(54,915 in June 2012 compared 42,615 with in June 2017).

However the valuation (Taylor Fry Ltd, 2016) reported that:

- Māori clients remained significantly overrepresented in both the benefit and social housing systems cohorts. While Māori clients comprise only 15% of the general population, they make up 31% of the benefit system cohort and 36% of the social housing system cohort.
- The average future lifetime cost for Māori clients was $55,000 higher (about 50% higher) than for non-Māori clients.

The Work Focused Service Delivery Model appears to have worked for some

MSD trialled various work focused case management services for different groups of clients in the period following the introduction of Welfare Reform. An analysis of MSD's intensive case management services (Ministry of Social Development, 2017a) found

- more intensive case management was effective for sole parents followed by work ready job seekers
- intensive case management services usually were cost-effective within 2 years
- intensive case management services were more cost-effective for some groups of job seekers (e.g. sole parents over people with health conditions or disabilities)
- one to many Work Search Support (WSS) service were effective
- there were some groups that were less likely to benefit from intensive case management services (e.g. those close to the labour market and those furthest from the labour market).
- In a small number of trials that looked at this, externally contracted case management services were less cost-effective than the internally run service.

The impact of self-service for clients is unknown as an impact evaluation has not been undertaken

Further research is needed on the less intensive General Case Management (GCM) service

There has been limited research exploring the quality of the service that GCM clients receive and what improvements could be made. It is unclear whether people who receive the GCM service receive their full and correct entitlements.

GCM service caseloads are typically large. There is no agreement in the literature on what the ideal size of a case managers caseload should be but there is evidence that having a large caseload has a negative impact on the

[6] https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/statistics/benefit/2017/quarterly-benefit-fact-sheets-national-benefit-tables-jun-2017.xlsx

ability of case managers to work effectively with clients[7] (King, 2009; Perkins, 2007).

We need to better understand case management within the New Zealand welfare context

Case management has become the mainstay of service delivery across welfare and health sectors in many countries. However, different people mean different things by the term "case management" (Grace & Gill, 2015). There is still no consensus among users regarding its components and appropriate application (Hanson etal 2006). Not only do definitions of case management vary across jurisdictions, its impact as an activity in itself has been difficult to isolate. This is often because it is typically implemented as part of a package of initiatives. However, evidence indicates that effective case managers are critical to the success of interventions aimed at assisting people into work.

Obligations and sanctions for clients under Welfare Reform were not evaluated

Impact of pre-benefit obligations is unknown

We do not know the effectiveness of pre-benefit activities as a whole but Wrk4U[8] appears effective for work ready jobseekers. The WRK4U seminar is rated as effective in areas with labour demand and for participants with work obligations (Ministry of Social Development, 2017a). In this context, the introduction of a WRK4U seminar reduced both the number of people applying for an unemployment related benefit, but also lead to fewer people commencing an unemployment related benefit. However Wrk4U seminars may not be effective for the wider group of people that were subject to pre-benefit activities under Welfare Reform because they are further from the labour market.

Impact of the work preparation obligations is unknown

At the time the changes were introduced work preparation obligations were seen as effective at increasing the time Job Seekers spend off benefit. Evidence indicated that

- there was a compliance effect of planning and job search requirements: getting clients to come in for planning meetings or requiring them to undertake job search increases benefit exits. It is less about the activities themselves.
- it makes the most difference for people who can easily move into employment

The impact of extending work obligations under welfare reform was not evaluated

The impact of extending work obligations to sole parents with younger children under Welfare Reform was not tested. However past evaluations of work obligations for sole parents suggest they may have had a positive impact. An impact assessment of the the Future Focus changes to the sole parents on benefit between 27 September 2010 to the end of December 2012, found they:

[7] A German study looking at the impact of lower caseloads found that they resulted in a decrease in the rate and duration of local unemployment and a higher reemployment rate. Cost-benefit calculations suggested that the costs from employing additional case managers was offset by the savings from decreased benefit expenditures after a period of about ten months (Hainmueller, Hofmann, Krug, & Wolf, 2015).

[8] WRK4U is a pre-benefit seminar for people planning to apply for unemployment related benefits. The seminar sets out the eligibility criteria and mutual obligations for unemployment-related benefits as well as identifying available job opportunities

- reduced the time clients spend on benefit by an average of 5 days
- resulted in an average reduction of 400 clients on main benefit per month
- saved $12.9 million (this figure is in 2012 dollars) in main benefit expenditure (Ministry of Social Development, 2013)

It appears there was a signalling effect for sole parents associated with the October 2012 Welfare Reform changes. An analysis of exits following change notification letters sent to sole parent benefit recipients found a small increase in benefit exits for clients who received the letters did not occur directly after the letters were sent out, but later after the obligations came into effect on 15 October 2012. It was not possible to determine whether the change amongst those who received the letters was due to either receipt of the letters, the new obligations coming into effect, or some other event at that time that influenced the behaviour of these clients.

The impact of the work obligations for JS HCD is unknown but it is likely it was limited. Prior to Welfare Reform some steps were taken to introduce work obligations for those on benefit for health related reasons. Under Future Focus a small number of Sickness Beneficiaries (up to 6000) were expected to be available for part-time work, and could receive some work-focused case management. It was not possible to assess the impact of this change[9]. However staff feedback in the evaluation of Future Focus indicated that employment outcomes for this group were limited and hard to come by (Ministry of Social Development, 2011).

Extending 52 week reapplications to all clients receiving Jobseeker Support has had limited impact. Future Focus introduced a requirement for people on the Unemployment Benefit to reapply for their benefit and complete a comprehensive work assessment each year. From July 2012 this requirement was extended to all clients receiving Jobseeker Support – many of whom had health conditions. From July 2012 monitoring data indicates that most who reapplied for benefit remained on JS. For example, 82% of completed job seeker support reapplications to end of February 2015 resulted in people continuing to receive JS.

Monitoring data indicates:

- few people were sanctioned for refusing an offer of suitable employment. Monitoring data indicates that each month between September 2013 and September 2017 on average about 4,700 work related obligation sanctions were applied. However when looking at the reasons for the sanctions being applied, less than 10 a month were for refusing an offer of suitable employment
- there was little change in the pattern of people sanctioned for failing to comply with overseas travel obligations.
- the number of people who had benefits suspended or reduced for failing to have their Warrants to Arrest cleared was small and fluctuated with an average of 148 per month between August 2013 and September 2017. Critics of limiting social assistance for people who commit crimes argue it contributes to increased stigmatisation and criminalisation of welfare recipients and that withdrawing a benefit is likely to exacerbate other poverty-related risks and affect others in the household e.g. children.

We do not know the impact of the pre-employment drug testing policy but it is likely to have been limited because as at the end of February 2015:

- relative to the number of people referred to drug testable jobs the numbers failing drug tests was small
- numbers sanctioned for failing drugs tests were small

[9] Data on SB clients' ability to work part-time was not captured prior to Future Focus. It is therefore difficult to find a natural comparison group to gauge the impact of the work obligations on exit rates or declared earnings for affected SB clients.

- there was some use of 0800 helpline but few people were referred to AOD services.

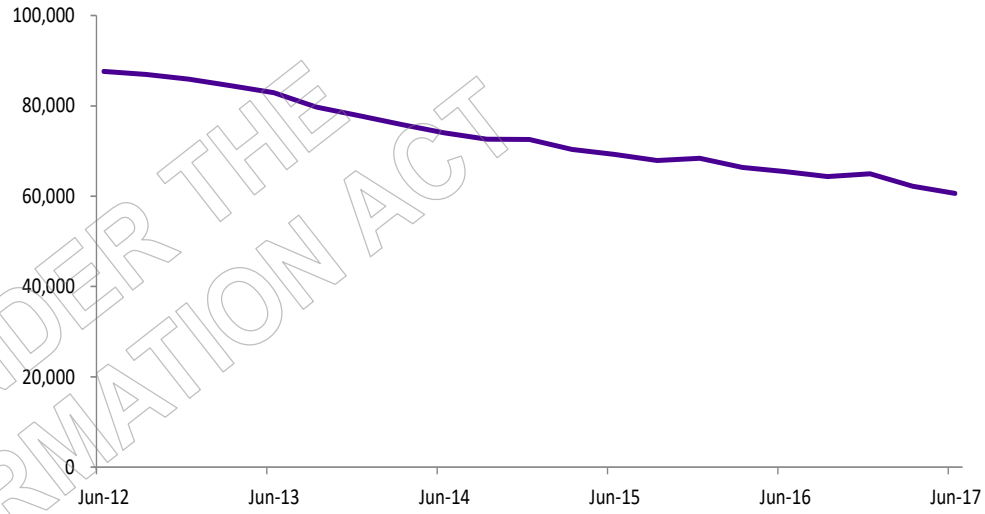
Recent US evidence looking at the effectiveness of welfare reforms undertaken there has found that work requirements are less effective than initially thought. In particular employment, increases among recipients subject to work requirements were modest and faded over time. Stable employment among recipients subject to work requirements was difficult to obtain. Most recipients with significant barriers to employment never found work and the large majority remained poor. Over the long term, the most successful programs supported efforts to boost the education and skills of those subject to work requirements, rather than simply requiring them to search for work or find a job (Pavetti, 2016).

Different ways of working with sole parents and clients with multiple barriers were trialled with had mixed results

The number of working-age people receiving Sole Parent Support has declined over the past five years

The number of working-age people receiving Sole Parent Support at the end of June decreased over the last five years (Figure 2). This pattern reflects changes in economic conditions and the decrease in the number of sole parents. There does not appear to have been a decrease in the number of sole parents overall over this period based on HLFS data. While the *proportion* of families with dependent children headed by a sole parent fell slightly, the total *number* of sole parent families was relatively static. However, there is some indication of a recent reduction in numbers of sole parent families with very young children, and because rates of benefit receipt are highest among those with the youngest children, this may have contributed to the decline in numbers.

Figure 2: Quarterly Sole Parent Support numbers, June 2012 to June 2017



Note 1: Working-age people are aged 18 to 64 years. This definition reflects the minimum age of eligibility for most main benefits and the age of qualification for New Zealand Superannuation.

SOURCE: https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/statistics/benefit/archive-2017.html

Several Investment Approach trials focused on sole parents with mixed results

MSD implemented several trials aimed specifically at improving work outcomes for sole parents on benefit with mixed results. For example:

- an Auckland trial testing intensive case management with sole parent clients found there were no significant differences in declared earnings for clients in the trial compared to clients in the control group.
- an externally contracted Sole Parent Employment Services Trial did not increase clients' time off main benefit compared with MSD-delivered case

management, yet was more expensive (Ministry of Social Development, 2017a).

- the Flexible Childcare Assistance (FCA) trial appears to have had a positive impact but the imperfect nature of the comparison groups means that it is not possible to definitively conclude that the FCA payment is improving off-benefit outcomes.
- overall the findings from the first year of Wāhine Activate - a service for young for young Māori mothers were mixed. While stakeholders were generally positive about the service there were some inconsistencies between facilitators. However with the employment of the new facilitator the service has improved (e.g. improved engagement with young Māori mothers and focus on outcomes, improved pastoral care, initiation of co-design to improve the service). Wāhine Activate was a useful testing ground for service delivery ideas that largely came from MSD/Work and Income, with Te Runanganui O Ngāti Porou contracted for delivery (Cram & Cram, 2017).

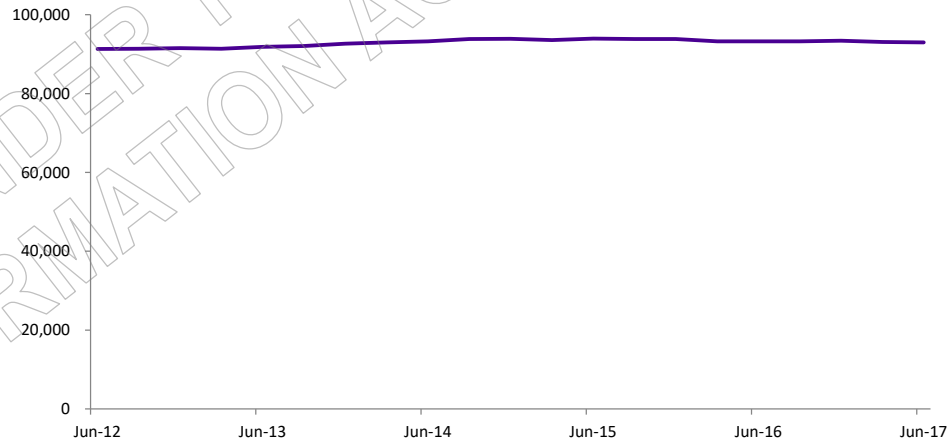
Success helping disabled people and people with health conditions into work was limited

The impact of welfare reform changes for people with health conditions or disabilities is unknown but likely to have been limited

There has been no change in the number of people on SLP since the introduction of the fast track process

There has been little change in the number of people on SLP between June 2012 (just prior to Welfare Reform) and June 2017 (Figure 3). The long-term nature of conditions for those on SLP means that very few people move from SLP into paid work or on to a work focused benefit. Estimating the difference that Welfare Reform health condition and disability changes made based on trends in numbers alone is problematic as numbers are driven by a range of factors, including some transfers from the old DPB-SP to SLP by sole parents with older children who were unable to meet the requirements of JSS.

Figure 3: Quarterly Supported Living Payment numbers, June 2012 to June 2017



Note 1: Working-age people are aged 18 to 64 years. This definition reflects the minimum age of eligibility for most main benefits and the age of qualification for New Zealand Superannuation.

SOURCE: https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/statistics/benefit/archive-2017.html

It is unclear how effective changes to assessment processes for clients with health conditions or disabilities have been

The original intent of these assessment tools was to support stair casing clients with health conditions or disabilities into sustainable employment and independence. The assessments, if used correctly, may also help case managers determine if the client is streamed into the most appropriate case management service and receiving correct financial assistance.

Over the past four years case management practice has evolved, and recently some regions have given staff flexibility on how and when to use the work ability assessment tools to better align these tools to case management practice. It is unclear whether these assessments have been delivering the original intent of the policy.

Evaluations and internal reviews indicate there is room for improvement.

- There is no accurate information on the volume of Self-Assessments, Structured Interviews and WAAs undertaken or on client experience.
- The self-assessment requires time and often assistance from case managers to complete and some staff have reported that information collected is not relevant in assisting to return to work (Ministry of Social Development, 2014).
- Work is needed to better use the work capacity medical certificate to assist return to work. The large volume of medical certificates (about 432,000 medical certificates completed each year) imposes costs on cost to clients, medical practitioners and MSD. More frequent medical assessments do little to increase the time spent of benefit. It is unclear whether or how case managers were using the information provided in the medical certifcates beyond the benefit grant to assist clients into work. Internationally evidence indicates that medical assessments may be effective at assisting people with health conditions return to work if matched with appropriate reintegration support (OECD, 2015).
- Structured Interview use by case managers is low. Case manager knowledge of what a Structured Interview is, when it is to be used, or what it is intended for is low.
- Information on the use and effectiveness of Work Ability Assessment (WAA) is limited. Its use has not been formally evaluated. However, indications are that WAA are infrequently used as a basis to form a plan with clients at risk of remaining on benefit for a long time.
- Responding in a timely manner with the right approach to the needs identified in the assessment process is challenging. The various assessment processes can provide Work and Income staff (e.g. case managers, work brokers) with better information to assist clients. However a process evaluation indicated that there were barriers to providing the right assistance at the right time to assist return to work. For example, case managers reported not always having enough time available to have work focused conversations; difficulty connecting clients with services that may help; employer reluctance to employ clients with health conditions or disabilities; and work broker reluctance to push employers to take on such clients (Ministry of Social Development, 2014).

Several trials sought to improve outcomes for those with health conditions or disabilities but few assessed effectiveness and those that did reported mixed results

Work Focused Case Management-Health Conditions or Disability (WFCM-HCD) service had a small positive impact (Ministry of Social Development, 2017a). However, most people on JS-HCD do not receive active case management, with only 20,000 places available for disabled people and people with health conditions (includes JS-HCD and SLP) in Work-Focused Case Management.

The externally contracted Mental Health Employment Services Trial (a case management service) was no more effective than internally provided services. The various other case management trials proved least effective for people with health conditions or disabilities (Ministry of Social Development, 2017a).

It may be that case management is necessary but not sufficient to achieve positive outcomes for many clients with health conditions or disabilities. Evidence indicates that models that integrate employment services and treatment services may be more promising than offering either strategy alone (Butler et al., 2012).

Several trials sought to improve outcomes for clients with mental health conditions, but many were small and did not assess impact. More work is needed implement and evaluate evidence-based mental health and employment services.

Take-up of mainstream supports appears to be lower for disabled people receiving a benefit

A variety of supports are available for all recipients of main benefits (including those with a disability or health condition). They are designed to help people find sustainable work in the open labour market. Take-up of mainstream supports appears to be lower for disabled people receiving a benefit: only 13% of participants in an employment programme (excluding case management but including some disability-specific programmes) have a health condition or disability despite being half of the population receiving a main benefit. In particular, work-focused case management is often a gateway to employment support, so clients on SLP who do not have access to this service have little access to support to find work.

Information on what works to achieve positive outcomes for people on Supported Living Payment is limited

There is limited information on effectiveness of Employment Assistance for people on SLP, reflecting their low participation in Employment Assistance interventions. MSD has information on only five interventions for SLP participants.

However the Young SLP Opt-In trial showed the value in working with people with disabilities. Under the trial SLP clients aged 16-29 years could to voluntarily opt-in to WFCM-HCD to focus on employment, up-skilling and higher education outcomes in the medium to long-term. Based on what MSD learned from the Young SLP Opt-In trial and its early success the SLP Opt-In service for 16 – 59 year olds was made available in all sites that have a WFCM-HCD service.

MSD has a better understanding of people on benefit with disabilities or health conditions but there is more to learn

A close look at the population revealed:

- a significant proportion of current JS-HCD clients (64 per cent) are aged 40 years or older
- Māori are over-represented
- just over 90 per cent are single and around 88 per cent have no dependent children
- over a third of people on JS-HCD live in the wider Auckland region
- most people receive income only from benefit payments with only a small proportion receiving income from work
- almost 50 per cent of people on JS-HCD identify mental health as their main health barrier to work.

While only 30 per cent of people granted JS-HCD in 2014 were still on JS-HCD at the end of two years, churning back onto benefit is an issue for this group. Many are re-granted JS-HCD or transferred to another benefit, including SLP.

Disabled people and people with health conditions face health and disability barriers to work as well as non-health barriers, such as lack of work experience or educational achievement. Disabled people and people with health conditions also face discrimination from others (e.g. some employers and medical practitioners) and barriers within the benefit system. For example, people on SLP have reported that they fear losing their benefit entitlement if they try work and it does not work out. For those on Job Seeker Support the system incentivises participation in full time work making it hard

for people who need a more graduated return to work or may only ever be able to work part-time.

