



6 April 2023

Tēnā koe

On 23 February 2023, you emailed the Ministry of Social Development (the Ministry) requesting, under the Official Information Act 1982 (the Act), the following information:

*Under section 12 of the Official Information Act 1982, I request the following information:*

- *All official advice, analyses, assessments, recommendations, reports and forecasts you have received or produced about long-term benefit recipients, and any impacts stemming from being on benefit long-term, since 1 January 2022 that have not been previously released to me under the Act or are already publicly available.*

*This is not a request for officials personal or private details.*

*I ask you acknowledge receipt of this request.*

It was identified by the Ministry that there was a significant amount of information within scope of your request which would likely have required substantial manual collation to compile everything in-scope. As such, on 9 March 2023, the Ministry emailed you seeking a refinement of your request along the following lines:

*After liaising internally, there is a significant amount of information in-scope to the extent that your request would likely be refused under substantial manual collation in its current form.*

*To highlight this point, we produce routine data on benefit numbers and statistics by duration-on-benefit which is within scope of your request, however the sheer quantity of this information is too large to be able to provide it all to you within your date-range of interest.*

*As an alternative, can we please suggest that you consider refining your request to focus on any evaluations and reports about long-term benefit recipients since 1 January 2022?*

That same day, you agreed to the Ministry's suggested refinement of your request.

Accordingly, please find attached the following reports and evaluations identified within the parameters of your refined request:

- Draft Intensive Client Support – Extension (ICS-X) Trial: Quantitative evaluation at 12 months and 24 months. Please note, as this paper is a draft version, the final version may differ.
- In-scope paragraphs from the *New Employment and Social Outcomes Investment Strategy* report.

You will note that some information in the **Appendix** regarding the names of officials is removed as out of scope. Additionally, the Ministry has removed some information in the *New Employment and Social Outcomes Investment Strategy* report which has been identified as outside of the scope of evaluations and reports about long-term benefit recipients. Please contact the Ministry if this was not the intent of your request.

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 and
- 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'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](mailto:OIA_Requests@msd.govt.nz).

If you are not satisfied with this response, 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](http://www.ombudsman.parliament.nz) or 0800 802 602.

Ngā mihi nui



Rachel Skeates-Millar  
**General Manager**  
**Research and Evaluation**

# Appendix



**MINISTRY OF SOCIAL  
DEVELOPMENT**

TE MANATŪ WHAKAHIATO ORA

## **Intensive Client Support – Extension (ICS-X) Trial:**

**Quantitative evaluation at 12 months and 24 months**

**September 2022**

## Acknowledgements

Thank you to:

- Out of scope for their extensive work in producing not just the analysis for this report, but for their extensive work in producing analysis across this evaluation programme.
- Out of scope for your impact analysis for this report, extensive data checking, and co-ordinating the process for finalising this report.
- Out of scope for your feedback and work towards finalising this report.
- All the people who provided assistance on the analysis, as well as early drafts and feedback on the final report.

## Disclaimer

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

## Published

Ministry of Social Development  
PO Box 1556  
Wellington  
[www.msd.govt.nz/insights](http://www.msd.govt.nz/insights)

[Month and year will be published on the website]

## ISBN

[this will be provided by your comms person]

## Recommended citation

Ministry of Social Development. (202X). Intensive Client Support – Extension (ICS-X) Trial: Quantitative evaluation at 12 months and 24 months. Wellington, New Zealand: Ministry of Social Development.



# Contents

---

<b>Tables and Figures .....</b>	<b>5</b>
<b>Reference section.....</b>	<b>6</b>
Glossary .....	6
Terminology .....	6
<b>Executive summary .....</b>	<b>7</b>
ICS service aimed to improve work-readiness for clients who entered the benefit system before age 20 .....	7
ICS service expanded under the ICS-X trial .....	7
Little difference in percentage of time spent off benefit between treatment and control groups for most cohorts .....	8
The difference in percentage of time off benefit between treatment and control clients was minimal overall.....	9
Ways to improve client experience .....	11
Social context of trial extension .....	11
<b>ICS service aimed to help clients who entered the benefit system before age 20 and who faced multiple challenges towards employment .....</b>	<b>13</b>
ICS service: a new holistic case management approach based on Te Whare Tapa Whā .....	13
ICS service operated differently to enable more intensive support.....	14
ICS trial compared effectiveness with other services.....	16
Some aspects of the ICS service changed organically, and some operational changes were made for the extension trial.....	16
ICS service continued at the original sites and expanded to new locations.....	17
Broadening eligibility criteria created four cohorts for the ICS-X trial .....	18
<b>There were changes in social conditions between the ICS and ICS-X trials.....</b>	<b>19</b>
Housing affordability and security affected clients .....	19
Economic growth slowed across both trials .....	19
<b>Implementation issues.....</b>	<b>21</b>
‘Ring-fencing’ of the ICSM role is a challenge.....	21
High turnover of ICSM staff affected delivery of ICS service .....	21
A temporary waitlist maintained ICSM caseloads until new system adjustments were functional.....	22
<b>Methodology and data .....</b>	<b>23</b>
Evaluation questions.....	23
Client selection for ICS-X trial .....	23



Our main outcome measure was the percentage of time that clients spent off benefit, an imperfect measure of employment or study outcomes .....	24
As most ICS-X trial clients were Māori, subgroup analysis compared Māori treatment clients to Māori control clients.....	24
Scope of the ICS-X trial evaluation .....	24
MSD administrative data used to analyse staff time.....	24
Data on the first main benefit received had quality issues .....	25
Re-categorised treatment clients to GCM service for the reactive support given while on the ICS service waitlist .....	25
Data was re-weighted to enable a broad range of statistical analysis .....	25
Caveats about the data .....	25
<b>Demographic and benefit characteristics .....</b>	<b>27</b>
Demographic characteristics are similar for treatment and control groups, for ICS-X trial clients overall and Māori ICS-X trial clients .....	27
Benefit history prior to ICS-X trial selection .....	28
Age difference rather than entrenchment explains years on benefit .....	29
<b>Treatment clients received more intensive support than control clients .....</b>	<b>31</b>
Treatment and control clients received vastly different services .....	32
Frontline staff spent more time working with treatment clients .....	35
<b>ICS-X trial results showed few differences, with some notable exceptions .....</b>	<b>36</b>
There was little difference overall between treatment and control ICS-X trial clients with respects to time off benefit.....	36
There was little difference overall between Māori treatment and control ICS-X trial clients with respects to time off benefit.....	37
There was a non-significant difference at some time points between younger JS WR treatment and control clients with respects to time off benefit .....	38
Younger JS HCD control clients were more likely than their treatment counterparts to be off benefit from 21 months onwards.....	39
Older JS WR treatment clients selected on the first week of the trial were more likely to be off benefit than their control counterparts .....	40
There was a non-significant difference at most time points between older JS HCD treatment and control clients with respects to time off benefit .....	41
<b>Conclusion.....</b>	<b>42</b>
Future areas of analysis .....	44
<b>Bibliography.....</b>	<b>45</b>



# Tables and Figures

---

Table 1: Number and percentage of clients selected to the ICS-X trial by cohort, client group and allocation group at 24 months .....	8
Table 2: Average percentage of time off benefit for treatment and control clients and the difference (impact) between them, by cohort at the 12-month mark from the 24 months analysis .....	10
Table 3: Māori ICS-X trial clients – Average percentage of time off benefit for treatment and control clients and the difference (impact) between them, by cohort at the 12-month mark from the 24 months analysis .....	10
Table 4: Economic indicators and events relevant to the original ICS trial and the ICS-X trial .....	20
Table 5: Proportional split by cohort, benefit type and age group .....	23
Figure 1: Percentage of measured staff time spent working with ICS service clients and their partners .....	21
Figure 2: Average percentage of time on a main benefit prior to trial selection at analysis period, by cohort and allocation group .....	30
Figure 3: Māori ICS-X trial clients - Average percentage of time on a main benefit prior to trial selection at analysis period, by cohort and allocation group .....	30
Figure 4: Percentage of time spent in each service during the ICS-X trial period at analysis period, by cohort and allocation group .....	33
Figure 5: Māori ICS-X trial clients – Percentage of time spent in each service during the ICS-X trial period at analysis period, by cohort and allocation group .....	34
Figure 6: Percentage of time spent off a main benefit since trial selection at 12 months (left) and 24 months (right) .....	36
Figure 8: Māori ICS-X trial clients - Percentage of time spent off a main benefit since trial selection at 12 months (left) and 24 months (right).....	37
Figure 9: Younger JS WR cohort - Percentage of time spent off a main benefit since trial selection at 12 months (left) and 24 months (right).....	38
Figure 10: Younger JS HCD cohort - Percentage of time spent off a main benefit since trial selection at 12 months (left) and 24 months (right) .....	39
Figure 11: Older JS WR cohort - Percentage of time spent off a main benefit since trial selection at 12 months (left) and 24 months (right).....	40
Figure 12: Older JS HCD cohort - Percentage of time spent off a main benefit since trial selection at 12 months (left) and 24 months (right).....	41

## Reference section

### Glossary

Acronym	Full name
ICS	Intensive Client Support
ICS-X	Intensive Client Support - Extension
ICSM	Intensive Client Support Manager
JS HCD	Jobseeker Support - Health Condition and Disability
JS WR	Jobseeker Support - Work Ready
MSD	Ministry of Social Development
WFCM GEN	Work Focussed Case Management – General
WFCM HCD	Work Focussed Case Management – Health Condition or Disability
WFCM IS	Work Focussed Case Management – Intensive Support
WSS	Work Search Support
GCM	General Case Management

### Terminology

Term	Meaning
ICS service	An intensive, holistic and client-centric case management approach. The aim is to help clients progress towards employment and benefit independence through 'staircasing'
ICS trial	The original randomised control trial that evaluated effectiveness of the ICS service from March 2015 to March 2018
ICS-X trial	The extended randomised control trial evaluating effectiveness of the scaled-up ICS service from March 2018 to March 2021
Staircasing	Incrementally progressing the client towards work-readiness by focusing on the client's current challenges (for example, alcohol / drug dependency, training, etc.) before working on long-term goals of employment
Selection / Trial selection	First of two-step process where clients who met eligibility criteria for ICS service were randomly selected to be part of the ICS-X trial
Pre-trial benefit period	The period from when the client received their first main benefit up to the day prior to being selected to the ICS-X trial
Trial period	The period between when the client was selected for the ICS-X trial and the end of the analysis period (for example, 12 months). Selection dates vary between clients, so the length of trial period for each client also varies
Analysis period	This evaluation covers two analysis periods – 12 months (March 2018 to March 2019) and 24 months (March 2018 to March 2020, up to the COVID-19 lockdown). Only new clients who were selected to the ICS-X trial within those periods were included in the analysis



## Executive summary

---

### ICS service aimed to improve work-readiness for clients who entered the benefit system before age 20

Research shows that clients who enter the welfare system before age 20 often face multiple challenges towards employment. As a result, they tend to remain on benefit for longer and need more financial support while on benefit (Taylor Fry, 2012).

To provide more intensive support for clients who enter the welfare system before they turn 20, the Ministry of Social Development (MSD) created the Intensive Client Support service (ICS service) as a holistic case management approach. Key features of this new ICS service included:

- Long-term support from a specialised case manager
- Smaller caseload for these case managers allowing for individualised support
- A holistic focus on client and whānau wellbeing
- A 'staircasing' approach towards employment and benefit independence.

The Intensive Client Support trial (ICS trial) operated from March 2015 to March 2018 to measure effectiveness of the new service. All those selected for the ICS service entered the welfare system before they turned 20, no matter their age at the time of the trial.

Using a randomised control trial design, eligible clients on the Jobseeker Support – Work Ready (JS WR) benefit were split between the treatment group (who received the ICS service) and a control group (who received business-as-usual services). The ICS trial had two cohorts based on age at trial selection, 18-29 years old and 30-39 years old.