MSD has identified approaches that may work to improve outcomes for people with health conditions or disabilities

New Zealand and international evidence indicates that the best approaches to working with disabled people or people with health conditions have the following themes:

- **Multi-domain and coordinated interventions for the workplace are the most effective**. Combined, multi-domain, wrap around, interventions are the most effective. These tend to be more resource intensive, but by targeting multiple areas of a person's life (eg. Individual health, co-ordination of support, and workplace accommodations) the chances of a person with a health condition, injury, sickness, or disability finding and retaining employment tend to be more positive.
- **Planning and flexibility** regarding hours, adapted roles, work practices and environments are helpful in retaining disabled people in employment and helping them to return to work. Many interventions focus on allowing a person the flexibility to re-integrate into work in a way that works for them, but crucially encourages a return to work as soon as possible. This is most effective when the person, the employer, and health professionals develop a return-to-work plan together.
- **Viewing disability and employment from a capability perspective** rather than from a deficit perspective is an important part of opening up employment opportunities for disabled people. For example, not assuming disabled people can only perform low-skilled or menial jobs, and providing the opportunities and support to find employment and develop skills.
- **Intensive and individualised interventions are effective** for people with many difficult barriers to work. One successful example of this type of intervention used mostly for people with a mental health conditions is Individual Placement and Support (IPS)[10]. Typically IPS involves intensive, individualised support, rapid job search, followed by placement in regular, paid employment, and unlimited support for employee and employer (Contreras et al., 2012; Kinoshita et al., 2013).
- **Agencies, sector, health professionals, and employers should work together:** Supported employment programmes aim to integrate disabled people or people with health conditions into employment by assessing capabilities and matching job seekers with available jobs, whilst also providing on-going support as required.
- **A greater focus on employers is needed.** Another key and related issue is the focus on employers and the demand for workers with disabilities. Currently, many interventions focus on aiming to get a person work ready (eg. motivation, financial assistance, equipment, workplace modifications), however involving employers to a greater extent, and placing greater responsibility on employers seems to be a key aspect in increasing employment outcomes for disabled people or people with health conditions.

Social obligations

There was no evaluation of the implementation of the social obligations or their impact. However:

- MSD monitoring data indicates that the overwhelming majority of people on benefit with children targeted by the obligations met the obligations. As at February 2015 no social obligation failures had been recorded. Consequently, no sanctions have been applied.

[10] As part of Budget 2017, MSD is trialling IPS services in Auckland and Christchurch.

- over time the number of subsequent children on benefit has increased despite the measures to reduce this. However there were factors that would limit the impact of this policy (e.g. sole parents on benefit, like non-beneficiary parents, typically have subsequent children close in age to their previous child).

The Youth Service showed small positive impacts for some participants

The Valuation showed improved outcomes for youth

The 2016 Valuation reported that

> *Improvement in benefit system outcomes have been sustained for Young Parent Payment clients. The proportion of 18-year-old YPP clients remaining on the SPS benefit at age 20 has fallen from 75% to 71% over the year. Youth payment clients are exiting benefits more quickly, with average future years on benefit falling from 15.3 to 13.8. This is a reversal of the increase in last year's valuation* (Taylor Fry, 2016).

An evaluation of the Youth Service has shown small positive impacts for high and very high risk participants

The Youth Service was aimed at young people not in employment, education or training (NEET). It was strongly focused on educational participation, and as such would expect to see positive impacts on participation and achievement of qualifications. Key findings from the evaluation of the Youth Service were:

- there were small positive impacts for high and very high risk NEET service participants but not for lower risk participants
- for participants receiving the *Youth Payment (*YP), there were small positive effects on educational attainment but no impact on moving participants off benefit and into work
- the Youth Service was the most effective for Young Parent Payment (YPP) recipients , with positive effects on educational attainment, benefit receipt and employment
- the targeting of the Youth Service for NEET participants was fairly weak, with many participants being relatively low risk. The Youth Service: NEET was found to be only marginally effective at improving educational attainment and did not improve participants' employment or benefit outcomes
- overall the Youth Service (NEET) was not effective in improving the outcomes of most participants over the 24 month follow-up period. There were several possible reasons for the service's limited effectiveness including the nature of the programme, insufficient provider capability, poorly designed incentives in the provider payment structure, and poor quality of some of the level 1-3 tertiary programmes being undertaken by participants. The evaluation findings are consistent with international studies that have also found that mentoring programmes for disadvantaged youth have not been very successful in raising academic achievement, employment rates or earnings (Crichton & Dixon, 2017; Crichton etal, 2017).

Some commentators argue Welfare Reform did not focus enough on the underlying causes of young people's poor outcomes

Johnston (2016) argues that welfare reform's focus on reducing welfare dependency meant the underlying causes of welfare dependency for young people were overlooked. He goes on to state that "*educational inequality is one of these underlying causes. A number of structural inequalities persist*

across ethnicity, geography, and wealth and income, which means poorer students—who are also often Māori or Pasifika—are more likely to leave school without formal qualifications".

Cram & Cram (2017: 45) argue that support services should be developed and imposed on young people in a 'top down' manner. They recommend co-designing services with participants so their needs are met, and their aspirations are supported. They add

> *Services that prepare young people for work should also consider the changing nature of the work, and orient young people and potential employers to a new set of skills and expectations that will enable young workers to be flexible, adaptive and valuable additions to work places*

Further work was needed to better understand the client experience

MSD commissioned research looking at clients' experience of Welfare Reform[11]

The main findings from this research are listed below.

Client awareness of the changes was mixed

The evaluation found that many clients had heard about and could identify the changes that were most well-reported in the media (e.g. pre-employment drug testing and changes to overseas travel). There was less awareness of other changes that were more targeted (such as social obligations) but generally clients were able to identify the changes that affected them. Clients said they had heard about the changes from a variety of sources, including case managers, letters and phone calls from Work and Income, the media and their friends (Malatest, 2014).

Some clients had held or still held misconceptions about the content and effect of some of the Welfare Reform changes. For example, some believed that they were not allowed to travel overseas at all. Others initially thought that they would be drug tested to determine whether they were eligible to receive a benefit, but later realised that was not the case. The concerns clients held when they first heard about the changes, such as concerns about privacy and their rights, had not eventuated (Malatest, 2014).

Clients reported they understood what was expected of them

In discussing the service they received from Work and Income, almost all clients reported that they understood what Work and Income expected of them. Clients most commonly recalled their case managers discussing job searching and work readiness but also mentioned budgeting and financial awareness. The frequency of contact varied across clients and service levels[12]. Some clients that appeared to have similar circumstances reported very different levels of contact, as expected with different service levels (Malatest, 2014).

Clients reported mixed views on whether or not the Welfare Reform changes were positive

Clients often did not link changes in their interactions with Work and Income to Welfare Reform changes. Comments from clients who were able to compare Work and Income service before and after the changes focused on

[11] The 2014 client perspectives evaluation focuses on the effect of the changes from the point of view of Work and Income clients. The evaluation collected data from clients in three ways: in-depth telephone interviews with 40 clients, brief interviews with 100 clients at three Work and Income sites after they finished their appointments, and feedback forms from 215 clients who attended seminars and workshops.

[12] Information on clients' situations and service capacity is used to determine what intensity of services is most appropriate for each client. Clients can therefore experience different levels of service over the course of their involvement with Work and Income.

increased contact with case managers and more requirements for evidence to support their entitlement. Comments were mixed on whether the changes were positive or not, though many clients expressed their appreciation for the Work and Income support they received. Some clients held the view that the changes would prevent others from taking advantage of the benefit system because more evidence was required about clients' situations. Some clients felt that the work expectations were too high given their situations, the opportunities in their locality or what they thought about their capacity to work (Malatest, 2014).

Clients interviewed appreciated the support they received but did not necessarily see the Welfare Reforms as assisting them into work

Clients often judged their progress by whether they had entered employment or not and did not see themselves as having made progress if they had not achieved employment. Although few clients stated that the Welfare Reform changes had assisted them to progress towards employment, they did give examples of things they had done with Work and Income that appeared to be steps towards work. For example clients described Work and Income's assistance with preparing CVs and applying for specific jobs.

Most clients were positive about workshops and seminars and were able to identify the components they found most useful as well as areas for improvement. Some held negative views and made suggestions for improvement (Malatest, 2014).

Few interviewed experienced sanctions

The few clients interviewed who said that they had been sanctioned reported that they had quickly fulfilled Work and Income requirements to restore their benefits. While they did not feel that the sanctions had impacted their work search or their wellbeing, receiving notice of the sanction had encouraged a swift visit to their case manager (Malatest, 2014).

The relationship between the client and their case manager was important

For clients interviewed, it was important that Work and Income understood their situations and they did not have to explain their situations repeatedly whenever they spoke to a case manager. Having one case manager as a single point of contact reduced the re-explaining the client had to do. This may have been one of the reasons why clients were generally more positive about Work and Income when they had a single case manager. Overall, many clients interviewed made positive comments about the support they received from their case managers including those who did not identify significant changes in the service (Malatest, 2014).

Other non-MSD reports on client experiences of Work and Incomes have been more critical

Other reports have been critical of Work and Income's treatment of benefit recipients. They have commented on inconsistent treatment and/or application of policy within an agency. The Auckland City Mission Family 100 Research Project makes several references to difficulties interviewees reported in interacting with Work and Income (Garden etal., 2014). They reported

> *"many people speak of not wanting to be reliant on WINZ, describing the agency as a 'last resort' to be used only when they're unable to meet their needs through other means. This reluctance to engage with WINZ is in part due to what some describe as the unpleasant environment where the lack of basic facilities such as client toilets, privacy screens and drinking water adds to the stress of engaging with the service. Other participants prefer to turn to community agencies or to accrue debt from fringe lenders rather than risk the fear or shame of being turned down for assistance*" (Garden etal., 2014).

Other earlier research reported similar findings (New Zealand Council of Christian Social Services, 2009; Presbyterian Support Otago, 2008).

More recently MSD has commissioned other research to better understand the client experience

This research is taking place as part of the evaluations of trials. However it is also taking place as part of initiatives that are being co-designed.

Impact of the institutional arrangements

MSD has not evaluated the impact of the changes to institutional arrangements (e.g. the investment approach, the MCA, research and evaluation).

There is value in using an investment approach

Several commentators have stated the value in using large data sets to better understand the population on benefit and what works to improve outcomes so government can invest in the best collection of interventions, efficiently targeted for particular groups of people, to achieve the best possible social outcomes. The measurement of these outcomes over time allows the Government to determine if overall wellbeing is improving (Chapple, 2017; Alsop, 2017).

There have been criticisms of the investment approach

Several commentators have discussed the limitations of the Investment Approach as applied at MSD. Key criticisms have been:

- it focuses on costs and benefits to the government – but only costs and benefits to Vote Social Development (Rosenberg, 2015,; Chapple, 2017)
- it does not include the financial costs to individuals and firms of social welfare interventions (e.g. transport to interviews, work, child care, medical, additional training) or financial benefits to individuals and firms from social welfare interventions (e.g. additional earnings from finding better job, additional revenue to employer, reduced medical costs) (Rosenberg, 2015)
- it does not include the non-financial costs to individuals, households and society (e.g. less time with family, crime, ill health, poverty, poor education levels, failure to fulfill economic/social/ personal potential) or non-financial benefits to individuals, households and society (e.g. quality of work, reduced crime, improved physical and mental health, greater participation in society and social cohesion) (Rosenberg, 2015)
- it makes invalid assumptions about outcomes for beneficiaries which are central to its logic (e.g. being off benefit is good for well-being but not all exits are to work and not all work outcomes are positive) (Rosenberg, 2015; Chapple, 2017).

MSD is working to better understand the impacts of its services, particularly across a broader set of outcomes. Work is underway developing a social return on investment.

Only parts of the reforms were evaluated

Only some elements of the 2012 Welfare Reforms were evaluated. The various case management trials have received the most attention. Fletcher (2014) has criticised MSD for not comprehensively evaluating the reforms given their scale and potential to impact on vulnerable populations.

Other changes accompanied Welfare Reform which will have had an impact on benefit recipients

A focus on fraud accompanied Welfare Reform

In 2013 the Tackling Welfare Fraud and Welfare Debt Recovery package details an approach aimed at improving MSDs ability to prevent and detect

welfare fraud and introduce measures to ensure that MSD can recover debt effectively while enabling it to exercise discretion in managing recovery in individual cases. Measures included:

- information sharing between Inland Revenue and MSD
- establishing an interagency collaborative action programme to address welfare fraud
- strengthening the approach to relationship fraud, in particular by making both parties in a relationship accountable for relationship fraud from July 2014
- introducing new measures from July 2013 to respond to beneficiaries who have previously acted dishonestly in a welfare context (e.g. Benefit Fraud: Low trust client initiative)
- changes at the application process stage from July 2013 to check and confirm applicants' understanding of a relationship and allow for third party verification of a relationship
- follow up intervention trial commencing in early 2014 involving contacting a selection of clients 16-20 weeks after grant to check relationship status and reinforce obligations
- taking a more rigorous approach to recovering debt via seizing assets and reparation orders (McKenzie, 2017)

A new employer model was rolled out

The 'Employer Model', was the first significant change to Work and Income's employer services since 1998. It was precipitated by Better Public Service targets and Welfare Reform and informed through the organisation-wide realignment towards Investment Approach, which began with 'Future Focus'.

The previous approach was not well set up to respond to the significant growth in the number of work obligated clients which grew from 50,000 to roughly 200,000 following the July 2013 Welfare Reforms. The Employer Model aimed to facilitate a more effective and efficient Work and Income strategy of helping more New Zealanders into sustainable work.

Contracted Social Services: Investing in Services for Outcomes (ISO Programme) was launched

As part of the 2012 Budget, the Government announced changes in the way that social services were contracted by MSD. The Investing in Services for Outcomes (ISO) approach involved simpler and consistent contracting and alignment of MSD's $550 million investment in social services with achieving Government's results for families and communities. It was intended to ensure that Government priorities drive funding decisions, that funding was shifted to services that make a proven difference and that results are demonstrable. The key components of the new approach were:

- funding decisions were driven by Government priorities for families and communities (Government would detail its vision for the social services funded by MSD);
- a capability framework was developed which community services could use to strengthen their organisation, their responsiveness to their community and alignment with Government priorities;
- community social services funded by MSD were to have results-based contracts which focus on achieving real and lasting results; and
- MSD's funding and contracting of services would move to a more streamlined approach.

The ISO approach was launched in June 2012 and was implemented over the following 18 months (McKenzie, 2017).

Simplification

MSD has been working on the service delivery model to provide simpler transactional services and make our client experience seamless and easy. The intention was to reduce the time staff spent on repetitive tasks and

paperwork so they can spend more time assisting people using MSD services. Simplification has also sought to improve the people's experience of interacting with MSD.

Changes to social housing

Housing is a significant component of family budgets and plays a central role in the welfare of families. Homelessness, transience, overcrowding, poor quality indoor environments, and restricted family living standards as a result of high housing costs are all features of housing market outcomes that have undesirable impacts, particularly if they involve families with children.

As part of the 2013 Budget, the Government announced major reforms to the provision of social housing. This included extending Income-Related Rent Subsidies to approved community providers; a more comprehensive housing needs assessment; reviewable tenancies for all social housing tenants and regulation of Community Housing Organisations. These came in between 2012 and 2014 (McKenzie, 2017).

Refer to the WEAG presentation on housing.

Lessons in implementing large scale reforms

Banks (2010) argues successful reforms have two important features:

- the outcomes of the reform broadly accord with its objectives and what was anticipated when it was introduced. In other words it should achieve its goal, and do so without major 'collateral damage' or unintended consequences.
- it is *sustainable*; that it is not vulnerable to being reversed, or substantially amended in ways that negate its objectives.

The OECD (2010a) has undertaken research looking at what works to implement large scale reforms in the public sector. They acknowledge there are major challenges but success is more likely where the following lessons are adopted:

- Sound public finances are strongly associated with reform progress.
- It is important to have an electoral mandate for reform.
- Effective communication is essential.
- Policy design must be underpinned by solid research and analysis. However, evidence-based reform is difficult where the evidence is either lacking or contested. That is why work by national or international organisations to generate reliable, credible evidence on policy outcomes can be very valuable in clarifying the terms of debate
- Appropriate institutions are needed to make the transition from decision to implementation.
- Successful structural reforms take time.
- Leadership is critical. Government cohesion in support of reform is crucial but successful leadership is often about winning consent rather than securing compliance.
- Successful reform often requires several attempts.
- It usually pays to engage opponents of reform rather than simply trying to override their opposition.
- The question of whether, when and how to compensate the losers from reform requires careful consideration.

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EVALUATION REPORT

Work Focused Case Management for clients with a health condition or disability (WFCM: HCD)

Process Evaluation Report

March 2014

MINISTRY OF SOCIAL DEVELOPMENT
Te Manatū Whakahiato Ora

Prepared by
Knowledge & Insights Group
Prepared for
Work and Income

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ACKNOWLEDGEMENTS

We wish to thank the Ministry of Social Development staff who gave us their time to be interviewed. We also thank staff from Work and Income National Office for their feedback over the course of the evaluation.

DISCLAIMER

The views and interpretations in this report are those of the researcher and are not the official position of the Ministry of Social Development.

Readers should note that this report was prepared for internal use only, and has not been through the Ministry's full publication quality assurance process.

SUGGESTED CITATION

Ministry of Social Development (2014). *Work Focused Case Management for clients with a health condition or disability: Process evaluation report*. Ministry of Social Development, Wellington, New Zealand.

DISCLAIMER

This report was completed in March 2014, and published internally in January 2020.

ISBN

978-0-9951240-7-3

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Abbreviations

Common abbreviations used throughout this report are listed below.

Abbreviation	**Meaning**
ASCM	Assistant service centre manager
CM	Case manager
KPI	Key Performance Indicator
RDA	Regional disability advisor
RHA	Regional health advisor
SCM	Service centre manager
SDM	Service Delivery Model
WFCM: Gen	General Work Focused Case Management
WFCM: HCD	Work Focused Case Management for clients with a health condition or disability

Executive summary

The Work Focused Case Management for clients with a health condition or disability (WFCM: HCD) service was piloted in 23 Work and Income sites between July 2013 and February 2014. It is part of the Service Delivery Model that supports the delivery of the wider welfare reform programme of work.

The WFCM: HCD service was evaluated by Knowledge and Insights, Ministry of Social Development, in November 2013. It involved interviews with staff from six of the pilot sites, a national survey of regional health advisor (RHA) and regional disability advisor (RDA) staff, and an analysis of administrative data.[1]

The findings provide insights into the delivery of a specialised case management approach for clients with a health condition or disability, which will enable Work and Income to further develop the WFCM: HCD service. Three areas were evaluated: transitioning to the WFCM: HCD service, working with clients and supporting clients into employment.

How did staff find the transition to the WFCM: HCD service?

Having experienced case managers helped mitigate transition issues

- Many case managers were able to draw on their prior experiences of working with clients who had a health condition or disability, or prior experience as a Work Focused case manager. This made the transition to the new way of working easier than for those with no experience in those roles.
- No specific practice guide was developed for WFCM: HCD because one WFCM guide was developed and implemented as part of the roll out of the Service Delivery Model. Staff reported that having one WFCM guide did not provide specific information to support them in their preparation to deliver the service, and they were often unsure of the client transition requirements. This was less of a problem for experienced case managers.
- All staff we interviewed agreed 'Mental Health 101' training was useful. Staff reported that similar training for other common health conditions would be helpful because case managers did not always feel confident to have 'courageous conversations' with clients who had health conditions they did not understand.

How did staff work with clients in the WFCM: HCD service?