### ICS service expanded under the ICS-X trial

Mixed-method evaluations of the ICS trial at 12, 24 and 36-months provided positive results and also identified some opportunities to strengthen the service. In response, the Government funded an extension and scaled-up expansion of the ICS service to run for another three years (March 2018 to March 2021).

In the evaluation of the original ICS service, it was found that existing services for clients under 25 in the control group were similar to those in the trial, and made no significant difference to outcomes. Therefore, the age range for the younger cohort was reduced (from 18-29 to 25-29).

The Intensive Client Support - Extension (ICS-X) trial included:

- **More sites:** an increase from five sites (six Intensive Client Support Managers (ICSMs)) to 22 sites (25 ICSMs)<sup>1</sup>

---

<sup>1</sup> The ICS-X trial initially had 21 sites with two ICSMs in Whanganui. Due to staff changes, the second ICSM role was transferred to the New Plymouth site in November 2018.



- **Broader benefit coverage:** clients receiving the Jobseeker Support - Work Ready (JS WR) benefit were joined by clients receiving the Jobseeker Support - Health Condition and Disability (JS HCD) benefit<sup>2</sup>
- **More cohorts:** the combination of two age groups (25-29 years old and 30-39 years old) and two benefit types (JS WR and JS HCD) created four cohorts.

The ICS-X trial also operated as a randomised control trial using a 1:1 ratio of treatment clients (who received ICS service) to control clients (who received business-as-usual services). As over half of clients identified as Māori, subgroup analysis of Māori treatment and Māori control clients was also completed.<sup>3</sup>

**Table 1: Number and percentage of clients selected to the ICS-X trial by cohort, client group and allocation group at 24 months**

24 months	ICS-X trial clients		Māori ICS-X trial clients	
	Treatment	Control	Treatment	Control
25-29 years old JS WR	410 (16.4%)	410 (16.4%)	256 (18.5%)	232 (17.9%)
25-29 years old JS HCD	365 (14.6%)	365 (14.6%)	147 (10.6%)	137 (10.5%)
30-39 years old JS WR	780 (31.3%)	780 (31.3%)	530 (38.4%)	483 (37.2%)
30-39 years old JS HCD	940 (37.7%)	940 (37.7%)	449 (32.5%)	447 (34.4%)
<b>Total</b>	<b>2,495 (100.0%)</b>	<b>2,495 (100.0%)</b>	<b>1,382 (100.0%)</b>	<b>1,299 (100.0%)</b>

## Little difference in percentage of time spent off benefit between treatment and control groups for most cohorts

This evaluation found that:

- clients in the ICS-X trial received more longer and more focused care
- both treatment and control groups spent more time off benefit the longer they were in the trial. Clients who were in the trial for the full 24 months (both treatment and control) spent over 24% of the trial period off benefit
- the extension trial was not as immediately successful as the initial trial. This was likely to be the result of the changing social context, including a fall in unemployment and available jobs, and the issues raised by the COVID-19 pandemic

<sup>2</sup> For definitions of these benefits see <https://www.workandincome.govt.nz/products/a-z-benefits/jobseeker-support.html#null>

<sup>3</sup> As ethnicity was not a RCT selection criterion, the 1:1 treatment to control client ratio does not hold for the Māori treatment and Māori control analysis.



- the results of the trial are trending in a positive direction, although the results are not always significant. We would expect more positive results to general outcomes (not just employment) in the longer term.

The ICS-X trial did have statistically significant results for two groups. However, these results should be considered with caution as some time periods had small client numbers, particularly for Māori. We found that:

- for Māori ICS-X trial clients, the younger (25-29 years old) JS HCD treatment clients spent significantly more time on benefit than those in the control group for part of the analysis period
- younger JS HCD treatment clients spent more time on benefit than those in the control group part of the time.

## **The difference in percentage of time off benefit between treatment and control clients was minimal overall**

New clients were added to the ICS-X trial throughout the full 24 months as spots became available on the ICS service, meaning clients were selected to the trial for a period anywhere from one week to 24 months. Within the 24 months analysis results, we focus on clients at 12 months since selection to the ICS-X trial to allow most of the clients to be included in this summary.

Table 2 and Table 3 (overleaf) show impact results for clients across the different cohorts at the 12-month mark after selection to the trial. On average, the difference (impact) in time off benefit at the 12-month mark between the treatment group and the control group was -0.1 percentage points for the ICS-X trial overall and -0.3 percentage points for Māori ICS-X trial clients overall.

Clients in the JS WR cohorts spent more time off benefit than clients in the JS HCD cohorts, for the ICS-X trial overall and for Māori ICS-X trial clients. This result was expected to some extent, given that JS HCD clients are more likely than JS WR clients to have health conditions or disabilities that may affect their ability to work full time, therefore being less likely to exit benefit for full-time employment.

**Table 2: Average percentage of time off benefit for treatment and control clients and the difference (impact) between them, by cohort at the 12-month mark from the 24 months analysis**

ICS-X trial clients	From the 24 months analysis, results at the 12-month mark			
	Treatment	Control	Difference (Impact)	Percentage of total cohort <sup>4</sup>
25-29 years old JS WR	24.6%	27.6%	-3.0 percentage points	75%
25-29 years old JS HCD	15.7%	19.6%	-3.9 percentage points <sup>5</sup>	68%
30-39 years old JS WR	22.3%	21.5%	+0.8 percentage points	99%
30-39 years old JS HCD	16.6%	15.2%	+1.4 percentage points	79%
<b>Total</b>	<b>19.8%</b>	<b>19.9%</b>	<b>-0.1 percentage points</b>	<b>83%</b>

**Table 3: Māori ICS-X trial clients – Average percentage of time off benefit for treatment and control clients and the difference (impact) between them, by cohort at the 12-month mark from the 24 months analysis**

Māori ICS-X trial clients	From the 24 months analysis, results at the 12-month mark			
	Treatment	Control	Difference (Impact)	Percentage of total cohort <sup>3</sup>
25-29 years old JS WR	25.2%	23.0%	+2.2 percentage points	77%
25-29 years old JS HCD	14.7%	22.4%	-7.7 percentage points <sup>6</sup>	70%
30-39 years old JS WR	21.3%	22.2%	-0.9 percentage points	99%
30-39 years old JS HCD	17.4%	16.1%	+1.3 percentage points	79%
<b>Total</b>	<b>20.2%</b>	<b>20.5%</b>	<b>-0.3 percentage points</b>	<b>85%</b>

<sup>4</sup> This identifies how many clients from each cohort were included in the 12-month mark results as a percentage of the total cohort at the end of the 24 months analysis period.

<sup>5</sup> While the difference (impact) between the ICS-X younger (25-29 years old) JS HCD treatment and control clients was not statistically significant at month 12, it was statistically significant from month 20.5 onwards.

<sup>6</sup> The difference (impact) between the Māori younger (25-29 years old) JS HCD treatment and control clients was statistically significant at month 12 and other time points across the 24 months analysis period.



## Ways to improve client experience

A companion qualitative study<sup>7</sup> examining the ICS-X trial in combination with our quantitative analysis found that:

- individual service managers were key in their clients' success
- almost all clients were affected by low confidence and self-esteem and often also had mental or physical health issues. Challenges to work included substance use and addiction, complex family issues, housing issues including homelessness, challenges with reading and writing, a criminal history, low motivation to work, or attitudes and social issues that made it difficult to stay in work
- changes to ICS service over time had an increased focus on broader client and whānau wellbeing, consistent with changes in the Ministry of Social Development's strategic direction with Te Pae Tawhiti – Our Future in 2018
- clients receiving ICS service reported feeling treated more "like a person" than in their previous Work and Income experiences.

The trial also showed that effective ICSMs:

- used the 'staircasing' approach, where they began with the client's most pressing need and continued at the client's pace to build incremental progress towards the client's goals
- built a strong relationship between the ICSM and the client by demonstrating empathy and displaying a non-judgemental approach
- were able to provide an ongoing service, with few intrusions from other service requirements
- had the skills to build relationships with clients with multiple challenges.

If the ICS service (or something similar) was to be implemented as a business-as-usual service, the findings of this evaluation suggest MSD should:

- adjust eligibility to focus on truly 'entrenched' clients
- ensure greater understanding of the ICS service by Service Centre Managers and other case managers to help enforce ring-fencing of the ICSM role
- reduce the high ICSM staff turnover.

## Social context of trial extension

The original ICS trial and the expanded ICS-X trial operated in substantially different economic conditions. These differences may partly explain why the ICS-X trial did not achieve the same positive results of the original ICS trial.

---

<sup>7</sup> "Intensive Client Support – Extension (ICS-X) Trial: 12-month process review and client case stories evaluation" by Malatest International <https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/research/ics-qualitative-evaluation-2017/12-month-process-review-and-case-studies-report.pdf>

For the first two years of the original ICS trial, the economy was growing and provided many entry-level jobs for clients to move into. From historical experience, these entry-level jobs were the most common job opportunities for the types of clients selected into the ICS trial.

From March 2017 onwards, slowing economic conditions resulted in fewer entry-level jobs becoming available during the ICS-X trial period. This meant that the job market was markedly more adverse for clients in the ICS-X trial than the original ICS trial.

During the ICS-X trial, housing affordability and housing security affected MSD's clients in general. The number of applications on the Social Housing Register increased 102 percent. Additionally, usage of hardship assistance increased, mostly related to increased financial stress attributed to housing costs.

Added challenges in delivering ICS services due to COVID-19 may also have contributed to the ICS-X trial results.

DRAFT/CONFIDENTIAL



## ICS service aimed to help clients who entered the benefit system before age 20 and who faced multiple challenges towards employment

---

Clients who enter the benefit system before age 20 often face multiple challenges towards employment. These challenges include low literacy or numeracy skills, drug or alcohol dependency, mental health issues, multi-generation dependency on the benefit system, poor housing conditions, unreliable transportation, child-care concerns, etc.

Findings from research suggest that clients who entered the welfare system before age 20 often remained on a benefit for longer and received more financial support during their time on benefit (Taylor Fry, 2012). In response, the Ministry of Social Development (MSD) created the Intensive Client Support service (ICS service) to provide more intensive support for these clients. Criteria for ICS service required:

- the client to be:
  - receiving the JS WR benefit
  - between 18-39 years old (pre-17 April 2017).<sup>8</sup>
  - between 25-39 years old (post-17 April 2017).
- that the client's entrance into the benefit system:
  - had occurred before age 20
  - excluded their first benefit being the Supported Living Payment, Invalids Benefit, Domestic Purposes Benefit - Caring for Sick or Infirm or Unemployment Benefit Student Hardship.

### ICS service: a new holistic case management approach based on Te Whare Tapa Whā

The ICS service was designed as a new, holistic case management approach based on Te Whare Tapa Whā model of Māori health (Durie, 1998). Te Whare Tapa Whā states, wellbeing is based on the balance of four dimensions. If any of these dimensions is missing or damaged, the wellbeing of the person decreases:

- **Taha tinana:** physical health
- **Taha wairua:** spiritual health
- **Taha whānau:** family health
- **Taha hinengaro:** mental health.

---

<sup>8</sup> Previous evaluation of the original ICS trial determined that clients aged 18-24 years old already received intensive support through other business-as-usual services and therefore were no longer eligible for selection to ICS service. From 17 April 2017 onward, treatment clients within this age range could continue ICS service if they were currently on an ICSM's caseload. After naturally exiting ICS service, these clients were able to return to ICS service when they were 25 years or older, met eligibility criteria and space was available on the ICSM's caseload.



With this concept in mind, ICS service started with an in-depth discussion with the client. This enabled the Intensive Client Support Manager (ICSM) to start to understand the client's situation. They worked with the client to identify immediate challenges that could be dealt with (such as housing, family, or health challenges), then kept building and progressing to improve the client's work-readiness toward employment. This 'staircasing' approach helped create greater stability in the client's life, putting them in a better position to think about work and sustaining employment.