Aspects of the WFCM: HCD service enabled case managers to provide a 'best practice' service to clients

- Current caseload size and the flexibility to provide tailored case management practices helped case managers build effective relationships with clients. However, at some sites, case managers were not sure how flexible they were allowed to be in their approach.
- Most case managers reported that their caseload size was 'about right'.
- The one-to-one case management approach of WFCM: HCD developed trust and rapport between the case manager and client, enabled case managers to remain with a client as they progressed through the WFCM: HCD service and enhanced case managers' job satisfaction.

[1] Note this report discusses staff feedback on their perceptions of the Service, which may or may not align with international evidence around best practice.

- The physical layout of the service centre, for example, quiet meeting areas, can help clients with particular health conditions, such as anxiety, to feel more comfortable and able to come into the service centres to have one-on-one meetings.[2]
- All staff we interviewed agreed that RHA and RDA were an extremely helpful resource for all staff working with clients with a health condition or disability. Most case managers reported they wanted to meet with RHAs and RDAs more frequently.

Self-Assessment and Work Capacity Medical Certificate provide useful information when filled in correctly

- Most staff agreed the new assessments (the Self-Assessment and the Work Capacity Medical Certificate) provide useful information about a client's work capability, aspirations and barriers to work.
- Case managers reported clients often find it difficult to complete the Self-Assessment on their own, and more meaningful information is gained when it is completed together as part of a discussion.
- Staff reported that medical practitioners are not always providing enough information in the medical certificate to enable WFCM: HCD case managers to determine a client's work capacity.

Staff faced challenges when helping clients move towards employment

- Staff across a range of roles reported that the ability of WFCM: HCD case managers to maintain a 'work focus' with their clients was limited by other requirements of their role, including the back-to-back appointment schedule, paperwork and administration tasks, and extra processing requirements for WFCM: HCD clients (eg, medical certificate renewals and Disability Allowance applications).
- Many case managers reported there were limited services or training providers in their local community to refer clients with health conditions or disabilities to. Some staff reported a lack of suitable training for their clients, for example, some clients are not able to sit or stand for extended periods.

How do staff support clients into employment and beyond?

Work brokers provide a vital link to employers, but are not always well equipped to place clients with a health condition or disability into work

- Some staff felt that work brokers do not always have the understanding required to be able to effectively profile clients with a health condition or disability to employers.
- Some work brokers were reluctant to place clients with a health condition or disability with an employer because they were concerned about compromising their existing relationships if the placement did not work out.
- Some work brokers felt that employers viewed these clients as a greater risk, especially in areas where the labour market consisted of a lot of small to medium sized employers.

[2] The layout of the service centre is not prescribed as part of the WFCM: HCD service.

Once a client is in work, further support may help sustain employment outcomes

- Most WFCM: HCD case managers do not currently provide post-placement support for clients once they are in employment, because they are often unable to track where their clients go once they exit off benefit. Many reported that they would like to provide this type of support and felt it would help clients sustain employment, for example, ensure financial entitlements are in place and offer other motivational support.

Background

The Service Delivery Model (SDM) was introduced in July 2013 to all Work and Income service centres and community link sites across the country as part of the welfare reform changes. The SDM supports the welfare reform delivery by grouping clients into different services, enabling resources to be targeted towards those clients with the highest risk of long-term benefit dependency.

Work Focused Case Management for clients with a health condition or disability (WFCM: HCD) is one service provided under the SDM. It involves specialised case management support for clients with a health condition or disability that presents a significant barrier to their employment. Between July 2013 and February 2014, WFCM: HCD was piloted at 23 Work and Income sites nationally.

An evaluation of the WFCM: HCD service was undertaken by Knowledge and Insights, Ministry for Social Development, in November 2013. It involved interviews with staff from six of the pilot sites, a national survey of regional health advisor (RHA) and regional disability advisor (RDA) staff and analysis of administrative data. The evaluation was undertaken to provide insights and learnings about the delivery of a specialised case management approach for clients with a health condition or disability. This information will enable Work and Income to further develop the WFCM: HCD service under the SDM.

Transitioning to the new service

Transition was relatively smooth because of experienced case managers

Many case managers we interviewed had prior experience[3] working with clients with a health condition or disability. This meant they were more comfortable working with clients with a health condition or disability and had good relationships with the wider health community.

Case managers who were already experienced in the Work Focus Case Management approach of working with clients found the transition to working with clients with a health condition or disability easier than those who were new to the approach. Nevertheless, working with these clients still proved challenging in the early days for most staff.

Some case managers found the initial transitioning process difficult because the system was not as streamlined as it could have been. Initially, the absence of clear rules for transitioning clients into the service meant case managers sometimes had to go back and ask clients to repeat information, to make sure they had fulfilled the process requirements. This left case managers feeling frustrated about wasting their clients' time.

Training specific to the WFCM: HCD service was limited

No specific practice guide was created for the service. The WFCM practice guide includes a section on disability awareness that provides case managers with some information on how to interact with clients with a health condition or disability, identify their barriers and what type of intervention is likely to be effective. However, it does not contain information on specific health conditions. This left case managers feeling unsure about objectives and timeframes specific to the service. The WFCM: General practice guide served as a guide in this instance.

Most staff were given 'Mental Health 101' training, although this was not specific to the WFCM: HCD service. Case managers generally found Mental Health 101 training useful. Case managers reported that the Mental Health 101 training course provided useful basic knowledge about mental health conditions and gave them a greater understanding of their clients' needs.[4]

Case managers did not always feel confident when working with clients with a health condition

Case managers received no specific training on other health conditions or disabilities besides mental health conditions. As a result, many case managers felt they did not have enough knowledge about the barriers presented by common health conditions. They felt training would give them a better understanding of clients' needs and enable them to provide adequate and appropriate support.

[3] For example, working in the health and disability sector prior to becoming a case manager, or specialised Sickness Benefit case managers.

[4] Appendix 3 contains more information about the types of health conditions recorded for clients in the WFCM: HCD service. As of 5 February 2014, about 45 percent of clients in the service were recorded as having a psychological or psychiatric incapacity.

[To be a good WFCM: HCD Case manager] you need to have some understanding and basic training in the range of medical conditions, including mental health, addictions, suicide. For example, to be able to work with a person with an alcohol problem you need to be able to understand it and to understand how to work with them. – WFCM: HCD case manager

Staff particularly did not feel confident dealing with clients with severe health conditions. One service centre manager (SCM) described the severity of some clients' conditions as a "whole different kettle of fish" in comparison with dealing with milder health conditions. For example, clients with short-term memory issues may need support by reminding them about the process of maintaining their benefit.

Some case managers felt they needed a deeper understanding about mental illness than they received through Mental Health 101 training. One of the main concerns case managers had was unintentionally aggravating a client. Some case managers had difficulty knowing the right questions to ask at interviews, which left them lacking confidence in their ability to effectively work with clients with a health condition or disability.

Since July 2013, RHAs and RDAs have noticed an increase in the number of cases referred to them. Some RHAs and RDAs felt that case managers tend to recommend a client should be transferred to Supported Living Payment instead of trying to understand what their work capacity is.

Limited knowledge about specific health conditions also raises the risk that case managers may inadvertently cause harm by giving the wrong advice when working with clients with a health condition. Box 1 contains an example from a case manager that highlights how understanding a client's condition is important for providing the most appropriate advice to them.

BOX 1: UNDERSTANDING THE CLIENT'S CONDITION HELPS US PROVIDE BETTER SUPPORT

Jason* has obsessive compulsive disorder (OCD). At his first appointment with his case manager, he mentioned he was interested in being a gardener. His case manager gave him some information about self-employment and the Flexi-wage subsidy.

One week later, Jason called the Work and Income Call Centre to cancel his benefit, despite having no work lined up. Jason had 'compulsively decided' he was going to work as a gardener. By cancelling his benefit, Jason deprived himself of benefit income for four weeks.

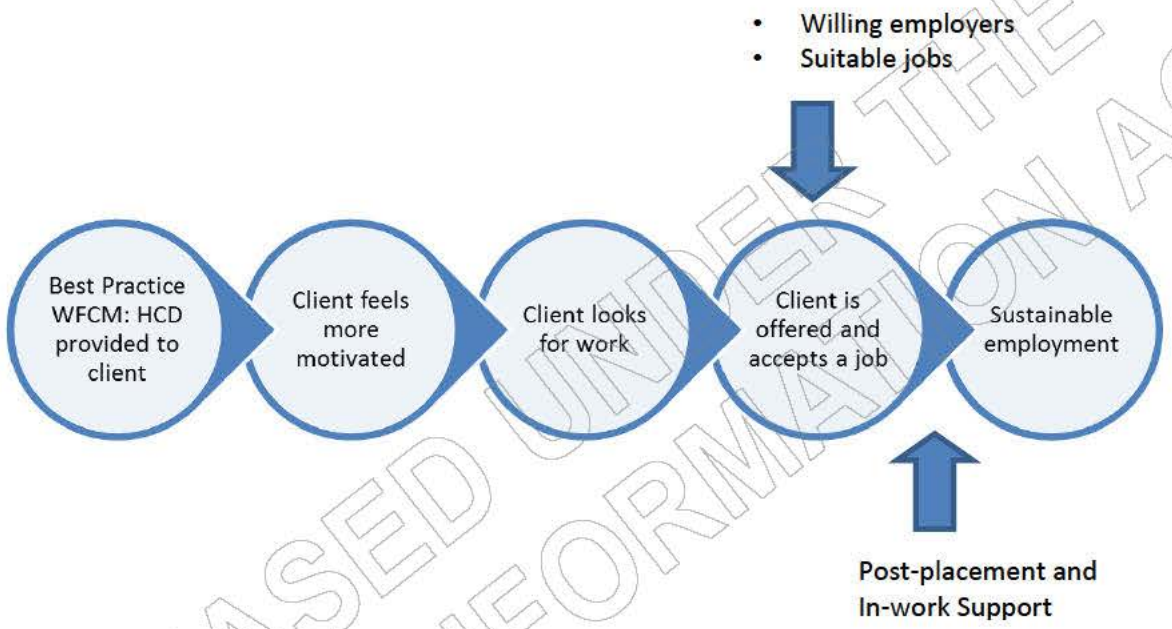
During this time, his case manager fought hard to convince Jason that, while it was great he had decided what work he wanted to do, they needed to put in some steps to get there. The case manager felt she may have been more cautious and made sure Jason had considered his options fully if she had a better understanding of his condition.

**Name has been changed to protect privacy.*

Working with clients

Figure 1 summarises the client's progression through the WFCM: HCD service. Systems and processes at each stage can support or hinder the client's progress towards sustainable employment.

Figure 1: Client's journey through the Work Focused Case Management for clients with a health condition or disability (WFCM: HCD) service



Providing best practice WFCM: HCD service to clients

Site management and design support clients and case managers

SCMs and assistant service centre managers (ASCMs) make important decisions on how the service centre operates, such as the criteria they use to select WFCM: HCD case managers, and how much flexibility case managers have over their calendars and appointment times. These decisions affect the skills and resources available to case managers to enable them to work successfully with clients.

Some case managers found the physical layout of the service centre provided support for clients with certain health conditions. For example, some service centres have quiet secluded waiting areas that are offered to clients with conditions such as anxiety, resulting in those clients being more comfortable with going into the service centre.

Tailored case management and caseload ratios enable best practice

Clients and case managers liked one-on-one case management. Case managers valued seeing their clients' progress towards, and ultimately into, work. They felt more motivated and gained a better understanding of the client's situation. Proactive engagement with clients also reduced reactive processing for case managers, for example, hardship applications. Case managers reported that clients generally liked not having to repeat their story to different people. One-on-one case management enables case managers to build trust with their clients, resulting in clients becoming

more comfortable opening up to them over time. However, some clients who were not used to regular engagement found it difficult to adapt to the new approach.

Most case managers reported their caseload size was 'about right' and enabled them to meet clients on a regular basis. The mix of high-needs versus low-needs client cases affected the burden of the caseload on the case manager. Some case managers thought their caseloads could be heavier, because some of their clients could be seen less frequently. Conversely, clients with health conditions or disabilities who also face other challenges, such as housing needs or domestic violence, need more intensive case management.

At some sites, case managers felt pressured for time because of prescribed back-to-back appointments, large amounts of paperwork and administration, and extra processing requirements for clients with a health condition (eg, for Disability Allowance applications and medical certificate interpretation).[5] RHAs and RDAs agree that processing requirements of WFCM case managers could limit their ability to have work-focused conversations with clients.

Case managers generally adapted their approach to suit their clients' needs. For example, clients with severe anxiety may be initially interviewed through a phone call rather than a face-to-face appointment. Being flexible in this way helps keep clients engaged and builds clients' trust in the case manager. Apparent inconsistent messaging about how much flexibility case managers have left some case managers with the impression they had to follow certain rules around how and where client appointments can take place. For example, some case managers believed that they could no longer run one-to-many seminars under the new service, which left them feeling less enabled to best meet their clients' needs.

New assessments provide useful information but can be difficult to interpret

Case managers, RHAs and RDAs agree that, when filled in 'correctly', the new medical certificate gave case managers an objective assessment of the clients' work capability. However, some case managers felt that doctors were not always providing enough information about the client's work capacity. Educating doctors to provide more detailed information about the client's work capacity would help case managers more easily determine the clients' work obligations.

RHAs and RDAs believe the 'two-year review' aspect of the medical certificate is confusing case managers into thinking a client needs to be on Supported Living Payment, even if the doctor states the client has some capacity to work. Greater clarity for case managers on what the 'two-year review' means would help in this regard. Some case managers also raised concerns that the layout of the medical certificate was not well aligned with the screen in SWIFTT,[6] making it more difficult to process.[7]

Case managers reported the self-assessment form gave them a good starting point to create a plan for the client because it helps them understand the client's barriers and their aspirations. The self-assessment form can also help highlight any differences of opinion between the clients' view on their work readiness and the doctor's assessment.

5 Appendix 3 contains detailed information about the service centres' capacity to provide the WFCM: HCD service.

6 SWIFTT is the operational system used by Work and Income to assess and pay clients.

7 From 4 December 2013, the SWIFTT screen for part-time work and study obligations that is used to process medical certificates has been changed to make processing easier.

Some RHAs and RDAs reported that, although the self-assessment form captures information about the client's hobbies and interests, its usefulness is limited because it does not always show how the client's interests might relate to their work skills. As one advisor observed, "Listing hobbies & interests themselves don't indicate the level of involvement in the interest…; how does this interest translate to skills for work?"

Case managers also reported that self-assessment forms were not always completed well initially. They often contained brief one-word answers that lacked the information needed to help a case manager fully understand a client's situation. Some clients found it difficult to fill in the self-assessment form on their own if they had literacy barriers or were unable to understand the intent of the questions. Some case managers found it more effective to fill in the form while the client was present so that they could explain what was being asked and why.

Regional health and regional disability advisors are useful resources for case managers

Case managers felt well supported by the RHAs and RDAs. Amongst other things, RHAs and RDAs offer case managers advice on their clients' ability to work from a medical perspective and their eligibility for Supported Living Payment. Although RHAs and RDAs were not based on-site for most of the service centres, they could usually be reached by phone or email as needed.

Being on-site was the most useful way for RHAs and RDAs to engage with staff and provide support. Since July 2013, all RHAs and RDAs surveyed had visited a Work and Income Service Centre in their region – with half visiting all, and the rest visiting most or some of these sites. Most RHAs and RDAs would visit the site for a day, to provide tailored support to case managers, for example, discussing complex cases and sitting in with the case manager in a client appointment.

Site visits also gave RHAs and RDAs an opportunity to coach and train case managers to work with clients with health conditions or disabilities. Some RHAs and RDAs were able to identify case managers who appeared to need more assistance in this area based on the referrals they made. Other RDAs and RHAs had set meetings with WFCM: HCD staff to help them with issues, or presented at Wednesday Briefs on common issues, such as how to effectively communicate with clients who have communication barriers.

In regions where the number of RHAs and RDAs is relatively small and spread across a large number of service centres, case managers sometimes found it difficult to access them in a timely manner. Some case managers reported wanting to meet with their RHA and RDA more frequently than they currently do.

Motivating clients to engage in work or training

Staff felt clients who were more motivated were generally easier to engage with

Case managers reported that clients who were motivated and willing to work were the easiest to engage with. Work brokers reported that motivated clients tended to be easier to place into work, because employers were more willing to give them a chance.

Conversely, many of the case managers and work brokers we interviewed described clients who were discouraged or unwilling to work as the most difficult to engage with. However, case managers recognised that a client's discouragement or lack of motivation to search for work may be symptomatic of their health condition (eg, depression or anxiety) and not necessarily under their control.

Some case managers noted that clients in the older age groups were at times more difficult to work with because they appear discouraged or do not seem motivated to look for work. This might be partly explained by the fact that older clients form a large proportion of the total client group in the WFCM: HCD service.[8] RHAs and RDAs noticed that longer-term clients could also lack motivation, despite having a condition that they could work with.

> *With more client engagement the motivation to work for longer term beneficiaries seems to be an issue. People who have been sick/disabled by a condition that many would continue to work with seem to find it difficult to imagine working.* – RHA/RDA

RHAs and RDAs stressed the need for case managers to have work-focused conversations with clients with a health condition or disability at every interaction. Work-focused conversations are needed to set up the expectation of future employment and to stop clients 'slipping through the cracks'. Even clients who are too unwell to work can have goals that place them on the pathway toward work, such as increasing socialisation or up-skilling.

Building trusting relationships with clients enables case managers to motivate clients

Case managers who focus initially on understanding their clients' needs and ensuring they receive their full and correct entitlements are better able to build trust with the client. It can sometimes take months of engagement before a client trusts a case manager enough to open up fully. Generally, case managers are able to successfully motivate clients through having 'courageous conversations', building trust, recognising clients' achievements and using innovative approaches such as tailored seminars. Box 2 gives an example of how one of the sites we visited used such an innovative approach to motivate clients.

BOX 2: CASE MANAGERS TAKE INNOVATIVE APPROACHES TO MOTIVATE CLIENTS

Case managers at one service centre held a seminar for a group of clients with a health condition or disability. A former client who has a mental illness spoke at the seminar about his journey. The speaker emphasised that it is great to have a dream job, but sometimes you have to be realistic about what type of jobs are available.

The seminar included a client with depression, a client with obesity who lacked confidence and a client with chronic fatigue syndrome, amongst others. No more than 15 people attended the seminar. Clients were chosen because they had a positive attitude to work but had barriers they needed to overcome.

Client feedback for the seminar was very positive. Case managers noticed clients' body language changed during the seminar, from slouching to leaning forward. Clients felt that if the speaker could achieve, so could they.

Encouraged by the success of this seminar, the site plans to run similar sessions in the near future.

[8] See appendix 3 for more information about the age distribution of clients in the WFCM: HCD service.

Service-matching rules initially saw some clients being moved to different caseloads. WFCM: HCD case managers reported that some of their clients were dropped off their list once their work obligation deferral was lifted.[9] Case managers found this frustrating because they believed it interrupted their clients' progress and undermined the relationship they had built with their clients.

Most case managers we interviewed believe successful case managers are those who are able to empathise with their clients, are passionate and can have 'courageous conversations'. RHAs and RDAs also agreed that case managers need to have the 'right' attitude and be willing to use available resources to access their clients' work capacity. Establishing trust with the client means that clients are more willing to share their concerns with the case manager so that they are better informed about the clients' barriers and can take the most appropriate steps to address their clients' needs.