Another key aspect of ICS service was working with the whānau of the client. Partners of clients were also assigned to ICS service<sup>9,10</sup> so the ICSM could work with them as a couple and individually. The ICSM could also provide support for the client's children, siblings or parents if needed - or include these family members in appointments to better support the client. This reflects that the wellbeing of one affects the wellbeing of all.

The five core principles of the ICS service were:

- **Client centred:** letting the client navigate their way forward while being supported and guided to achieve; every client is an individual, and should be treated as such
- **Goal focused:** each intervention and engagement include steps that make progress towards the client's goals
- **Strengths-based approach:** focus on the client's abilities and what they can do
- **Guide and navigate to obtain support:** identify the client's needs, and the right support and services are agreed upon that align with the client's goals
- **Promote client's independence:** working with the client to achieve their goals and gain independence from the benefit system.

## ICS service operated differently to enable more intensive support

ICS service operated differently from other business-as-usual services in several key aspects:

- **Long-term support by the same ICSM:** clients worked with the same ICSM while in ICS service, this helped develop rapport and reduced client frustration of re-telling their story or justifying their need each time they had contact with MSD
- **Smaller caseload for ICSMs:** allowed more time with each client, plus flexibility on when and how often appointments happened

---

<sup>9</sup> There were a few exceptions to this operational practice: that is, when the client and their partner did not share the same benefit, or the partner was receiving a service with priority over ICS service (for example, Youth Service).

<sup>10</sup> As partners were not randomly selected to the ICS-X trial, they were not counted within the ICSM caseload of 60 clients and were excluded from analysis.



- **Direct contact:** ICSMs had a work phone and work email on which clients could contact them directly, rather than going through the contact centre or the reception desk
- **Alternative check-in methods:** clients could check-in with their ICSM via phone, text or email if traveling to the site for a face-to-face meeting was challenging (for example, anxiety inducing, transportation issues, etc.)
- **Reduce benefit sanctions:** sanctions for failure to meet benefit obligations were relaxed to give clients more leeway to progress at their own speed
- **Clients were able to return to ICS service:** changes in client circumstances sometimes resulted in treatment clients no longer being eligible for ICS service and removed from ICSM caseload (for example, went off benefit); however, treatment clients could return to ICS service if they still met eligibility criteria and one of the following scenarios:
  - **Direct transfers:** a treatment client currently on ICS caseload and directly transferred to another ICS service site was automatically added to the new ICSM's caseload regardless of current capacity<sup>11</sup>
  - **Returning to ICS service within two weeks:** as changes in client circumstances were often short-term, treatment clients were automatically allowed to return to ICS service within a 2-week period to minimise disruption of service, regardless of current capacity on the ICSM caseload
  - **Returning more than two weeks off ICS service:** as turnover of ICS service clients was much higher than anticipated, operational processes were changed in April 2016 to allow treatment clients to return after being off ICS service for more than two weeks if there was space available on the ICSM caseload.
- **Exclusion of clients from ICS service:** ICS service was a mandatory service for treatment clients while on ICSM caseload, just as if the client was assigned to any other business-as-usual service. ICSMs could temporarily or permanently exclude treatment clients from ICS service in the following circumstances, after all options have been exhausted:
  - Client did not respond to any contact attempts made by the ICSM
  - Difficult to have regular contact as the client lived in a rural area where traveling long distance to the site was not feasible and alternative contact methods (for example, phone, text, or email) were not reliable
  - Client was in late pregnancy or had a new-born child.

---

<sup>11</sup> Automatic return to ICS service, regardless of current capacity, meant that ICSM caseloads were temporarily over-capacity (that is, more than 60 treatment clients) at times.



## ICS trial compared effectiveness with other services

The Intensive Client Support trial (ICS trial) was designed to compare effectiveness of the ICS service with other business-as-usual services. It ran for three years from March 2015 to March 2018. Evaluations (including Gravitas, 2017)<sup>12</sup> suggested that treatment clients preferred the new case management approach due to the dedicated relationship with their ICSM and the support and trust this afforded, and spent a significantly higher percentage of time off benefit. This was particularly true for older clients.

Based on these positive results, additional government funding was obtained to expand the service to more sites and broaden the client base, while continuing to fine-tune the ICS service itself. This Intensive Client Support – Extension trial (ICS-X trial) was scheduled to run for three years (March 2018 to March 2021).

In March 2020, Aotearoa New Zealand entered a countrywide lockdown to reduce the spread of COVID-19. The ICS service was put on hold so ICSMs could assist with the high demand to process wage subsidy applications from businesses and benefit payment applications from individuals. This quantitative evaluation covers the ICS-X trial up to these COVID-19 changes. This coincidentally happened shortly after the 24-month mark.

## Some aspects of the ICS service changed organically, and some operational changes were made for the extension trial

While the core principles and operational processes of ICS service remained similar across the original ICS trial and the expanded ICS-X trial, some aspects organically changed over time to reflect the changing environment in which the service operated. An increasing focus on client and whānau wellbeing followed the change of government in 2017 when the Labour Coalition Government replaced the National Government. This focus was further supported by MSD's new strategy *Te Pae Tawhiti – Our Future* in 2018, which placed greater emphasis on wellbeing of the people, whānau, families and communities that MSD served (MSD, 2018).

Other factors that influenced the organic development of ICS service included the knowledge and experience that ICSMs brought to their role, the locations that ICS service operated in, and lessons learned along the way.

A few additional operational components were added to the ICS service during the extension trial:

- **Community liaison:** part of the ICSM role was to network with local support services to better understand what additional resources were available for their clients if needed

---

<sup>12</sup> Other internal Ministry of Social Development evaluations that were not published at the time of completion are being released over time, as part of a programme of work to develop a research archive and improve access to that research. We will be adding material to the website as resources permit.

- **Navigators:** NGOs were contracted for the ICS-X trial to provide additional support to ICS service clients out in the community, as safety regulations placed some limitations on what ICSMs could do for clients outside of the site.
- **No time limit:** as clients were often dealing with multiple challenges, it was expected that treatment clients would be receiving ICS service for a long time to help them 'staircase' towards employment, based on this:
  - Treatment clients were allowed in ICS service if they met eligibility criteria and space was available on ICSM caseload – including treatment clients from the original ICS trial
  - While clients had to be between 25-39 years old at time of selection for the ICS-X trial, there was no maximum age limit to receive ICS service.

## ICS service continued at the original sites and expanded to new locations

When the ICS-X trial went live on 18 March 2018, 357 (out of 360) clients continued receiving ICS service from the same ICSMs. These clients could remain in the service as long as they met the eligibility criteria.

The five original sites continued with one ICSM each, except for Rotorua, which increased from two to three ICSMs under the ICS-X trial:

- Manurewa
- Porirua
- Invercargill
- Rotorua
- Naenae

Seventeen additional ICS-X trial sites were selected based on number of clients who satisfied the eligibility criteria for ICS service. Each site had one ICSM, except for Palmerston North with two<sup>13</sup>:

- Kaitaia
- Whangarei
- Waitakere
- Tamaki
- Mangere
- Papakura
- Five Cross Roads
- Dinsdale
- Tokoroa
- Whakatane
- Gisborne
- Hastings
- New Plymouth
- Whanganui
- Palmerston North
- Linwood
- Dunedin.

<sup>13</sup> The ICS-X trial initially had 21 sites with two ICSMs in Whanganui. Due to staff changes, the second ICSM role was transferred to the New Plymouth site in November 2018.



In total, the ICS-X trial had 25 ICSMs at 22 sites. The expansion increased the number of clients receiving ICS service at any given time from 360 to 1,500. Due to a staffing delay, ICSMs at the Kaitaia and Whanganui sites started ICS service three weeks later, on 8 April 2018.

## **Broadening eligibility criteria created four cohorts for the ICS-X trial**

In a previous evaluation of the original ICS trial, ICSMs commented that many JS WR clients were dealing with mental health problems, substance abuse, or both (Gravitas, 2017). These issues were often not officially diagnosed or acknowledged. This informed the decision to expand eligibility for the ICS-X trial to JS HCD clients, as medical certificates indicated that JS HCD clients were often dealing with the same problems.

The combination of benefit type and separation into two age groups (25-30 and 30-39) created four separate cohorts for the ICS-X trial.

Although this evaluation shows only outcomes of the four cohorts and the ICS-X trial overall, we sometimes compare results between the two age groups or the two benefit types to show similarities or differences across the four cohorts.

## **There were changes in social conditions between the ICS and ICS-X trials**

---

Our impact analysis found there was little difference in percentage of time off benefit between treatment and control for most cohorts, for ICS-X trial clients overall and Māori ICS-X trial clients. However, the original ICS trial and the expanded ICS-X trial operated in quite different economic conditions. These differences may partly explain why the ICS-X trial did not achieve the same positive results of the original ICS trial.

### **Housing affordability and security affected clients**

During the ICS-X trial, housing affordability and housing security affected MSD's clients in general. For example, the number of applications on the Social Housing Register increased from 9,695 at the end of March 2018 to 19,621 at the end of March 2020 (an increase of 102.4%). Additionally, usage of hardship assistance increased, mostly related to increased financial stress attributed to housing costs.

### **Economic growth slowed across both trials**

The original ICS trial and the ICS-X trial operated under different economic conditions. Table 4 (overleaf) describes some differences in those conditions.

These shifts in economic conditions affected MSD clients in general in a few ways, including (but not limited to):

- The slowing of economic growth from March 2017 was particularly felt in the lower skilled sectors (for example, construction, retail trade, administration and health care) our clients are more likely to access
- Employment growth during the ICS-X trial came in fields that don't typically provide entry level employment (for example, financial and professional services) for our clients receiving the Job Seeker benefit.
- For clients in the JS HCD cohorts of the ICS-X trial, these economic conditions would have made it harder to gain work (Statistics New Zealand, 2019), in addition to the already pre-existing attitudes, misconceptions and barriers they face (MSD, 2006).
- The initial impacts of COVID-19 began to be felt within New Zealand during February and March 2020. While it is difficult to quantify what impacts COVID-19 had on the trial, one possible impact is to reduce the number of employers hiring, particularly those in low skilled and/or export focussed industries.



**Table 4: Economic indicators and events relevant to the original ICS trial and the ICS-X trial**

Topic of comparison	ICS trial (March 2015 – March 2018) Three years of the trial	ICS-X trial (March 2018 – March 2020) Two years of the trial
<b>NZ Gross Domestic Product (GDP)<sup>14</sup></b> Measures how well NZ's economy is doing overall	<ul style="list-style-type: none"> <li>GDP annual growth fluctuated between 3.6% and 3.9% for the first two years, then slowed down to 3.2% by trial end</li> <li>0.4 percentage point decrease across three years</li> </ul>	<ul style="list-style-type: none"> <li>GDP annual growth maintained 3.2% until December 2018, then decreased to 2.3% by December 2019 and ended at 1.5% in March 2020 as the impact of COVID-19 began</li> <li>1.7 percentage point decrease across two years (including early COVID-19 impacts)</li> </ul>
<b>NZ employment rate<sup>15</sup></b> Measures the percentage of people (aged 15 or older) who are in employment	<ul style="list-style-type: none"> <li>Employment rate decreased 65.5% to 64.4% during the first six months, then grew to 67.7% by trial end</li> <li>Strong growth in lower skilled jobs (for example, health care, construction), though slowed down in the third year</li> <li>2.2 percentage point increase across three years</li> </ul>	<ul style="list-style-type: none"> <li>Employment rate started at 67.7%, then fluctuated between 67.3% and 68.0% to end at 67.5%</li> <li>Limited growth in lower skilled jobs</li> <li>Growth switched to higher skilled jobs (for example, financial and professional services)</li> <li>0.2 percentage point decrease is not a significant change</li> </ul>
COVID-19	X	<ul style="list-style-type: none"> <li>Initial impacts on economic growth and employment could already be seen in March 2020</li> <li>Early days of COVID-19 so full impacts were unknown</li> </ul>

<sup>14</sup> Statistics New Zealand. (2020). *Gross domestic product (GDP)*. Retrieved 15 July 2020, from <https://www.stats.govt.nz/indicators/gross-domestic-product-gdp>. Referencing March quarter results with revised numbers as given on the website.