Recognising staff and client achievements helps motivation

Case managers reported that the small step achievements clients with a health condition or disability make towards employment (staircasing achievements) are not formally recognised in the Key Performance Indicators (KPIs). As a result, it is up to the SCM and ASCM of a service centre to keep WFCM: HCD case managers motivated by informally recognising their progress with clients. This recognition helps case managers stay focused on supporting their clients on their path to sustainable employment.

Recognising case managers' and clients' achievements for this client group is especially important because clients with a health condition or disability do not always progress smoothly and will often have setbacks along the way. Box 3 contains an example given by a case manager of a setback one of their clients had.

BOX 3: CLIENTS WILL OFTEN HAVE SETBACKS AS THEY PROGRESS FORWARD

Sarah* was uncomfortable around men because she had been raped. She and her case manager had talked about her socialising in safe environments with men, as a step forward for her. Sarah had then gone out and done voluntary work in a male environment and was feeling much better as a result. She had also applied for a job.

However, when Sarah's perpetrator arrived back in the community, it served as a major setback. The case manager reassured Sarah that she had made progress and that setbacks like this are normal. She also recommended that Sarah return to the doctor and attend more counselling, because it was about "making sure she has all the tools in her kitbag" to deal with such setbacks.

**Name has been changed to protect privacy*

Peer support exists for case managers but greater clinical support may be needed

Case managers at most service centres engage in some form of reflective practice. They discuss difficult cases with other case managers and their manager. However, reflective practice is not always focused on the challenges specific to working with clients with a health condition or disability.

[9] The service-matching rules have since been adjusted to address this problem. Appendix 3 contains more detailed information around the incidence and resolution of this.

Most staff felt it would be useful for WFCM: HCD case managers, RDAs and RHAs to engage in more reflective practice together, to discuss how to tackle problems involving specific health conditions faced by clients. This would help case managers to feel supported and allow them to exchange ideas on how to work with difficult clients.

Case managers reported that working with clients with a health condition or disability often requires them to use counselling or social work skills that they are not trained in. They reported that this can be overwhelming and can lead to emotional turmoil. Because of this, there may be scope for case managers to receive clinical support, for example, from a trained counsellor, to help them better manage this stress.

Supporting clients into work

Helping clients access training or employment

Limited services to refer clients to in the community is a challenge

Case managers reported often reaching a plateau by their fourth or fifth engagement with a client. Community provider placements are often limited or unsuitable for clients with particular health conditions or disabilities, and some case managers do not have a thorough knowledge about what services exist in their community to refer clients to for further training or treatment.[10]

Case managers felt more courses teaching basic computer skills, interview skills and techniques, life skills, and integration into work, are needed to increase clients' chances of finding work. They also felt there are not enough courses of a short duration (one-to-two days). The standard 13 weeks for courses can be too long for clients who cannot sit or stand for extended periods.

Limited available medical services are also presenting problems for some case managers. For example, the absence of the Providing Access to Health Solutions (PATHS)[11] programme and a lack of doctors in one region are limiting the support that clients can access to help them into work. Some case managers also felt there was a shortage of services for clients with alcohol or drug addictions.

Work brokers need to have effective strategies to better meet the needs of clients with a health condition or disability

Many staff felt that work brokers needed to focus more on profiling clients with a health condition or disability to an employer, and gain a better understanding of how the client's condition affects (or does not affect) their ability to work in specific environments. RHAs and RDAs generally felt that work brokers were matching clients to jobs based on work skills, without taking into account the clients' health conditions or disabilities.

Most RHAs and RDAs surveyed appeared to have little contact with work brokers and employment co-ordinators. One RDA/RHA raised concerns about where work brokers were getting their knowledge from to work with clients with a health condition or disability, and that they may not be working with these clients in the most appropriate way.

> *I am not sure where our work brokers are getting their health & disability knowledge from to help clients with these issues into appropriate workplaces. I expect work brokers are used to matching work skills to job [sic] but not necessarily with the addition of a health condition or disability. I haven't been involved in any training for work brokers.* – RHA/RDA

Some RHAs and RDAs are offering work brokers assistance to help them better understand the work ability of these clients and their needs based on the information provided in the medical certificate, the

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10 The new Work Ability Assessment, introduced on 24 February 2014, is aimed at addressing this issue. It will give case managers a place to refer clients with more complex circumstances to, when they have exhausted other options.

11 Providing Access to Health Solutions (refer Doogle: http://doogle.ssi.govt.nz/resources/helping-clients/procedures-manuals/work-and-income/health-disability/paths/).

client's health conditions, and appropriate work, tasks and accommodations that would be required. RHAs and RDAs have also provided advice on how to work with clients with more complex health conditions or disabilities, how to transition clients into work through using subsidies and working with other agencies, and how to support clients who are struggling once placed in a job.

Work brokers generally felt that employers were reluctant to hire clients with a health condition or disability because they viewed them as a greater risk, especially in regions where the labour market is dominated by small businesses. The ability to offer employers subsidies, for example, the Flexi-wage subsidy, mitigated this to an extent. Similarly, some work brokers said they felt reluctant to place clients with a health condition or disability into work because they were concerned about compromising their relationships with employers if the placement did not work out.[12]

Supporting clients once they find employment

Post-placement support may enable a smoother transition to work

Many of the sites we visited do not currently provide support for clients transitioning into work. Case managers at some sites reported they could not track where clients were going once they transferred off benefit, if they were not placed by Work and Income, and therefore could not ensure they were receiving the financial or other support (eg, motivational) they were entitled may need.

Post-placement support may involve talking to the client once they start work and supporting them where needed, talking with the employer, to address any concerns they may have or issues that have arisen (in instances where Work and Income placed the client), and ensuring the client is receiving their full and correct financial entitlement (eg, Inland Revenue Working for Families payment). Providing this support to clients means they may be less likely to accumulate benefit debt and may be more likely to stay in work.

12 The Employer Strategy Model recognises the importance that effective work brokerage has on placing clients into sustainable employment. It involves refocusing work brokerage to be more tailored to the employers' needs and a greater focus on profiling clients to jobs that would help clients with a health condition or disability, in particular. The Employer Strategy Model is being piloted in the Wellington, East Coast and Nelson regions and will be gradually implemented across all sites by July 2014.

Appendix 1: Methodology

In late 2013 and early 2014 Knowledge and Insights carried out a process evaluation of the Work Focused Case Management for clients with a health condition or disability (WFCM: HCD) service being piloted in 23 sites. The evaluation's purpose was to help Work and Income deliver a better service because more deferred work-obligated clients with a health condition or disability receive Work Focused Case Management.

The evaluation aimed to answer the following questions about WFCM: HCD.

1. Was WFCM: HCD being implemented and operating as intended?
2. Which key processes and practices were working well and which were presenting difficulties?
3. Which aspects of the WFCM: HCD service contributed to client outcomes?

This process evaluation involved interviews with Work and Income staff from selected service centres where WFCM: HCD was being piloted. We also analysed administrative data and surveyed regional health advisors and regional disability advisors across all service centres.

Staff interviews

Semi-structured interviews of Work and Income staff took place in November 2013. Sites were selected only if they had enough clients within the target groups to meet the required caseload numbers in WFCM: HCD. Variation in labour markets, client demographics and current service centre resourcing was also required across the selected sites to ensure we understood the WFCM: HCD practice across a range of conditions.

Work and Income guided Knowledge and Insights on site selection based on its knowledge of how the different sites operate in practice.

We interviewed staff at the following six sites:

- Tamaki Community Link
- Whangarei Community Link
- Nelson City Service Centre
- Papakura Community Link
- Hastings Community Link
- Riccarton Service Centre.

We interviewed staff in the following roles:

- service centre managers
- assistant service centre managers
- WFCM: HCD case managers
- General Work Focused Case Management case managers
- employment co-ordinators and work brokers.

Analyses looked at similarities, differences and anomalies across and within the sites visited. Interview lengths and questions varied based on the staff's role and their interaction with the WFCM: HCD service.

Findings from the in-depth discussions with staff represent only the conditions present at the sites we visited at the time of our fieldwork.

Regional health advisor and regional disability advisor surveys

We surveyed regional health advisors (RHAs) and regional disability advisors (RDAs) across all regions.

We sent the survey to 25 RHAs and RDAs, of which 56 percent responded. Findings from their responses are integrated into the report.

Administrative data

We analysed Ministry of Social Development administrative data to support qualitative findings in the following areas:

- the age distribution of clients in the WFCM: HCD service
- the primary incapacity recorded for clients in the WFCM: HCD service
- the capacity of service centres to provide the WFCM: HCD service
- how often and how many clients were dropping off the WFCM: HCD case management list.

Appendix 2: WFCM: HCD service

The Work Focused Case Management for clients with a health condition or disability (WFCM: HCD) service is part of the Service Delivery Model (SDM) that groups clients into different services based on their risk of long-term benefit dependency. Resources are targeted towards higher-risk clients, to prevent long-term benefit receipt in line with the 'Investment Approach' introduced as part of the welfare reform changes.

The SDM consists of three distinct workstreams: Work Focused Case Management, Work Search Support and General Case Management. The intensity of service a client receives within each workstream depends on how much support they need to find a job.

Work Focused Case Management involves case managers providing intensive one-on-one support to clients to help them into employment. WFCM: HCD specifically supports clients with a health condition or disability by preparing them for work while taking steps to resolve any specific barriers to work they might have.

To be eligible for the WFCM: HCD service, a client must be on a Jobseeker Support benefit but have deferred work obligations due to a health condition or disability. Current WFCM: HCD caseloads are capped at 100 clients.

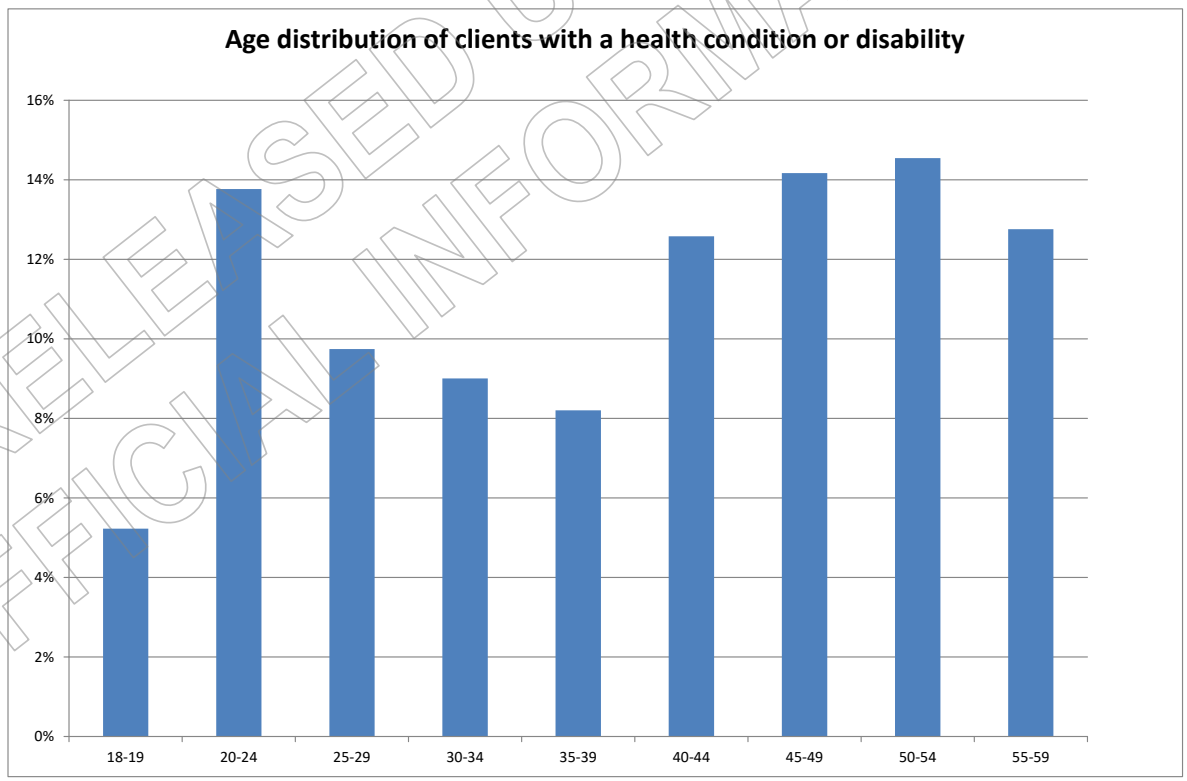
Appendix 3: Administrative data

Client profile

The administrative data we analysed gave us a picture of the characteristics of clients in the Work Focused Case Management for clients with a health condition or disability (WFCM: HCD) service. As of 5 February 2014, 4,475 clients have received or were receiving the WFCM: HCD service across all pilot sites.

The average age for clients in the WFCM: HCD service across all pilot sites is 39 years. However, the uneven age distribution means less than 8 per cent of clients actually fall within the 35 year and 39 year age group. Over half of all clients are between 40 years and 60 years old. A further 14 percent of clients are between 20 years and 24 years old. Figure 2 shows the age distribution of clients in the WFCM: HCD service.

Figure 2: Age distribution of clients in the Work Focused Case Management for clients with a health condition or disability service



Psychological or psychiatric conditions were the most common type of primary incapacities and were recorded for 45 percent of all clients in the WFCM: HCD service across all pilot sites. These conditions predominantly include stress, depression, bipolar disorder and schizophrenia. Depression was the most common recorded condition within this group.

Capacity for the WFCM: HCD service

The maximum number of clients that can be work focus case managed under the WFCM: HCD service varies across the pilot centres. Roughly half of all sites have two WFCM: HCD case managers and are able to provide the service to up to 200 clients. Of the remaining sites, roughly half have only one case manager working in the WFCM: HCD service. One pilot site in Auckland has five WFCM: HCD case managers and is therefore able to provide the service to up to 500 clients.

Reasons for clients leaving the WFCM: HCD service

We also analysed data relating to the number of clients leaving the WFCM: HCD service. As at 5 February 2014, nearly 3,500 clients had left the service. Thirty five percent of clients with a health condition or disability across all pilot sites exited the WFCM: HCD service because they stopped receiving a benefit altogether. We are unable to tell whether this was because they found full-time employment or if they left for some other reason. A further 25 percent of clients left because they moved away from the pilot area.

Of clients who exited the service across all pilot sites, 11 percent were transferred to General Work Focused Case Management (WFCM: Gen), suggesting that their work obligation deferral was no longer appropriate. The incidence of this was varied across the regions, from 2 percent to 24 percent.

Since mid-November 2013, no client has exited the WFCM: HCD service to transfer to WFCM: Gen. This was due to the adjustment of the service matching rules to prevent WFCM: HCD service clients being moved onto a different workstream once their work obligation deferral was dropped. As a result, fewer clients have exited from the WFCM: HCD service than would have if the rules had not been adjusted.

MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

Young SLP Opt-In Trial

Process evaluation report
October 2015

Author

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Acknowledgements

The author thanks the participants who gave their time to be interviewed for the evaluation.

The author also thanks s 9(2)(a) who assisted in the fieldwork and analysis of data for the evaluation.

Disclaimer

The views and interpretations in this report are those of the researcher and are not the official position of the Ministry of Social Development.

Readers should note that this report has not been through the Ministry's full publication quality assurance process, but is being published for internal use as it may be of value and interest to Ministry staff.

Date of publication

This report was completed in October 2015, and published internally in January 2020.

ISBN

978-0-9951240-6-6

Contents

Abbreviations

Abbreviation	Meaning
ASCM	Assistant Service Centre Manager
DEF	Disability Employment Forum
DPA	Disabled Persons Assembly
DPOs	Disabled Persons Organisations
HCD	Health condition, injury or disability
JS HCD	Jobseeker Support clients who have deferred work obligations due to a medical condition or disability
MSD	Ministry of Social Development
RDA	Regional Disability Advisor
RHAs=	Regional Health Advisor
SCM	Service Centre Manager
SDM	Service delivery model
SLP	Supported living payment
WFCM	Work Focused case management
WINZ	A term used by many clients to refer to Work and Income

Executive summary

This report details findings from a process evaluation of the young Supported Living Payment (SLP) Opt-In trial that was initially launched in 16 Work and Income sites on 3 November 2014. The results of the evaluation will inform future development of the young SLP service model and its potential roll-out nationwide as well as the SLP expansion.

People who receive SLP have a permanent and/or severe health condition or disability and do not, under legislation, have work obligations.[1] However, according to a Statistics New Zealand report[2], many people with a disability or health condition do want to work but feel they have not been given the opportunity. The aim of the young SLP Opt-In trial is to provide specialist case management support for young people in receipt of SLP who have a personal goal of gaining employment. The trial is voluntary and allows SLP clients aged 16–29 years to opt into Work Focused Case Management: Health Condition or Disability (WFCM: HCD).

An evaluation of the trial was undertaken by Insights MSD between June–August 2015. It involved interviews with the National Office project team, staff from six of the pilot sites, 13 clients who had opted into the trial, the Disability Employment Forum (a sector-based reference group for the trial) and analysis of administration data. The evaluation considered:

- the design and implementation of the trial
- case managers' experiences of the transition to the new service and working with young SLP clients
- factors that support or hinder best practice case management
- client engagement in the service.

Key findings from the evaluation are outlined below.

Aspects of the design process worked well but areas could be improved

- Early engagement with internal and external stakeholders was critical and helped to secure buy-in and support for the trial. Involvement with the disability sector was seen as particularly important. Members of the trial project team felt that by involving the disability sector early in the trial design, they had been rewarded with the sector's support.
- The Disability Employment Forum (DEF), a network of organisations that advocate for the disability community around issues of employment, was invited by the Ministry of Social Development (the Ministry) to partner with them in the design of the trial. While the Ministry saw the DEF's role largely in a co-design capacity, the DEF saw their involvement largely as a consultative role. This disconnect highlights the need

[1] People who are not able to work because they are caring for a person who requires full-time care and attention at home may also receive SLP. However, the focus of this trial and the evaluation is exclusively on those who themselves have a health condition or disability.

[2] Statistics New Zealand (2008). *Disability and the labour market in New Zealand in 2006.* Statistics New Zealand, Wellington.

for an agreed understanding of co-design and/or of each actor or group's role in the project.

- The DEF also felt there was a lack of transparency around what the end of the trial would mean for contracted supported employment providers. Of particular concern was whether the young SLP Opt-In trial signalled that the Ministry was unhappy with contracted providers' performance and were looking to bring the service in-house. The DEF's concerns about the trial can be seen in the context of changes happening in the contracting space more broadly and the uncertainty that some providers feel about the future.
- Earlier involvement with experienced frontline staff may have benefitted the trial design. For example, some employment co-ordinators already had considerable experience working with SLP clients and the disability sector. Involving them in the design would have provided an opportunity to share their knowledge and experience.