<sup>15</sup> Statistics New Zealand. (2020). *Employment rate*. Retrieved 15 July 2020, from <https://www.stats.govt.nz/indicators/employment-rate>. Referencing seasonally adjusted numbers for March quarter results.



## There were some implementation issues

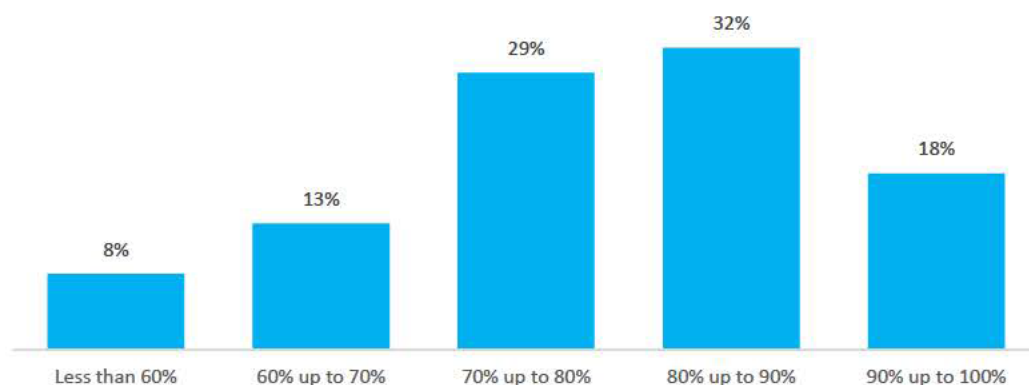
### 'Ring-fencing' of the ICSM role is a challenge

ICSM roles were designed to be 'ring-fenced' within their site, meaning they would work full-time on providing ICS service. Previous qualitative evaluation of the original ICS trial (Gravitas, 2017) and the expanded ICS-X trial (Malatest, 2019) indicated that 'ring-fencing' was challenging to maintain, particularly when the site was under high demand for business-as-usual case management support.

When ICSMs were pulled into helping with business-as-usual support, it reduced the time they had available to work with the ICS service clients (and partners) assigned to their ICSM caseload. Therefore, it may have had a negative impact on the quantity and quality of ICS service provided.

Prior to COVID-19 having any effect on frontline support, half (50%) of the ICSMs spent at least 80% of their time providing support to ICS service clients. Another 29% of ICSMs were able to focus on ICS service between 70% up to 80% of their time. The remaining 21% of ICSMs spent less than 70% of their time working with ICS service clients.

**Figure 1: Percentage of measured staff time spent working with ICS service clients and their partners**



### High turnover of ICSM staff affected delivery of ICS service

A key component of the ICS service case management approach was having clients work with the same ICSM long-term. This continuity was broken when ICSMs left their role, particularly when there was a gap before the ICSM role could be filled.

The original ICS trial had six ICSMs that rolled-over to the ICS-X trial. All six (100%) moved to new roles during the first year of the ICS-X trial, with four of them leaving within the first four months. Some transferred to another role within their site. Others moved to a long-term secondment role within MSD's national office, including joining the project team that managed the ICS-X trial. One ICSM took a similar role with another agency.

Six out of 19 (32%) new ICSMs hired for the ICS-X trial expansion also left their role. The three who moved on within the first year all left MSD, while the other three either shifted to another MSD role or were out on maternity leave during the second year of the trial.

Thirteen out of 25 ICSMs (52%) employed at the start of the ICS-X trial still held that role two years later when ICS service was put on hold due to COVID-19. Across two years, there were 18 staff changes covering 12 ICSM roles. Some roles saw multiple changes due to short-term coverage while people were away on secondment or maternity leave.

## **A temporary waitlist maintained ICSM caseloads until new system adjustments were functional**

The ICS-X trial used a computer system to update and fill the ICSM caseloads each week. MSD switched to a new computer system on 8 July 2018 that was more efficient at streaming clients to business-as-usual services but could not fully replicate the randomised control trial design.

The ICS-X trial was put on partial hold for three months while computer code adjustments were made to replicate the client selection and allocation process for new clients.

We pre-selected 374 treatment clients to a waitlist so ICSM caseloads could be maintained in the meantime. The waitlist period lasted for 15 weeks until 15 October 2018 when the code adjustments were functional. These waitlist clients only received reactive support. This meant the client could contact Work and Income for assistance if needed but Work and Income would not initiate assistance to the client.



# Methodology and data

## Evaluation questions

Evaluation of the ICS-X trial sought to explore five key evaluation questions.

1. Did the ICS-X trial achieve the same positive outcomes for clients as observed in the original ICS trial?
2. Did the ICS-X trial achieve better outcomes for Māori treatment clients than Māori control clients?
3. Does the ICS-X trial achieve similar impact on JS HCD client outcomes as for the JS WR clients?
4. Does the ICS-X trial achieve similar impact on outcomes for younger clients as for older clients?
5. If ICS service was rolled out as a business-as-usual service, what are suggested changes to improve the service?

Because of time constraints, the analysis could not fully answer questions three and four. We do, however, compare some results between the two age groups or the two benefit types to show similarities or differences across the four cohorts.

## Client selection for ICS-X trial

Both ICS and ICS-X trials operated as randomised control trials, using a 1:1 ratio. This meant that for each client in the treatment group (who received ICS service), there was another client in the control group (who received business-as-usual service). By comparing outcomes of the treatment versus control group, we can measure effectiveness of the expanded ICS service (within the ICS-X trial) compared with other business-as-usual services.