Overall, the trial was well implemented but aspects could be improved

- A multi-discipline working group helped to bring all aspects of the trial together. This meant that nothing was overlooked and things happened in a co-ordinated and timely manner.
- Comprehensive training specific to the trial was developed for frontline staff. The training was generally well received by case managers and provided them with a good foundation to build on with clients.
- The launch of the trial in November was not ideal because momentum was lost through the Christmas/summer holiday period. However, the trial start date was constrained by other trials starting in the New Year.
- Case managers selected for the young SLP Opt-In trial had been working with a caseload of 100 Jobseeker Support clients with a health condition or disability (JS HCD). Ten of their JS HCD clients were to be replaced with 10 young SLP clients who had opted into the trial. The tapering off of case managers' JS HCD caseloads needed to start earlier because some case managers had to wait several weeks after the trial start date before they had capacity to take on young SLP clients.
- Specific engagement with service centre managers (SCMs) and assistant service centre managers (ASCMs) about the trial was needed because some case managers felt isolated and unsupported by their managers and colleagues in the early days of the trial. For subsequent trials, members of the project team have done more to specifically enrol SCMs and ASCMs.
- Two new types of provider contracts were established to support the young SLP Opt-In trial: peer support and career services. However, the contracts for these services were not in place for the trial 'go live' date and, at the time of evaluation fieldwork, were still not working well.
- More planned, strategic engagement with frontline staff post-launch would have helped with the implementation and 'bedding-in' phase of the trial.

Case managers enjoy working with young SLP clients but find their workloads have increased

- Experienced case managers helped facilitate the transition to the new service although the transition was not without its challenges.
- Case managers enjoy working with young SLP clients and find them motivated and enthusiastic. The voluntary nature of the trial means that clients who opt in are likely to be naturally more motivated or able to work and, therefore, are not necessarily representative of the young SLP populations as a whole.
- The voluntary nature of the trial also appears to create a different dynamic in the case manager–client relationship. Compared with work-obligated clients, where there is an element of compliance, young SLP clients have chosen to be involved and have no specific obligations to meet. Without specific targets to meet, the case manager can take a person-centred approach with young SLP clients and focus more up-front time on building the relationship.
- The design of the trial implies that 10 young SLP clients are comparative in work load to 10 JS HCD clients. However, case managers' experience suggests there is a difference and most reported an increase in workload after starting the trial. Case managers find many young SLP clients to have higher needs and be more time intensive than JS HCD clients, and facing more barriers to employment.

Some factors support best practice but others hinder best practice

Case managers highlighted a number of factors that appear to contribute to best practice case management with young SLP clients. These factors, in many respects, centre on relationships: building trusting relationships with clients; adopting a person-centred approach; and establishing collaborative working relationships with employment co-ordinators and other service providers to provide the best possible service to the client. Qualities that support best practice case management include an ability to empathise and connect with clients and to think creatively to achieve outcomes for clients.

Factors that hinder best practice case management include: high workloads and a lack of time to do justice to clients' needs; a shortage of training courses for young SLP clients; limited support from work brokers; and a lack of clarity around who is responsible for post-placement/in-work support for clients and employers.

Clients are positive about the trial but there are areas of frustration

As at 18 September 2015, 170 SLP clients had opted into the service. The average age of clients who have opted into the trial is 23 years and the majority (62 percent) are male. Psychiatric or psychological conditions are the most common type of primary incapacity recorded for clients in the trial. Forty-two clients (24 percent) have exited the service. Of these:

- eight have been into sustained employment
- nine have been at the client's request
- four were the case manager's decision
- seven were because the client had transferred to a non-trial site
- fourteen were coded either as 'unspecified' or 'other'.

Clients participating in the trial are generally positive about the service. They appreciate having a single point of contact at Work and Income and someone who they can trust and who supports them. Some early outcomes are evident but because clients often work with multiple service providers they cannot be attributed to the trial alone. As well as feeling more supported, several clients also report feeling more optimistic about the future and/or more confident in themselves since starting the trial.

Areas of frustration for clients include not enough face-to-face contact with case managers, the length of time it takes for case managers to follow-up on actions, the length of time it is taking to find a job and the limited range of training courses available.

Barriers to client uptake of the service include being too busy, studying, not being well enough, protective parents and concerns over losing their benefit.

Opportunities recommended for consideration

- Review provider contracts for peer support and career services to understand why they are not working well and what can be done to improve the services.
- Develop clear process guidelines to clarify roles and responsibilities when clients are also working with supported employment providers. Interviews with supported employment providers are also recommended to gain an understanding of their experience of working with Work and Income case managers and what process would work best for them.
- Clarify the roles and responsibilities of employment co-ordinators and work brokers in the trial and who has responsibility for post-placement/in-work support.
- Review the range of training courses available to young SLP clients and the flexibility of these courses to accommodate people with health conditions or disabilities. A review of training providers' contracts is also recommended to determine if they in any way disincentivise providers to take on young SLP clients.
- Because work brokers reportedly have limited capacity and/or confidence in working with SLP clients, explore the possibility of a partnership model with contracted supported employment providers for work placement services.
- Review case managers' caseloads, and the extent to which other demands are being placed on their time, to assess whether they have sufficient time to work with clients. Recognise that some clients have higher needs and are more time intensive than others.
- Case managers do not appear to be using the resources available through their regional disability advisors (RDAs) and regional health advisors (RHAs). Remind case managers and RDAs/RHAs that RDAs and RHAs are there to support them.
- Case managers feel they need a deeper understanding of certain health conditions and disabilities and would like the opportunity to learn from examples of best practice. Facilitate ongoing training for case managers.
- Investigate the possibility of providing case managers with access to clinical supervision to help them better manage stress and maintain boundaries with clients.

Introduction

Purpose of the evaluation

This report details the findings from a process evaluation of the young Supported Living Payment (SLP) Opt-In trial. People who receive SLP have a permanent or severe health condition or disability and do not, under legislation, have work obligations. The young SLP Opt-In trial is part of a series of new approaches being piloted as part of Work and Income's Service Delivery Model (SDM) and investment approach. The aim of the young SLP Opt-In trial is to provide specialised case management support for young people in receipt of SLP who have a personal goal of gaining employment.

A process evaluation of the young SLP Opt-In trial was undertaken by Insights MSD between June–August 2015 and involved interviews with the trial project team, staff from six of the pilot sites, a sample of SLP clients who had opted into the trial, the Disability Employment Forum (a sector-based reference group) and analysis of administrative data. The Ministry of Social Development (the Ministry) wanted to understand how the service is working in practice and how it is contributing to client outcomes of work, up-skilling and higher education. The results of the evaluation will inform the future development of the young SLP service model and its potential roll-out nationwide as well as the SLP expansion.

Background to the young SLP Opt-In trial

The investment approach strategy

The young SLP trial grew out of the Service Delivery Model (SDM) and Service Delivery's investment approach, which was introduced in July 2013 as part of wider welfare reform changes. The aim of the investment approach is to reduce long-term benefit receipt in order to better manage the future liability of the benefit system. The SDM supports the investment approach by streaming clients to different levels of case management based on the clients' circumstances, enabling resources to be targeted to the right client at the right time to reduce long-term welfare dependency.

The use of an actuarial valuation helped identify five priority client cohorts based on their future liability in the benefit system (sole parents, long-term jobseekers, high-churn clients, early entrants and entrenched beneficiaries, and young SLP clients). Trials are underway for each priority cohort.

The high-level outcomes being sought from the investment approach trials are to:

- improve client outcomes
- generate fiscal savings
- reduce future liability.

Young SLP clients do not have work obligations but some want to work

Young SLP clients have the highest liability of any priority cohort. Many enter the benefit system early and rarely leave once they have received the benefit long term. This means they are often excluded from the labour market for their entire lives. Long-term benefit receipt is associated with poor economic and social outcomes and can have a negative impact on health and wellbeing.

According to a Statistics New Zealand report[3], though, many people with a disability or health condition want to work but feel they have not been given the opportunity. There is also evidence to suggest that work is beneficial for people who have a health condition or disability when health conditions permit and the demands of the work are adjusted where necessary to match individual capacity (Waddell & Burton, 2006). People who move off unemployment and disability benefits and (re-)enter work generally experience improvements in income, socio-economic status, mental and general health, and well-being (CSRE, 2009).

People in receipt of SLP do not, under legislation, have work obligations due to the permanent and/or severe nature of their health condition or disability. This means they have not historically received the same level of employment support from Work and Income as work-obligated clients. Some in the disability sector have argued that, from a human rights perspective, people with a health condition or disability should be offered the same services as their non-disabled peers, with a provision of specialist knowledge and support for particular groups. There is also evidence that early intervention for people with a health condition or disability can be effective in supporting them into paid employment (CSRE, 2010).

The young SLP Opt-In trial supports young people into work

The theory of change[4] is that by providing young SLP recipients with access to specialist case management and additional support services they will move into work and off benefit (figure 1). Allowing young SLP clients to access specialist case management addresses the need for early intervention and gives them access to mainstream services. By intervening with SLP clients while they are young, the Ministry also hopes to address both the age and benefit duration factors which influence the average long-term liability of this cohort. By maximising the opportunity for disabled people to realise their employment aspirations, it is also expected that social and economic outcomes for this cohort will improve, for example, through better health, increased self-esteem, general quality of life, social and economic participation, and improved confidence to learn, grow and try new experiences.

Because SLP clients have received little in the way of employment services from Work and Income in the past, the young SLP Opt-In trial is also an opportunity for Work and Income to learn how to work with this cohort to effectively support them towards their employment, up-skilling or education goals. Learning from the trial will inform future case management practice with this client group.

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[3] Statistics New Zealand (2008). *Disability and the labour market in New Zealand in 2006*. Statistics New Zealand, Wellington.

[4] A theory of change outlines the rationale for the trial, the changes that are expected and how the change can be achieved.

Figure 1: Young SLP Opt-In trial intervention logic

Young SLP Opt-In Trial Intervention Logic

Problem Statement

- Young SLP clients have the highest liability of any cohort. Many enter the benefit system early and rarely leave once they have received the benefit long term. This means they are often excluded from the labour market for their entire lives. Long-term benefit receipt is associated with poor economic and social outcomes and can have a negative impact on health and wellbeing.
- According to a Statistics New Zealand report, though, many people with a disability or health condition want to work but feel they have not been given the opportunity.
- People in receipt of SLP do not, under legislation, have work obligations due to the permanent and/or severe nature of their health condition or disability
- This means they typically have not received the same level of employment support from Work and Income as work obligated clients. Some in the disability sector have argued that from a human rights perspective, people with a health condition or disability should be offered the same services as their non-disabled peers, with a provision of specialist knowledge and support for particular groups.
- There is evidence that early intervention for people with a health condition or disability can be effective in supporting them into paid employment (CSRE, 2010).

Theory of Change

- The theory of change is that by providing young SLP recipients with access to specialist case management and additional support services they will move into work and off benefit.
- Evidence shows that people who move off unemployment and disability benefits and (re-) enter work generally experience improvements in income, socio-economic status, mental and general health, and well-being (CSRE, 2010).

GOAL: to support young people with a health condition or disability, who want to work, into work

Resources / inputs	*Activities*	*Initial outcomes*	*Intermediate outcomes*	*Long-term outcomes*
Adequate resourcing at a system level to deliver outcomes • Financial resources to support the trial • Technology that supports the achievement /reporting of outcomes • Workforce resourcing and training to build capability of staff to work effectively with SLP clients	**Referral and engagement** • Case managers contact eligible young SLP clients to inform them about the trial and how to participate. Participation is voluntary • Non-trial case managers refer SLP clients to trial case managers	**Young SLP clients** • Understand what's on offer through the Opt-In trial and how it can help them • Choose to engage in the Opt-In trial • Feel supported and valued by Work and Income case managers • Have a sense of ownership of the process • Set goals • Increased motivation and confidence to study or find work • Improved self-esteem and optimism about their future	**Young SLP clients** • Engage in study or training as appropriate • Employment outcome if appropriate • Increased income as a result of being in work • Higher education outcome if appropriate • Improved physical and emotional wellbeing • Improved confidence to learn and grow; to try new experiences • Improved sense of social integration and participation	**Fewer young people with a health condition or disability remain on benefit long-term because they are engaged in sustainable employment** **More people with a health condition or disability experience improved social and economic outcomes** **Long-term benefit liability of SLP clients is reduced**
Service delivery framework consistent with achieving outcomes for SLP clients • Trial is co-designed with sector-based reference group • Legislation, policies and programmes consistent with delivering outcomes • Priority approach to client contact • One-on-one case management for young SLP clients who want it • Voluntary participation • Focus on young people and individualised approaches • Person-centred approach • Access to a range of trial-specific and mainstream service and grant options to support outcomes for SLP clients • Collaboration with other service providers and support persons who can assist SLP clients	**Supporting clients to achieve their goals** • Case managers work one-on-one with young SLP clients who have opted-into the trial • Case managers build relationships with young people to develop trust and an understanding of their journey • Case managers work with young SLP clients to Identify their goals • Case managers develop a plan to achieve the young SLP client's goals • Case managers make appropriate referrals to external support services • Case managers work collaboratively with clients' other providers/support persons • Case managers and employment coordinators access a range of service and grant options to help place the young person in work, training or further education • Work brokers /contracted providers provide in-work support for clients and employers until support is no longer required	**MSD** • Understand how to effectively support young SLP to achieve their work, training or further education goals	**MSD** • More young SLP clients make a successful transition to work • Extend service model to other SLP groups	
System focused on quality improvement • Shared vision; clear strategic direction • Driven by the question "how can we support young SLP clients, who want to work, into work?" • Underpinned by evaluation, systematic collection of data and information on outcomes to inform implementation of action strategies • Use of evidence-based policies and practices	**Evaluation of the young SLP Opt-In Trial**			

WHO: People in receipt of the Supported Living Payment who are aged 15-29 years and have a personal goal of gaining employment.

External factors affecting outcomes

- Availability of the right type, level and mix of services to support young people (eg training courses, work placement and in-work support)
- Health and stressors affecting young peoples' ability to work, study, participate in training.
- Labour market
- Employer attitudes towards employing SLP clients

Components of the young SLP Opt-In service model

Client participation is voluntary

The young SLP Opt-In trial is voluntary and allows SLP clients aged 16–29 years to opt into Work Focused Case Management: Health Condition or Disability (WFCM: HCD). WFCM is a one-to-one intensive case management service for clients who are likely to remain on benefit long term without intervention. Until the young SLP Opt-In trial, WFCM: HCD had only been available to job seeker clients with deferred work obligations due to a health condition or disability (JS HCD). The focus of WFCM: HCD for young SLP clients is on work, up-skilling and higher education outcomes in the medium-to-long term.

Case managers have experience working with clients with a health condition or disability

One WFCM: HCD case manager from each Work and Income pilot site is allocated to work with young SLP clients. This means case managers participating in the trial already have experience working with clients who have a health condition or disability. At any one time, case managers work with up to 10 young SLP clients who have opted into the trial. In addition to their young SLP clients, case managers also have a caseload of 90 JS HCD clients.

Person-centred, collaborative approach

Case managers participating in the trial received four days of training specific to the trial and were also given a trial-specific Learner Guide and Practice Guide.[5] Because young SLP clients do not, under legislation, have work obligations, case managers are encouraged to adopt a person-centred approach when working with young SLP clients.

It was assumed that many young SLP clients would already be working with other health or disability providers in the community. Clients participating in the trial are able to continue working with these service providers and case managers are encouraged to work collaboratively with them where appropriate. Depending on the needs of particular clients, case managers are also encouraged to refer clients to other appropriate support services.

A priority contact order

Eligible clients can join the trial in one of two ways. Insights MSD provides participating case managers with weekly lists of eligible clients in their area who can be contacted and invited to participate. Alternatively, young SLP clients who have heard about the service but have not yet been invited to participate may also opt into the service if they meet the eligibility criteria and the case manager in their area has capacity.

Clients who meet one or more of the following criteria are given priority in the trial selection process: have a continuous benefit duration of less than one year; have applied

[5] The Learner Guide accompanied the four-day training course and provides in-depth details about the trial service model. The Practice Guide provides case managers with details on how they could deliver a service to young SLP clients.

for a benefit due to ceasing study, school or employment; are within eight weeks of their next medical reassessment date; have previously received a student loan or student allowance; have a medical reassessment period of two years; or have declared earnings.

Clients will be excluded from the trial contact list if they: have a terminal indicator in SWIFTT (Social Welfare Information For Tomorrow Today); are in residential support or residential care; are part of the mental health employment service trial; or have previously opted out of the young SLP trial. While these clients will not be proactively contacted, they can however still opt into the trial if they meet the criteria.

Mainstream and trial-specific service options

As well as one-to-one intensive case management, the young SLP Opt-In service model provides participants with access to a range of other service options:

- peer support (trial specific)
- career services (trial specific)
- multi-disciplinary support meetings
- work ability assessments
- individual employment plan
- cohort-specific work brokerage
- profiling to employers
- reasonable accommodations
- in-work support
- employment subsidies
- modification grants
- a site discretionary fund (trial specific).

Piloted in 22 Work and Income sites

The 'go live' date for the young SLP Opt-In trial was 3 November 2014 and is set to run until 2017. The trial was initially piloted in 16 Work and Income sites nationally: Avondale, Dunedin Central, Hastings, Mangere, Manurewa, Naenae, Nelson, New Plymouth, Papakura, Porirua, Rotorua, Tamaki, Timaru, Wairarapa, Waitakere and Whangarei Central. In April 2015, six additional Work and Income sites based in Waikato and Canterbury were added to the trial. Because the trial had only been operating in these additional sites for a short time, they were excluded from this phase of the evaluation[6].

Evaluation scope

The process evaluation will help the Ministry understand how the young SLP Opt-In trial is working in practice and how it is contributing to client outcomes of work, up-skilling and higher education. The results of the evaluation will inform the future development of the young SLP service model and its potential roll-out nationwide as well as the SLP expansion.

[6] A second phase of evaluation is planned for 2016.

Objectives that shape evaluation of the young SLP Opt-In trial

The key evaluation objectives are to:

- assess how well the young SLP service model has been implemented and if it is operating as intended
- provide feedback on key processes and practices that are working well or presenting difficulties and identify lessons that can inform future roll-out of the service
- monitor and assess client uptake of, and engagement with, the service
- examine how the service is contributing to client outcomes of work, up-skilling, higher education, and reduction of benefit receipt, as well as health and wellbeing. [7]

Mixed-method approach

The evaluation was conducted between June–August 2015. It involved 26 semi-structured interviews. The people interviewed for the evaluation included:

- the trial project team (four people)
- the Ministry's Principal Disability Advisor
- members of the Disability Employment Forum (a sector-based reference group for the trial)
- six work-focused case managers from six different sites
- three employment co-ordinators
- thirteen SLP clients who had opted into the trial
- three parents who accompanied their child to the interview.

Interviews were undertaken by an evaluator from Insights MSD along with a person with a lived experience of disability.

In addition, administration data was used to monitor client uptake and engagement in the service, early evidence of outcomes achieved and to profile the types of clients opting into the service.

Case manager selection

A purposive sample[8] of six case managers was selected to take part in the evaluation. Insights MSD were guided by the investment approach team in the selection of the case managers but took into account levels of client engagement in the trial and the size and location of the Work and Income site.

Client selection

Clients for the evaluation were selected on the basis of age, gender, ethnicity, incapacity, and willingness to take part in an interview. The clients selected were located

[7] The voluntary nature of the young SLP Opt-In trial meant that a randomised control trial (RCT) design was not possible. Many young SLP clients participating in the trial also work with multiple agents. These factors mean that a clear assessment of the impact the trial is having on client outcomes is unlikely.

[8] A purposive sample is constructed to serve a very specific need or purpose. It thus includes people of interest and excludes those who do not suit the purpose.

in the same areas as the case managers interviewed. The sample of clients is largely representative of all the young SLP clients who have opted into the trial thus far (see table 1).

Table 1: Profile of clients interviewed

Gender	Age	Ethnicity	Incapacity	Opt-in date
Male	s 9(2)(a)	NZ European	s 9(2)(a)	
Male		Maori		
Male		NZ European		
Male		NZ European		
Male		Pacifica		
Male		NZ European		
Male		NZ European		
Male		NZ European		
Female		NZ European		
Female		Maori		
Female		Pacifica		
Female		NZ European		
Female		NZ European		

Evaluation limitations and caveats

- The evaluation focused on the implementation of the young SLP Opt-In trial and on providing a description of early outcomes. The evaluation does not address questions of impact (eg, whether the trial is effective at achieving client outcomes).
- The voluntary nature of the trial means that clients who opt into the service are likely to be naturally more motivated and able to move towards independence from the benefit system. The SLP clients interviewed for this evaluation are, therefore, not necessarily representative of the young (16–29 year old) or older (over 29 years) SLP population as a whole.
- For the evaluation there was a heavy reliance on in-depth interviews. However, where possible this was supplemented with analysis of administrative data.

Design and implementation of the young SLP Opt-In trial

Key points

Aspects of the design process worked well but areas could be improved.

- Early stakeholder engagement and an 'options' workshop helped secure buy-in to the trial and meant the trial gained the disability sector's support.
- The Disability Employment Forum (DEF) was invited by the Ministry to partner with them in the design of the trial. While the Ministry saw the DEF's role largely in a co-design capacity, the DEF saw their involvement largely as a consultative role. This disconnect highlights the need for an agreed understanding of co-design and/or of each actor or group's role in the project.
- The DEF also felt there was a lack of transparency around what the end of the trial would mean for contracted providers.
- The trial design may have benefitted from earlier involvement from experienced frontline staff.
- Comprehensive training provided case managers with a good foundation to build on with clients.
- A November launch was not ideal because momentum was lost through the Christmas holiday period but was constrained by other trials starting in the New Year.
- The tapering off of case managers' JS HCD caseloads needed to start earlier.
- Provider contracts for peer support and career services were not in place for the trial 'go live' date and are still not working well.
- More planned, strategic engagement with frontline staff was needed post-launch.

Leadership of the trial

The project team

The investment approach unit established a project team to manage the design and implementation of the young SLP Opt-In trial. Many other internal and external stakeholders and Ministry staff were consulted throughout the development and implementation of the trial.

Key practices facilitated the design process

Early stakeholder engagement helped ensure buy-in

According to the project team, engagement with internal and external stakeholders early in the design process was critical and helped to secure buy-in and support for the trial. As one project team member explained: "In this space, engaging with your stakeholders is critical. If we thought someone at some stage would want a voice in this trial, they were around the table from the start."

Involvement from the disability sector was seen as particularly important. The Disability Employment Forum (DEF) was invited by the Ministry to partner with them in the design of the trial. The DEF is a network of organisations that advocate for the disability community around issues of employment. The DEF represents service providers in the disability sector as well as Disabled Persons Organisations (DPOs). In this way they bring both a provider perspective and a consumer perspective. The National Beneficiary Advocates group was also consulted on the development of the trial but in a lesser capacity than the DEF.

According to Ministry staff interviewed, members of the DEF were interested in being involved in the development of the trial. The willingness of the project lead to listen and respond to the sector's views helped to gain their trust and while there was some sorting through in terms of expectations, the project team saw the DEF's involvement largely in a co-design capacity. The concept of co-design is often ill-defined but typically implies shared understanding of a problem and/or solution as well as shared decision-making responsibilities. The idea behind co-design is that a solution can be improved if professionals, suppliers and consumers look at it together.

Members of the project team felt that by involving the disability sector early in the trial design, they had been rewarded with the sector's support. The Disabled Persons Assembly (DPA), for example, posted an article on its website about the trial and the fact that it had been developed in collaboration with the DEF.

An 'options' workshop helped cement stakeholder buy-in

The project team facilitated an 'options' workshop, which explored 69 options for providing assistance to young SLP clients who have a personal goal of gaining employment. The options were assessed based on the desired outcomes for the trial and critical success factors (CSFs)[9]. The workshop, while lengthy, worked well and helped cement stakeholder buy-in to the final product.

Targeting generated significant debate

Whether to target the service at clients with particular health conditions or disabilities generated a lot of debate in the design process. The controversy this issue generated highlights the political nature of the sector and raised questions over human rights. In an attempt to justify why targeting had arisen in the first place, one project team member commented: "It wasn't that we were trying to exclude clients. It was more that we were wanting to learn with a group of clients who might be more willing to work with us than others."

By listening and responding to stakeholders' concerns, a consensus was reached whereby there would be a priority order but no targeting of SLP clients.[10] This meant that over time all young SLP clients could be contacted, except those with exclusions.[11]

[9] CSFs for the project were derived from the Treasury's Better Business Cases Toolkit and included: strategic fit; business need; supply-side capacity and capability; potential affordability; potential achievability; and benefits optimisation (Business Case: Young Supported Living Payment, February 2014).

[10] See pages 14-15 for details on the priority order.

[11] See pages 14-15 for details on exclusions.

While targeting generated a lot of debate amongst stakeholders, according to one project team member, "once it was settled and everyone agreed, the work gained momentum".

Aspects of the design process could be improved

A co-design model was intended but greater clarity was needed around what it meant within the context of the trial

While the Ministry believed the DEF's involvement in the trial was largely in a co-design capacity, this was not, according to members of the DEF who were interviewed, their experience. In comparison with Ministry staff, DEF members saw their involvement in the development of the trial largely as a consultative role. Members of the DEF interviewed acknowledge that there was good intent on the Ministry's part but felt there was little opportunity for co-design and that the programme was already well developed when they were invited to be involved. One member of the DEF commented that the trial was another example of disabled people being "talked about rather than to". They felt the Ministry was still not willing to trust the disability community to self determine by involving them in the design process.[12]

While the project team actively sought DEF input during the design phase, the final decision-making power ultimately rested with the Work and Income leadership team. The interdependence of decision-making is important in co-design. Ideally, no one actor or group should dominate. In this respect, the working relationship between the DEF and the Ministry was not equal and, therefore, not a true co-design model.

The disparity in experiences between the Ministry and the DEF highlights the need for a stated definition of co-design and/or an agreed understanding of each actor or group's role in the project. Cultural differences between the Ministry and external organisations should also not be underestimated. Many external organisations and even frontline staff do not fully comprehend the policy intent and political constraints that the Ministry works within. More thought therefore needs to be given to how the Ministry can bridge this cultural divide.

Lack of transparency around the 'end game' concerned DEF members

Members of the DEF interviewed, who represent service providers, recalled feeling very uncomfortable about providing the Ministry with advice and information when there was little or no transparency around what would happen at the end of the trial. Their concerns centred around why the Ministry was implementing this trial in the first place: Was it about getting disabled people off benefit? Was it because MSD felt contracted providers were not doing a good enough job? Were contracted providers in competition with Work and Income? What does the young SLP trial mean for contracted service providers going forward?

[12] The DEF's stated experience stands somewhat in contrast to the article posted on the DPA's website. The article was written by a member of the DEF and, as noted above, claimed that the trial had been developed in collaboration with the DEF.

Members of the DEF were also concerned by some of the project team's apparent lack of content knowledge and understanding of issues such as national contracts.

Provider insecurity around contracts is not limited to the young SLP Opt-In trial alone but can be attributed to static funding in recent years and changes happening in the contract space more broadly. One DEF member noted that the Ministry appears to be in the process of transforming provider contracts but that providers have little idea about the end vision for this change. This perceived lack of transparency leaves providers with a feeling of uncertainty about the future and fuels a sense of mistrust.

Rather than replicating existing services, DEF members felt a better utilisation of funds would have been to increase service provider's capacity through increased funding or a co-production model whereby the Ministry works in partnership with service providers in the sector to achieve outcomes. Given that Work and Income work brokers have limited capacity and/or confidence in working with young SLP clients, a partnership model with supported employment providers may be worth exploring.

Members of the DEF interviewed also raised concerns about how the trial was to be evaluated and if the outcomes from the young SLP Opt-In trial would be compared with outcomes of those from contracted providers. However, a Ministry meeting summary[13] states that this is not the case and that the trial was being evaluated from a qualitative perspective with a focus on the process.

Early engagement with experienced frontline staff may have benefited the design

While the project team did much to engage stakeholders at a National Office and sector level, one member felt that more engagement with frontline staff early in the design process would have been an advantage.

Indeed, while there is variability amongst employment co-ordinators[14], there are some who have considerable experience working with young SLP clients and/or in engaging with the disability sector. One employment co-ordinator interviewed, for example, was already contacting and working with SLP clients in a manner not dissimilar to the young SLP Opt-In trial but without the support of a dedicated case manager. Another employment co-ordinator interviewed was extremely well connected in their local disability community and was pivotal in organising sector group meetings. Engaging with experienced employment co-ordinators early in the trial design process would have provided an opportunity to share in their knowledge and learn from their experiences of what works and what does not.

[13] Ministry of Social Development, Meeting Summary, 1 September 2014.

[14] Employment co-ordinators work with sole parents, people with health conditions and disabled people to help them move into or retain work. They provide a co-ordination service and link people to appropriate services and/or match them to job opportunities according to their need and suitability.

Overall, the trial was well implemented but aspects could be improved

A multi-discipline working group helped bring the trial together

A working group headed by the project lead worked through the different aspects needed to launch and implement the trial. People from different areas/disciplines across the Ministry were represented in the working group. Each working group member brought their particular expertise to the table which helped ensure that nothing was overlooked and that things happened in a co-ordinated and timely manner.

Comprehensive training provided case managers with a good foundation to build on with clients

Training specific to the trial was developed for frontline staff. The training was conducted over four days and was attended by case managers selected for the trial as well as a few frontline trainers. The project team recalled having two goals for the training: to have case managers walk away a) knowing why the Ministry were implementing the trial and b) how they were going to be able to support young SLP clients to achieve their goals.

The training was written by the project team, two of whom were ex-frontline staff trainers and one of whom was an ex-frontline case manager. Having "lived and breathed" the trial for so long, project team members said they had a clear vision of what the training needed to include. Being ex-frontline, they also understood what case managers would want/need to know. Being ex-frontline also gave the project team a degree of credibility with case managers and helped to overcome the "them and us" mentality that sometimes exists between National Office and frontline staff. Reflecting on the training, one senior project team member commented: "I think we probably tried to fit too much into it … but overall it is probably some of the best training I've seen being delivered to frontline staff."

The training was generally well received by case managers. Most case managers interviewed said they really enjoyed the training and thought the material was well presented. Some case managers felt that less time could have been spent on the 'why' (the investment approach strategy) with more time on the 'how'. As one case manager commented:

> *I think a lot of the case managers said, well we can get why; all we want to know is the how. We wanted to know what was in place to support [clients]. We don't want to go making promises and then not be able to follow through.*

While case managers felt the training was well presented, some felt that it was a lot of information to absorb in one go. Others would have liked the training spread out over an extra day with more practical exercises. Several case managers commented that they learn better by doing and noted that it takes a while before things become habitual.

People with a disability who had previously experienced unemployment were invited to be guest speakers at the training. The guest speakers shared their experience of what they had gone through and how they had responded. The personal experiences of the guest speakers was, for many case managers, a highlight of the training and gave them an insight into the challenges that people with a disability experience.

As well as the four days' training, case managers received a Practice Guide and Learner Guide specific to the trial.[15] Case managers said the guides were a good reference resource, particularly in the early days of the trial.

Timing of the launch was not ideal but was constrained by other trials

The young SLP Opt-In trial was launched in the initial 16 pilot sites on 3 November 2014. Being so close to Christmas, the launch date was seen as less than ideal and as one of the biggest implementation draw backs. As one project team member commented: "[The trial] got going, then it lost momentum with the Christmas break and people being away on leave and case managers having to cover for others. Timing was probably the biggest drawback." However, other investment approach trials were scheduled to start in the New Year, creating pressure for the young SLP Opt-In trial to 'go live' when it did.

The tapering off of JS HCD caseloads needed to start earlier

Case managers selected for the young SLP Opt-In trial had been working with a caseload of 100 JS HCD clients. The plan was to reduce their JS HCD caseload to 90 so they could then take on up to 10 SLP clients. However, because the tapering off of JS HCD caseloads did not start early enough, some case managers still had full JS HCD caseloads for the trial 'go live' date. Some case managers had to wait several weeks before they had caseload space to take on any SLP clients. This was a frustration for those case managers affected, because they were keen to put into practice what they had learnt from their training.

More could have been done to engage service centre managers

The project team felt that more could have been done to engage service centre managers (SCMs) and assistant service centre Managers (ASCMs) in the trial because this had consequences for some case managers once the trial was under way. As one project team member explained:

> *When case managers were looking for support [from their SCM or ASCM], it wasn't necessarily there because of a lack of knowledge or understanding about the trial. We assumed that by going to the regional directors there would be some downward management.*

Members of the project team said that specific "on-boarding" of SCMs and ASCMs is something they have done better in subsequent investment approach trials.

Provider contracts for peer support and career services were a disappointment and are not working well

Two new types of provider contracts were established to support the young SLP Opt-In trial: peer support and career services. However, the contracts for these services were not in place for the 'go live' date of the trial. This disappointed project team members because it meant they were unable to inform case managers at the training who the contracted providers were in their area. Take-up of the services by case managers has subsequently been low. Because the contracts were not ready for the 'go live' date,

[15] The Learner Guide accompanied the four-day training course and provides in-depth details about the trial service model. The Practice Guide provides case managers with details on how they could deliver a service to young SLP clients.

project team members wondered if they had sent a signal to case managers that they were not important.

The principal disability advisor interviewed was disappointed that the contracts did not stipulate that the peer support persons should have a disability. In their view, this was counter to the idea of peer support as a non-disabled person would not have a lived experience of disability and would not, therefore, have experienced a similar journey as a young SLP client.

Most of the provider contracts were in place by the time the fieldwork for this evaluation was undertaken. However, as mentioned above, take-up of peer support and career services by case managers has been low. Some case managers interviewed said they had contacted the contracted provider in their area for peer support but were told the organisation did not have anyone available. One employment co-ordinator interviewed said she had been contacted by the contracted provider for peer support in their region asking if she could explain to them what they were supposed to be doing because it was not clear from their contract.

Several case managers and employment co-ordinators interviewed felt that the contracted career services were ineffective and that the providers delivered little more than what they provided to clients. These opinions were largely based on clients' comments reporting that the career service was "a waste of time".

Ministry contract managers and contracted providers were not interviewed as part of this evaluation. However, given the apparent issues surrounding the contracts, it is recommended that further investigation is undertaken.

Communications about the trial appeared to be a problem in one region

Communications about the trial were sent to a comprehensive list of Disabled Persons Organisations (DPOs). One employment co-ordinator interviewed said they had a DPO call up saying they had significant numbers of clients who they wanted on the young SLP Opt-In trial. While the employment co-ordinator thought it was good that there had been such a positive response to the trial, they thought the communication should have placed more emphasis on the fact that the trial was only available to a limited number of people at any one time. The employment co-ordinator also said that it would have been helpful to have known in advance what was being communicated to whom.

This particular employment co-ordinator ended up asking National Office to provide a list of the organisations in their area that had been sent the communication. The employment co-ordinator then contacted the organisations, invited them in as a group and talked them though what the trial was about and how many people it could accommodate at any one time.

No other case managers or employment co-ordinators interviewed reported such a problem, so it appears to be particular to this region and may be because of the strong relationship the employment co-ordinator has with the disability sector in their region. Another case manager, based in an urban centre, said they had not had any contact from providers or DPOs in their area about the trial. Nevertheless, greater co-ordination

between National Office and key frontline staff around public relations (PR) communications would be worthwhile and is worth considering.

More planned strategic engagement after the launch was needed

A lot of the project team's time and effort was focused on the launch of the trial. However, reflecting on the post-launch phase of the trial, a senior member of the project team felt that more planned strategic engagement with frontline staff would have helped the implementation and bedding-in phase: "I think we launched the trial and then took a deep breath."

In the early days of the trial, the project team hosted weekly conference call meetings with case managers. These meetings were supportive and were an opportunity for case managers to share their experiences and discuss any issues that had arisen. However, the project team felt the conference call meetings were not entirely successful. Some case managers reportedly felt uncomfortable, particularly if they were struggling to get clients to opt into the trial. For many case managers, though, this was also the first time they had direct access to National Office staff and this may have added a layer of discomfort for some case managers.

The project team also felt that they had visited the participating Work and Income sites too soon after the launch of the trial. The aim of the site visits was to understand how each case manager was experiencing the trial and working with young SLP clients and to provide support where needed. Planning the visits for later would have given case managers more time to start working with young SLP clients and perhaps made the site visits more constructive and meaningful.

The young SLP Opt-In trial in practice

Key points

This section examines case managers' experiences of transitioning to the new service and working with young SLP clients.

- Experienced case managers helped facilitate the transition to the new service, although the transition was not without its challenges.
- In the early days of the trial, case managers felt supported by the National Office team but not necessarily by their own SCM or ASCM.
- Case managers enjoy working with young SLP clients and find them motivated and enthusiastic. However, case managers perceive young SLP clients to be more high needs and time intensive than JS HCD clients and as facing more barriers to employment. Ten SLP clients for 10 JS HCD is not, therefore, seen as a comparative exchange and most case managers have experienced an increase in workload.
- Case managers find that referrals from other case managers and providers are working better than the client call lists in terms of client conversion rates.
- Case managers would like ongoing training because they feel they need a deeper understanding of health conditions and disabilities, but particularly psychiatric and psychological conditions.
- Case managers receive peer support but there may also be scope for clinical supervision to help manage stress and maintain boundaries.

Transitioning to the new service

Experienced case managers facilitated the transition to working with young SLP clients

All the case managers selected to work on the young SLP Opt-In trial had already been working with JS HCD clients, and were experienced in the Work Focussed Case Management (WFCM) approach. This meant case managers were already comfortable working with clients with a health condition or disability which helped facilitate the transition to working with young SLP clients.

Case managers interviewed were generally very positive about the trial and liked the fact that it was voluntary. Many felt that not enough had been done in the past to support this client group and believed that everyone should be entitled to the same opportunities and support whether they had work obligations or not. As one case manager expressed it: "It's good … it's encouraging these kids and getting them the help that they need – that they've needed for a long time."

Many case managers said they enjoy working with people with health conditions or disabilities so were pleased to be selected to work with young SLP clients as part of the trial. They also like the one-on-one case management approach as it allows them to

build rapport and trust with a client and to see their progress as they support them in reaching their goals.

Some case managers and employment co-ordinators interviewed had a more personal interest in working with people with a health condition or disability, either because they or someone close to them had a health condition or disability. One case manager interviewed had also completed a certificate in mental health and a diploma in social services before joining Work and Income so was pleased to put her studies into practice.

While all case managers had experience in working with clients with health conditions or disabilities, the transition to working with young SLP clients was not without its challenges. As clients enrolled in the trial, case managers found themselves working with health conditions and/or disabilities they had little knowledge about (eg, intellectual disabilities) or, with conditions that were "a step up" from what they were used to.[16] Most case managers, therefore, found there was still a lot to learn and stressed the importance of researching a client's case notes and condition before contacting them.

Case managers felt supported by the National Office team but not necessarily by their own SCM or ACMs

Case managers interviewed felt well supported by the National Office project team and said the team were responsive in addressing any issues they had raised. Some case managers did not, however, feel quite so well supported by their own SCM or ASCM. Some recalled feeling quite isolated during the early days of the trial because there was little awareness about the trial among their colleagues. This meant they had no one else in their office they could talk to about the trial but also that time allocated in their calendar to work with young SLP clients was sometimes swapped out for general case management work and/or new business. Not specifically "on-boarding" SCMs in the trial was, as mentioned above, an issue recognised by the project team and is something they have sought to rectify in subsequent investment approach trials.

To help increase awareness about the trial in their office, some case managers had given presentations about the trial at their Wednesday briefs. This in turn had helped increase the number of client referrals they received from other case managers. One case manager said she had also started copying the minutes from the conference call meetings to her SCM and ASCM so they would understand what was happening in the trial.

[16] People who are eligible for SLP are both permanently and severely restricted in their capacity to work because of a health condition, injury or disability or are totally blind. People who are eligible to receive JS HCD, by comparison, are limited in their capacity or unable to work full-time due to a health condition, injury or disability, which may or may not be permanent.

Working with young SLP clients

Case managers enjoy working with young SLP clients and find they are motivated and enthusiastic

All case managers interviewed expressed how much they enjoy working with young SLP clients in the trial. Many commented on how motivated and enthusiastic they are compared with many JS HCD clients they worked with. Speaking about a particular client's success in finding work, one case manager commented:

> *I'd like to say I had a lot to do with his success but I virtually feel I don't have anything to do with it. You know, this boy is motivated. His parents are really supportive. If parents are supportive, you don't have any hassles.*

Some case managers interviewed attributed clients' enthusiasm to their youth. Others felt that because most young SLP clients had lived with their disability for a long time, they were more comfortable with their condition than many JS HCD clients, whose health condition or disability may be more recent. One experienced employment co-ordinator interviewed felt that many young SLP clients already have an idea about what they want to do with their life and are excited by the fact that Work and Income is showing an interest in helping them achieve it.

The voluntary nature of the trial is also significant. Young SLP clients who opt into the service are likely to be naturally more motivated to work and, therefore, are not necessarily representative of the young SLP population as a whole.

The voluntary nature of the trial also appears to create a different dynamic in the case manager–client relationship. When working with clients who have work-based obligations, there is a focus on compliance and on meeting key performance targets. Because the young SLP Opt-In trial is voluntary, the client is there because they choose to be. Without specific targets to meet, the case manager feels less pressured and can take the time needed to build rapport and trust with the client before moving on to facilitation of clients' personal goals.

The ability to switch between these two modes of case management should not be underestimated because it requires some degree of personal agility on the part of the case manager.

Ten SLP clients for 10 JS HCD clients is not perceived as a comparative exchange

The design of the trial implies that 10 young SLP clients are comparative in workload to 10 JS HCD clients. However, case managers' experience suggests there is a difference and most reported an increase in workload since starting the trial.

While case managers enjoy working with young SLP clients, they typically find most to be high needs and to require more intensive individual time than JS HCD clients. As one case manager put it: "It's not just looking for work. It's everything: financial issues, hardship issues, you have clients sharing stuff that they haven't even told their counsellor. One client I had to refer to Women's Refuge. So it's quite overwhelming."

Case managers find that young SLP clients with particular disabilities (eg, intellectual disabilities) are particularly vulnerable and time intensive. Once they gain the trust of these clients, case managers said they often find they are contacted by them daily, and that the clients sometimes come into the centre wanting to see them without an appointment. As one case manager put it: "It's like you're their new best friend, counsellor, and social worker rolled into one."

Many case managers and employment co-ordinators interviewed also felt that young SLP clients face greater barriers to employment than their JS HCD counterparts and attributed this to the severity of their health condition or disability as well as employer perceptions.

Because the time and effort needed to get an outcome with young SLP clients is perceived to be greater than that with JS HCD clients, most case managers felt that replacing 10 JS HCD clients with 10 young SLP clients was not a comparative exchange.

Referrals have a higher client conversion rate than the call lists[17]

Case managers are provided with client call lists generated through Insights MSD. Most case managers interviewed found that initially contacting clients on their call list by telephone was more effective than contacting them by mail. Once the case manager had spoken to a client and gauged their response, then a letter and a copy of the young SLP Opt-In fact sheet was typically forwarded to the client. However, a few case managers who attended a re-group session in Auckland[18] reported they got a better response from letters as clients typically did not answer calls where there is no caller identification[19]. Some case managers thought that the letter was too passive and that including an appointment time in the letter might elicit a better response.

Most case managers found that once awareness about the trial had increased, they started receiving referrals from other case managers and sector-based providers and that the opt-in conversion rates from these referrals was typically higher than from the call lists. This is not surprising because young SLP clients who have come into Work and Income for an appointment or who are working with a support service provider are likely to already be motivated to work. A higher conversion rate from referrals does not, however, discount the need to continue to provide case managers with call lists; approximately half of clients who have opted into the trial have been via the call lists.

Case managers found the re-group session helpful but would like ongoing training

A re-group session was held in Auckland on 29 May 2015. Not all case managers interviewed had attended the re-group session but those who had found it helpful. What they valued most about the re-group session was the opportunity to share experiences in an open and relaxed forum and to learn what other case managers were doing.

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[17] Conversion rate refers to the number of clients contacted versus the number of clients who opt into the trial.

[18] A re-group session was held in Auckland for all the case managers involved in the trial. The session was a chance for case managers to share experiences and for the project team to update them on new developments.

[19] Numbers on outbound calls from Ministry phones are blocked for security purposes.

All case managers interviewed would, however, like ongoing training. Most felt they needed a deeper understanding about different health conditions and disabilities, but psychiatric and psychological conditions in particular. One of the main concerns case managers had was that they might unintentionally cause harm by giving a client the wrong advice.

Both case managers and employment co-ordinators would like the opportunity to learn from examples of best practice.

Case managers receive peer support but there may be scope for clinical supervision

Most case managers interviewed engaged in some reflective practice, typically with other WFCM: HCD case managers but also with employment co-ordinators where there is a strong working relationship. While other WFCM: HCD case managers do not specifically work with young SLP clients they do have a shared understanding of what it is like to work with clients who have a health condition or disability.

One case manager interviewed said that in their office they have regular health and disability meetings. These meetings are attended by the WFCM: HCD case managers, the SCM, two staff working on Providing Access to Health Services (PATHS), the regional disability advisor (RDA), the regional health advisor (RHA) and the employment co-ordinator. In these meetings they discuss different cases and how to tackle different problems. These meetings support the HCD case managers and allow them to exchange ideas on how to work with complex or challenging clients. The case manager interviewed said these meetings are the reason why their Work Ability Assessment (WAA) numbers are so low: "Clients are getting the right support; it's just that we've approached it in a different way."

Case managers said that working with people with a health condition or disability often requires them to use counselling or social work skills in which they are not qualified.[20] They reported that this can sometimes be overwhelming and lead to stress. As one case manager put it:

> *Sometimes I almost feel like a counsellor and, I'm thinking, 'I need to pull back. That's not my role. They need to be seeking professional help.' But I've had people tell me things that they don't even tell their counsellor.*

Because of this, there may be scope for case managers to receive clinical supervision to help them better manage stress and maintain boundaries.[21]

[20] While a session on motivational interviewing (a counselling approach) was part of the training held in Auckland, case managers' comments, perhaps highlight the need for further training in this area.

[21] A similar issue came up with case managers interviewed in the WFCM: HCD process evaluation.

Supporting young SLP clients to achieve their goals

Key points

Case managers highlighted a number of factors that appear to contribute to best practice case management with young SLP clients. These factors, in many respects, centre on relationships: building trusting relationships with clients; adopting a person-centred approach; and establishing collaborative working relationships with employment co-ordinators and other service providers to provide the best possible service to clients. Qualities that support best practice case management include an ability to empathise and connect with clients and to think creatively to achieve outcomes for clients.

Factors that prevent best practice case management include:

- high workloads and a lack of time to do justice to clients' needs
- a shortage of training courses for young SLP clients
- limited support from work brokers
- lack of clarity around who is responsible for post-placement support for clients and employers.

Factors that support best practice case management

Empathy and a passion for working with people with a health condition or disability is fundamental

Most case managers interviewed believe that successful case managers are those who are able to empathise with clients and have a passion for working with people with a health condition or disability. While certain skills can be learnt, case managers believe that some skills are innate and cannot be learnt. As one case manager tried to explain:

> *I don't think there's any fixed way of doing it. … It comes down to the delivery; it always comes down to the delivery. But I don't think it's something you can train a case manager to do. You've either got it or you don't.*

Building trusting relationships with clients is essential to engagement

All case managers interviewed agreed that building rapport and trust with young SLP clients is essential for engaging them in the trial. Most adopt a "soft and friendly" manner when initially contacting the young clients and all case managers stressed the importance of not coming across as "pushy". This is how one case manager described her approach when first contacting clients:

> *Just a very gentle approach … no pressure … just really kind, bubbly sort of conversation over the phone so they feel comfortable and they're not threatened in any way. And if they are unsure and feel insecure about it then I say, 'well I'll ring back next week. You just think about it'.*

Case managers are also careful in the first appointment to ensure that clients do not feel any pressure to opt into the trial and instead focus on building the relationship. Even if a client expresses an interest in signing up for the trial during the first appointment, case managers typically recommend they go away and think about it and discuss it with family, agents or their support person. The case manager then contacts the client a week later to see if they are still interested.

Many young SLP clients were initially very anxious about coming into a Work and Income office either because they did not know what to expect or had had negative experiences in the past. As one client interviewed put it: "I used to hate coming into WINZ. I'd have to tell my 'story' to a different person every time and I never felt they really listened or were interested in helping me."

Certain health conditions or previous experiences of bullying meant that some clients were also generally more anxious or fearful than others. Some case managers had developed strategies to help reduce clients' anxieties, for example, by greeting them at reception or scheduling appointments straight after their lunch break so there would be no waiting time for the client. Some case managers scheduled their appointments at the end of the day so they could spend longer with the client if necessary. One case manager had positioned their desk at the front of the office so clients could see them as soon they entered and another case manager had told their young SLP clients that they could come straight over to their desk, rather than queuing up at reception.

Establishing a trusting relationship also means that clients are more willing to share concerns with their case manager. The better informed a case manager is about their clients' needs, the better placed they are to then take appropriate steps to address them.

Case managers tailor their approach to suit each client's needs

Young SLP clients are a very heterogeneous group covering not only a wide range of types of disability and health condition but also a wide variety of other socio-demographic and economic characteristics. Clients are also at different stages of work readiness when entering the service. Many clients interviewed were already working part time and were looking to either increase their hours or get a better job. Other clients had been trying to get a job for some time but without success. Some clients had more immediate issues that needed addressing (eg, housing, hardship, domestic violence and personal hygiene) before getting to a point when they would be ready for work or further training.

While all young SLP clients are to some extent high needs, some clients, with particular health conditions or disabilities require more intensive one-on-one case management. Other clients, by comparison, require less face-to-face case management contact and are happy to be contacted mostly via telephone.

Successful case managers recognise that a single case management approach will not suit all clients. As well as building a trusting relationship, their initial focus is on understanding where the client is at in their journey and what their specific needs are. They then tailor their case management approach to best meet both the stage and the needs of the individual client.

When a client is ready, the case manager will then work with them to identify short-term and longer-term goals. Some case managers pointed out the importance of the goals identified being the client's goals and not those of the case manager.

Case managers have the support of an experienced and motivated employment co-ordinator

Case managers who work with an experienced and motivated employment co-ordinator have a distinct advantage. They have access to a knowledgeable resource and can learn from the employment co-ordinator's experience of working with young SLP clients and the disability sector. One case manager interviewed said that it was also helpful in the early days of the trial to observe how her employment co-ordinator interacted with SLP clients and this helped give her confidence when working with young SLP clients herself.

Case managers who have an experienced and motivated employment co-ordinator typically work with them collaboratively. In one site, for example, the case manager and employment co-ordinator have joint appointments with clients and share actions and responsibilities according to the skillset required.

From interviews with case managers it is apparent that employment co-ordinators' experience and motivation is variable. One case manager, for example, had a relatively new employment co-ordinator who was also new to the business. The case manager said she was very worried about the employment co-ordinator's attitude and was hesitant to pass clients on to her.

Another case manager interviewed had, until recently, been working without the support of an employment co-ordinator or work broker. This meant she had been working alone to achieve employment outcomes for clients: "I'd watch out for jobs and refer appropriate clients to them."

Case managers are knowledgeable about the sector or use the supports available to them

The disability sector is diverse and services are often fragmented. Successful case managers know what agencies and providers are available in their community and are able to navigate their way through the ambiguity. Being knowledgeable and well connected in the sector not only means that case managers know what services are available to support young SLP clients, but also who/what would be the most appropriate fit for a particular client. Well-connected employment co-ordinators are an advantage here because they often facilitate introductions or provide advice on appropriate services.

Regional disability advisors (RDAs) and regional health advisors (RHAs) are also a resource available to case managers. RDAs and RHAs provide advice and recommendations on disability and health-related factors associated with benefit applications. They also have established relationships with external providers in the health and disability sectors and can advise case managers on the appropriateness of different services. However, very few case managers interviewed mentioned that they were consulting RDAs and RHAs when they were uncertain about a particular health condition or disability or when they were uncertain about what service would be most appropriate for a particular client. Case managers were not specifically asked why they

are not using RDAs and RHAs. Therefore it is not entirely clear if there is an underlying reason or if they just need to be reminded that the resource is there to support them.

One case manager interviewed had proactively visited disability sector providers in her region when the trial first began. Her aim was to inform organisations about the trial and establish relationships with them. Another case manager had accompanied her employment co-ordinator when visiting sector-based providers and said she had found this experience very valuable. The value was also apparently mutual because, according to the case manager, the providers also benefited from talking directly to a case manager who could advise them on different processes, income support options and employment subsidies.

However, several case managers interviewed had limited knowledge of the disability services available in their community and felt that this was one of their biggest challenges. One such case manager said she was interested to hear at the re-group session in Auckland that other case managers had access to vehicles and were going out and visiting providers and building relationships with these organisations:. "It's never been mentioned that I could go out to these disability meetings at all."

Several case managers interviewed said they would like the flexibility to be able to visit providers more regularly, particularly those providers where they have mutual clients.

Case managers work collaboratively with clients' other providers

Clients participating in the trial are able to continue working with other service providers. Most case managers interviewed reported that, where relevant, they are working with clients' other providers and/or support persons. Most case managers said they had found other providers generally very supportive and they saw a collaborative approach as beneficial for the client. As one case manager explained:

> *Other providers I have worked with have been very open and supportive and see a place for both of us. So it's a shared approach all for the betterment of the client. It's like we have a clear understanding of what the total needs of that person are and whose role it is to provide each individual need.*

Some case managers invite providers in for joint meetings with clients. Others reported that they mostly keep in touch via telephone or email.

However, one employment co-ordinator said they had found supported employment providers in their area were initially keen to get their clients enrolled in the trial but then later stopped working with them, claiming that it was too confusing for the client to work with two different providers. For the clients involved, being dropped by a provider they had an established relationship with was, according to the employment co-ordinator, confusing and disappointing.

Supported employment providers were not interviewed as part this evaluation. Therefore it is not possible to say with any certainty why they might think that it is confusing for clients to work with multiple providers. However, the issue highlights a need for greater clarity and communication around respective roles and responsibilities when working with a shared client.

Using networks and thinking creatively to achieve outcomes

Some case managers and employment co-ordinators interviewed felt that because of the barriers that young SLP clients face, there is a greater need to draw on networks and to think "outside the box" to identify employment opportunities. Clients are also encouraged to draw on their own networks, via family and friends.

Successful case managers have regular "brainstorm" sessions to identify different opportunities to achieve an outcome for a client. For some case managers, these sessions are with another WFCM: HCD case manager. As one case manager explained:

> *We help each other out and talk about our clients. You need to be able to talk with someone who deals with the same issues. So we can discuss issues, bounce ideas off each other and come up with different solutions. It's great. I think it would be quite hard working solo on a project.*

Other case managers have brainstorming sessions with their employment co-ordinator. One particularly collaborative case manager-employment co-ordinator team said they also involve clients' other providers/support persons in these sessions.

One motivated employment co-ordinator said she will do "drive-bys" near where clients live to get ideas for employment opportunities. For example, from one of her drive-bys she identified an opportunity for a client to get part-time work in their local dairy where he was a regular customer.

Individual's journey: best practice in action

About the individual

Susan[22] is aged 25 years. Her primary incapacity is s 9(2)(a) . Susan has a tertiary qualification. She used to be a s 9(2)(a) until her s 9(2)(a) meant she no longer had the strength to continue. After s 9(2)(a) I like that I can help the girls and the guys and have a positive influence on them." s 9(2)(a) Susan had been looking for work for some time but without success.

Joining the young SLP Opt-In trial

Susan joined the trial s 9(2)(a) . By chance she happened to see the young SLP Opt-In trial case manager, who was helping out with general case management that day.

Her case manager initially talked to her about financial matters and the implications of s 9(2)(a) . They then talked about her goals and interests and her desire to get work. The case manager helped Susan with her CV and engaged an employment person from another agency to help Susan get clothes that were suitable for job interviews.

Working with her case manager

> *I get on really well with [case manager]. I think she really listened to all the different things that were happening. She would actually tell me the options. Like I hated coming here to WINZ until [case manager] helped me. [Case*

[22] All client names have been changed to protect their identities.

manager] could see that I was really motivated to work and that I wanted to keep moving forward. She knew it was important. (Susan)

As well as face-to-face meetings, Susan's case manager would ring her every week to update her on what was happening in terms of work opportunities. Susan was happy with this arrangement because it meant she did not have to come into Work and Income so often.

Supporting her into employment

Susan's case manager facilitated an introduction with a work broker who was willing to work with her. The work broker was able to use his networks to get Susan a job for 20 hours a week in s 9(2)(a) . They used Mainstream[23] to help Susan get the job. The employment co-ordinator took over the arrangements while the work broker was away on leave. s 9(2)(a) , provided the adaptive equipment Susan needed for her new role.

Susan has since exited the Supported Living Payment.

What made a difference for Susan?

I had someone advocating for me with s 9(2)(a) *and stuff. There's still quite a big prejudice against people with impairments. So I don't usually like having someone advocate for me but sometimes you need someone to back you up a bit. And I think [work broker] and [case manager] did that. I was quite blown away at the amount of help and effort they put in. Yeah, they got me a job pretty much.* (Susan)

The above example illustrates a number of best practice features including:

- a tailored case management approach and a relationship built on trust
- referrals to other appropriate support services
- a supportive employment co-ordinator and work broker
- working collaboratively
- using their networks
- supporting the employer by using Mainstream and the Foundation for the Blind providing the necessary adaptive equipment.

[23] The Mainstream Employment Programme provides a package of subsidies, training, and other support to help people with significant disabilities get work and to enable them to gain sustainable employment. Amongst other things, Mainstream provides a 100 percent salary subsidy for the first half of an agreed term of a maximum of 104 weeks/two-years, and 80 percent of the salary for the second half.

Factors that prevent best practice case management

Time pressure is the biggest challenge faced by case managers

By far the most common challenge expressed by case managers was the lack of time to do justice both to their JS HCD clients and their young SLP clients, as well as keeping up with the "paperwork".

On top of their caseload of 90 JS HCD clients and 10 young SLP clients, most case managers said they are also required to help out with new business and general case management when staff are away sick or on leave. Some case managers interviewed felt more supported by their SCM and ASCM and had the flexibility to say "no" to working on new business if they had young SLP clients coming in for appointments. However, other case managers did not feel they had either the support or the flexibility to do this.

A few case managers interviewed said quite a few staff were away on long-term sickness leave in their office and that there had not been any backfilling of these positions. This meant that all the other case managers in the office had to cover the caseloads for those who were away, as well as their own.

Case managers often reported working unpaid overtime and working through their breaks in order to catch up on the processing side of the business. Many case managers interviewed also said they feel guilty that they do not have enough time to do more for their young SLP clients. Indeed, a common complaint by young SLP clients interviewed was that they would like more frequent/regular appointments with their case manager. They also felt frustrated at how long it took for their case manager to follow up on actions they said they would do.

A shortage of training courses for SLP clients is frustrating

One of the biggest frustrations faced by all case managers and employment co-ordinators interviewed was the lack of appropriate training courses available to young SLP clients. Training courses were seen as important in helping to increase clients' chances of obtaining work. Case managers said that because young SLP clients do not have work obligations, they qualify for very few courses funded by Work and Income. Many of the courses that are available to young SLP clients, though, are too long or do not provide the flexibility for young SLP clients to drop in and out of the training course depending on the status of their health at the time.

Some case managers and employment co-ordinators also felt that there was a perception among course providers that it is "too hard" to get an outcome with SLP or JS HCD clients in general. Because provider funding is often based on achieving certain results or outcomes, providers will take able-bodied clients who they perceive as being easier to achieve an outcome with than people with a health condition or disability. As one case manager put it: "There's not much benefit in them accepting someone who has lots of health issues."

It is recommended that training courses along with provider contracts for peer support and career services receive further investigation.

The role of work brokers and employment co-ordinators in the trial is unclear

Work brokers support the delivery of employment services by focusing on the skill and labour needs of employers and matching these needs with clients. Work brokers were not interviewed as part of this evaluation. However, according to case managers most work brokers do not have the time, the interest and/or the confidence to work with young SLP clients. As one case manager put it: "SLP clients are not a priority for them [work brokers]." This tends to put the onus on case managers and/or employment co-ordinators to help clients find suitable work.

Employment co-ordinators are responsible for linking people with health conditions and disabilities to appropriate services but are also meant to match people to job opportunities according to their need and suitability. However, one employment co-ordinator interviewed said she had not received training in how to work with employers and, until recently, had not experienced much employer contact at all, having previously gone through the work brokers. While this might be an isolated case, it highlights the need to ensure that all employment co-ordinators receive adequate support or training, particularly if work brokers are only providing limited support in the HCD area.

Another option, as mentioned above, is to develop a partnership model with supported employment providers who can work with case managers and employment co-ordinators to profile and place young SLP clients in employment and provide post-placement support.

It is unclear who is responsible for providing post-placement support to clients and employers

Post-placement/in-work support for clients transitioning into work may involve talking to the client once they start work, ensuring they are receiving their full and correct financial entitlement, and supporting them when needed. It also, importantly, involves talking to the employer to address any concerns they may have or issues that may have arisen. Providing this support to clients and employers means they may be more likely stay in work.

From interviews with case managers, though, it was unclear who was taking responsibility for providing post-placement/in-work support for young SLP clients and employers. Some case managers believed it was the responsibility of the work brokers. It was also unclear whether a client should receive in-work support in instances where the client has found the job themselves. Further clarification is needed in this domain.

Individual's journey: The importance of post-placement support

About the individual

Josh is aged 22 years. His primary incapacity is s 9(2)(a) . Josh lives alone and gets in-home help. He said he tried flatting with other people but found that "it was a bit up and down".

Josh was enrolled in a tertiary course but said he got behind the other students because he did not have a reader/writer person until midway through.

Josh loves socialising with his "mates" and family. He likes going swimming, fishing and snow

skiing. s 9(2)(a) ... yeah, I love it."

Josh said his goal is to be employed and off the benefit.

> *Because I see everyone else going out to work four or five days a week.... And at the end of the week they might go out and have a yarn with their workmates and like the end of year thing. And I want to be like them, exactly like them.* (Josh)

Josh's dream job is to be a s 9(2)(a) .

Joining the young SLP Opt-In trial

Josh was initially contacted by the employment co-ordinator, who apparently had told him she wanted to help him find a job. Josh said he was very excited to hear that someone from Work and Income was interested in helping him.

> *I was like, 'yes, yes, yes' because this time last year I was practically tearing my hair out. Sometimes in a week, I might go a few days without doing anything and that drives me crazy; I start getting real anxious.* (Josh)

Josh signed up for the young SLP trial s 9(2)(a) . He said he felt quite nervous about it at first but told his case manager what he expected and that he really wanted to find a job.

Working with his case manager

Josh said he really enjoys working with his case manager and the employment co-ordinator and finds them very supportive. They have joint meetings with CCS Disability Action, who Josh also works with.

Finding work

Josh is a highly motivated person. After a suggestion from his case manager, he approached his local s 9(2)(a) and soon found himself with a job. However, after two-to-three weeks, the employer dismissed Josh on the grounds that he was too slow. Josh had only just heard the news when we interviewed him and was very upset about it. "It's sad really because I was starting to get to know everyone and everyone got to know me too." (Josh)

Feeling frustrated

Josh said he feels frustrated that it is taking so long to find a job. "It's been about eight months. Yeah, I thought I would have found a job by now. There's nothing around. And I think they [case manager and employment coordinator] are starting to feel frustrated for me too." (Josh)

The above example illustrates a situation where post-placement/in-work support could have made a difference in this client retaining their job:

- by addressing any concerns the employer was having in terms of Josh's disability or performance
- by providing wage subsidies if appropriate
- by providing supports to enable Josh to perform in his job to a standard required by the employer.

Client engagement with the young SLP Opt-In trial

Key points

- As at September 2015, 170 SLP clients had opted into the service. The average age of clients is 23 years. The majority (62 percent) of clients are male. Psychiatric or psychological conditions are the most common type of primary incapacity recorded.
- Forty-two clients (24 percent) have since exited the service and, of these, eight have been assisted into sustained employment.
- Young SLP clients are generally very positive about the trial and appreciate having a dedicated case manager.
- Clients interviewed are motivated and many were already working part time when they opted into the trial.
- Some early outcomes are evident but they cannot be attributed to the trial alone.
- Areas of frustration for clients include not enough face-to-face contact with case managers, the time taken for case managers to respond, the length of time it is taking to find a job and the limited range of training courses available.
- Barriers to client uptake of the service include being too busy, study, not being well enough, protective parents and concerns over losing their benefit.

Characteristics of clients who have opted into the trial

Administrative data gave the Ministry a picture of the characteristics of clients in the Opt-In trial. As of 18 September 2015, 170 SLP clients had opted-into the trial.

The average and median age of clients in the service across all pilot sites (including the Waikato and Canterbury sites) is 23 years. Of those clients who have opted into the trial, 62 percent are male and 38 percent are female. It is not clear either from the data or the qualitative interviews why the proportion of females in the trial is so much lower than that of males. One theory posited by case managers is that some clients, but especially female clients, are being used as babysitters by their families. However, further research would be required to substantiate this theory.

The majority (55 percent) of clients across all pilot sites are New Zealand European, 21 percent are Maori, six percent are Pacific peoples and 17 percent are coded either as 'Other' or as 'Not stated'.

Psychiatric or psychological conditions were the most common type of primary incapacity and were recorded for 29 percent of all clients across the 22 pilot sites. These conditions predominantly include autism[24] (24 percent), specific learning difficulties (18 percent) and attention deficit with hyperactivity (14 percent).

[24] Autism is a neurodevelopment disorder. It is coded under psychiatric and psychological conditions because there is currently no primary incapacity category for neurological conditions.

Congenital conditions and intellectual disabilities were the second-most common type of primary incapacity with 15 percent of clients recorded for each of these categories. Of those with congenital conditions, 32 percent were coded as having congenital anomalies, 16 percent as having cerebral palsy and 16 percent as having spina bifida.

Schizophrenic disorders were the third-most common type of primary incapacity, with 10 percent of clients recorded across the 22 pilot sites. Five percent of clients had epilepsy recorded as their primary incapacity.

Reasons for clients leaving the trial

Of the 170 young SLP clients who have opted into the trial, 42 (24 percent) have since exited the trial. Of these 42 exits, eight have been into sustained employment (note: 10 clients from the trial have exited into employment but two have since returned to benefit). Nine exits have been at the client's request, four exits were the case manager's decision, seven were because the client had transferred to a non-trial site, and 14 were coded either as 'unspecified' or 'other'.

Note: a more detailed analysis of administration data will be provided at a later date.

Young SLP clients are generally positive about the trial

Clients interviewed for the evaluation were generally positive about the trial. They appreciate having a single point of contact at Work and Income and someone who they can trust and who supports them in achieving their goals. For clients with a psychological or intellectual disability, not having to explain their "story" to a different case manager every time was particularly important.

Parents who accompanied their child to the interview were also very positive about the trial and grateful that "someone is showing an interest". As one mother put it:

> *Because I never know who to go to or what to do. So when [case manager] rang me and offered to work with Jackson[25], we jumped at it. I thought, 'wow, someone's actually interested and is able to help him'. I think it's awesome – finally!* (Mum)

Several clients and parents expressed surprise that "WINZ" was offering such a service and that the case managers were so "nice" and "helpful".

However, clients were not always initially so positive about the trial. One client described his thought process when he was contacted about the trial:

> *One day [case manager] just gave me a call out of the blue and I thought, 'I'm in trouble for something' and she said, 'no, it's a good thing. No, it's about opting in'. And I thought, 'okay' and she wanted me to come and meet her, so I did. I wasn't too sure about it at first. I just thought, 'if I do this, will I lose all my benefit and my Community Services card?' because my medicines cost so much. [Case manager] said I wouldn't so that's when I decided to jump in.*

[25] All client names have been changed to protect their identities.

Clients are motivated and many are already working

All clients interviewed were motivated to work but not all saw themselves as exiting the benefit completely. Boredom is a key motivation for some clients wanting to work as is a desire to be more independent and like able-bodied people they know. As illustrated above, a few clients expressed concerns about how part-time work or study might impact their benefit and/or if they would even be better off financially if they exited the benefit into work.

Of the 13 clients interviewed, six were already working part-time or had casual work when they opted into the trial. These clients tended to want to increase their hours or find a better job. Several other clients had been looking for work for some time but without success. One client was on a work trial at the time of their interview but was confident that they would soon have 20 hours' work a week confirmed. Another client was on work experience. Only two clients interviewed expressed an interest in further study or training.

Many of the clients interviewed were already working with other service providers when they joined the trial. Of those who were already working part-time, four had received assistance from a supported employment provider and some were also receiving post-placement support from them. One client had got his part-time work through a church contact and another client had got her casual work through her own efforts.

Several case managers were using the Investment Approach Trial Payment (IA Trial Payment) – a discretionary fund – to assist clients to get their driver's licence. Having a driver's licence would not only help clients to achieve a level of independence but would also make them more attractive to potential employers. One case manager said she had also used the IA Trial Payment to cover a client's hairdressing course fees.

Some early outcomes are evident but they cannot be attributed to the trial alone

Across all participating Work and Income sites there have been eight sustained client exits into employment. Because clients work with multiple service providers, though, these exits cannot be attributed to the trial alone. However, Susan's case outlined earlier provides an example of an exit that can be directly attributed to the trial.

As well as feeling more supported, several clients said they also feel more optimistic since starting the trial. One client, for example, had told his case manager that what he really wanted to do most was to be a volcanologist. He said he was still waiting to hear back from his case manager about what qualifications he needed to start a course in volcanology but that she had made him believe that it was entirely realistic and possible.

> *It's just sort of re-spiked an old interest in me and got me a little bit excited. I don't think I would have that focus on my dream job if it wasn't for [case manager]. So that kind of exceeded my expectations a bit … I just never thought that being a volcanologist might be something I might be able to achieve.* (Client)

Some clients had also developed more self confidence since participating in the trial. For example, several participants initially attended meetings with their case manager accompanied by a parent. However, once a trusting relationship had been established,

the client – often with their case manager's encouragement – started to attend meetings on their own.

Clients would recommend the service to others

All clients interviewed said they would recommend the young SLP service to other people. When asked what they would tell someone about the service, one client replied:

> *If you're disabled and keen to work, WINZ does have a programme that can help people with disabilities get back into work. It's a good experience. If they want to get back into work they should go along and talk to them.*

There are areas of frustration for clients

The frequency of face-to-face contact that clients have with their case manager appears to be quite variable. Some clients had regular fortnightly appointments while other clients' appointments appeared to be more ad hoc. Many clients said they would prefer more face-to face contact with their case manager. One client interviewed in June, for example, had not had a face-to-face meeting with her case manager since January. While the case manager had apparently kept in touch with her via telephone, this particular client would have preferred more face-to-face interaction.

The most common frustration expressed by clients is how long it takes for case managers and/or employment co-ordinators to follow-up on actions they say they will do. One client, for example, said his last face-to meeting was two months ago. "I'm still waiting for them to get some information together. [Employment co-ordinator] was supposed to call me but I haven't heard from her. There's also sorting out a CV as well which hasn't happened yet."

While case managers continually attempt to manage clients' expectations about how long it might take to find them a job, clients are still frustrated. Clients with intellectual disabilities can be particularly impatient as some do not fully comprehend the processes involved. As one client's mother explained:

> *[Case manager] saying to Jackson that they have passed his CV onto an employer. Jackson takes that as I'm going to get a job. He thinks he's going to get a job if he gets his licence. That's his way of thinking. It needs to be communicated to him in a way that he understands.* (Mum)

Clients who wish to engage in further training are also frustrated by the lack of training courses available to them.

Barriers to client uptake

Clients who had chosen not to opt into the trial were not interviewed as part of this evaluation. According to some case managers, though, many clients they contact react quite positively to the idea of the trial but the majority will decline, saying they are too busy, are studying, or are just too unwell.

Case managers find that parents who act as an agent for their child can either be supportive of their child enrolling in the trial or present a barrier to it. Many parents are highly protective of their child and are also concerned that the trial is about moving their

child off the benefit. The medical certificate that states that the person is unfit to work also holds significant weight for many parents and clients.

Eligibility for other support services was also a concern for some parents. One parent, for example, had removed her two children from the trial because she was told by their respite care provider that they no longer qualified for this service, as by joining the trial they were now deemed fit for work.

Conclusions and recommendations

The young SLP Opt-In trial aims to provide specialist case management support to young people in receipt of SLP who have a personal goal of gaining employment. The trial is also an opportunity for the Ministry to learn how to work with this client cohort to effectively support them in achieving their goals.

The process evaluation finds that while there are areas for improvement, the trial was well designed and implemented overall. Experienced case managers helped facilitate the transition to the new service, although the transition had its challenges. Case managers enjoy working with young SLP clients and find them motivated and enthusiastic. However, case managers generally find young SLP clients to be more time intensive than JS HCD clients and report they have experienced an increase in their workloads since the trial started.

Factors that appear to contribute to best practice case management centre around relationships: building trusting relationships with clients; adopting a person-centred approach; and establishing collaborative working relationships with employment co-ordinators and other service providers to provide the best service possible to clients. Qualities that support best practice case management include an ability to empathise and connect with clients and to think creatively to achieve outcomes for clients.

Clients participating in the trial are generally positive about the service. They appreciate having a single point of contact at Work and Income and someone who they can trust and who supports them to achieve their goals. Some early outcomes are evident but because clients often work with multiple service providers, they cannot be attributed to the trial alone.

Opportunities recommended for consideration

The evaluation highlights areas that could be improved. Below are a number of opportunities for consideration.

- Provider contracts for peer support and career services do not appear to be working well. **Opportunity:** investigate provider contracts to understand why they are not working well and what can be done to improve the services.
- There appears to be a lack of clarity around respective roles and responsibilities when clients are working with multiple agents/providers. **Opportunity:** develop clear process guidelines to clarify respective roles in these situations. Interviews with supported employment providers are also recommended to gain an understanding of their experience of working with Work and Income case managers thus far and what process would work best for them. These interviews could be carried out in the second evaluation phase scheduled for 2016.
- There is a lack of clarity around the respective roles and responsibilities of employment co-ordinators and work brokers in the trial. It is also not clear who is responsible for providing post-placement/in-work support. **Opportunity:** clarify these roles and responsibilities and communicate to all concerned.
- A frustration for both case managers and clients is the limited number of training courses available to people with health conditions or a disability. **Opportunity:** review

the range of training courses available to young SLP clients and the flexibility of these courses to accommodate people with health conditions and disabilities. A review of training providers' contracts is also recommended to determine if they in anyway disincentivise providers from taking on young SLP clients.

- Work brokers reportedly have limited capacity and/or confidence in working with SLP clients. **Opportunity:** explore the possibility of a partnership model with contracted supported employment providers for work placement services.
- The most common challenge expressed by case managers was the pressure of time and their ability to do justice both to their JS HCD clients and their SLP clients. **Opportunity:** review case managers' caseloads to better understand how the needs profile of different clients impacts on their time as well as what other on-the-ground demands are being placed on their time (eg, new business, filling in for general case management).
- Case managers do not appear to be using the resources available through their RDAs and RHAs. **Opportunity:** remind case managers and RDAs/RHAs that RDAs and RHAs are there to support them.
- Case managers feel they need a deeper understanding of certain health conditions and disabilities and would like the opportunity to learn from examples of best practice. **Opportunity:** facilitate ongoing training for case managers. These training sessions would also provide an opportunity to remind case managers about resources available to them, discuss any new processes and share examples of best practice.
- Case managers sometimes have difficulty in maintaining boundaries and feel stressed or overwhelmed with JS HCD and SLP clients' issues. **Opportunity:** investigate providing case managers with access to clinical supervision.

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Appendix 1: Evaluation framework

Evaluation objective	High-level questions	Data sources
To assess how well the young SLP service model has been implemented and if it is operating as intended	• What supported and what hindered the implementation of the young SLP service model? • To what extent is the service model operating as intended? • Where there have been problems, how significant are they? • What can be done to resolve any continuing problems?	• Interviews with the trial project team • Interviews with case managers and employment co-ordinators
To provide feedback on key processes and practices that are working well or presenting difficulties	• From the perspective of staff, what is working well about the service model and what could be improved? • How is the client service allocation process working in practice? • Can examples of good practice be identified? • Are there sufficient supports and resources in place for case managers? • Are there particular barriers to placing young SLP clients into work?	• Interviews with the trial project team • Interviews with case managers and employment co-ordinators
To monitor and assess client uptake of, and engagement with, the service	• Are some clients more likely to opt into the service than others? • How do clients perceive and experience the service? • What barriers are preventing clients from opting into the service? • How relevant is the service for clients with specific needs? Are there any other services that could be helpful to clients?	• Analysis of MSD administrative data • Interviews with clients who have opted into the trial
To understand how the service is contributing to client outcomes of work, up-skilling, higher education, and reduction of benefit receipt, as well as health and wellbeing	• From the perspective of case managers, what difference is the service making to clients? • From the perspective of clients, what difference is the service having on their lives? • What outcomes are being achieved under the young SLP service model?	• Analysis of weekly/quarterly outcomes reporting • Interviews with case managers and employment co-ordinators • Interviews with clients who have opted into the trial