A two-step process was used to randomly select eligible people to the ICS-X trial and then randomly allocate them to either the treatment or control group.

The randomised control trial was designed so the proportional split between cohorts on the ICSM caseloads would reflect the natural distribution of people on benefit across New Zealand, as shown in Table 5.

**Table 5: Proportional split by cohort, benefit type and age group**

	Jobseeker Support Work Ready	Jobseeker Support Health Condition and Disability	Total by age
25-29 years old	15%	10%	25%
30-39 years old	40%	35%	75%
Total by benefit	55%	45%	100%

Based on random allocation, we would expect that characteristics (for example, ethnicity distribution, proportion of time on benefit, type of benefit they received, etc.) would be similar. This similarity strengthens our argument that any difference in observed outcomes between the two groups is due to the service they received.

## **Our main outcome measure was the percentage of time that clients spent off benefit, an imperfect measure of employment or study outcomes**

The main measurement of the ICS-X trial is the percentage of time that clients spend off benefit. There are issues with equating time off benefit as 'being in employment or study'. This is because people could be off benefit without being employed / in study and people could be employed / studying part-time while they received a benefit. There are also some data quality concerns with MSD's administrative data around the reason for benefit exit and the reporting of income earned from employment. Using the percentage of time off benefit was our best proxy metric. Additionally this measure is limited in measuring outcomes for other domains covered by Te Whare Tapa Whā.

## **As most ICS-X trial clients were Māori, subgroup analysis compared Māori treatment clients to Māori control clients**

Māori ICS-X trial clients were the largest ethnicity group in the ICS-X trial (overall average of 55.0% at 24 months).

Ethnicity was not a criterion for random allocation and 'luck of the draw' meant there was an imbalance where a larger number of Māori ICS-X trial clients were in the treatment group than the control group (1,152 versus 1,071 at 12 months and 1,382 versus 1,299 at 24 months).

## **Scope of the ICS-X trial evaluation**

With ICSM caseloads consisting of previous clients from the original ICS trial and new clients under the ICS-X trial, we decided to simplify the analysis. Clients who had participated in both trials were only included in longitudinal analysis of the original ICS trial, while clients who had only participated in the ICS-X trial were included in this evaluation.

Analysis was done by age group at time of selection. This kept the number of treatment and control clients consistent within each cohort over time for comparison purposes.

## **MSD administrative data used to analyse staff time**

We used MSD administrative data for staff time analysis. The staff time data was adjusted for transactions with excessively long durations (based on the 90<sup>th</sup> percentile) to remove outliers.



## **Data on the first main benefit received had quality issues**

There were three reasons why some clients were excluded from analysis based on first main benefit, accounting for 684 clients excluded at 12 months and 777 clients at 24 months:

- their client benefit history prior to 1996 was unclear
- there was a discrepancy between what the storage system recorded as the client's age at time of receiving their first main benefit versus what we calculated their age should have been
- a small number of clients within each cohort were excluded through the re-weighting process.<sup>16</sup>

## **Re-categorised treatment clients to GCM service for the reactive support given while on the ICS service waitlist**

Due to the introduction of a new computer system, some clients who were scheduled to receive ICS service were put on a waitlist for several months.

However, treatment clients only received reactive support while they were on the waitlist, like clients on GCM service. This reactive service was supposed to be provided by regular MSD case managers, as opposed to ICSM's. Analysis on who was providing reactive support for clients on the waitlist was unable to be undertaken for this report. However, as shown in Figure 1 (page 20) earlier in the report, it is possible that at some sites this would not have been the case for all clients, given that the ringfencing of the ICSM role was not achieved for all ICSM's.

Treatment clients were re-categorized from ICS service to GCM service while on the waitlist to reflect the lower intensity of service type during that period. This may have lessened the impact the ICS-X trial had on treatment clients that were on the waitlist.

## **Data was re-weighted to enable a broad range of statistical analysis**

Due to data limitations, either related to subgroup analysis or data quality issues, some data adjustments were needed to complete a broader range of analyses.

In situations where the number of clients was uneven between the treatment group and the control group, we re-weighted the data so that each control group client was of equal importance to any treatment group client for the purposes of statistical testing.

## **Caveats about the data**

Based on results of the original ICS trial, where the treatment group spent statistically significantly more time off benefit than the control group (particularly for the older clients), it was unethical to continue withholding the possibility of ICS service from the

---

<sup>16</sup> In the reweighting process, treatment clients would be excluded if there was no control client matches for them on the same selection date (and vice versa) following the prior two exclusion steps.

control group indefinitely. When the ICS-X trial went live, the control group hold period was changed from indefinite to three years. After the hold period ended, the control client could go through the client selection and allocation process again if they still met the eligibility criteria for ICS service.

Time constraints meant statistical tests were limited to comparing treatment and control clients within the same group. Although we comment on differences across groups (for example, JS WR versus JS HCD clients, younger versus older clients), statistical testing was not completed to determine if those differences were significant or not.<sup>17</sup>

Due to the high number of people on benefit who met ICS service eligibility criteria on any given day, only 25 control clients from the original ICS trial were re-selected to the ICS-X trial. Of these, 11 were re-allocated to the control group and 14 allocated to the treatment group. For the purpose of this evaluation, we only included data for these 25 clients from the date they were re-selected to the ICS-X trial.

Since treatment clients could add or remove partners from their benefit over time, and partners were also assigned to ICS service<sup>18</sup>, it was possible for the person to receive ICS service as a partner:

- prior to being allocated as a treatment client themselves
- prior to or after being allocated as a control client themselves.

There was a small discrepancy in how benefit data was treated, due to a difference in computer code discovered after the fact.

---

<sup>17</sup> The results of these statistical tests are not contained in this report, due to the quantity of tests undertaken, as presenting them is not practical in the context of this report. When findings are reported to be statistically significant, this is at the 95% significance level.

<sup>18</sup> There were a few exceptions to this operational practice: the client and their partner did not share the same benefit, or the partner was receiving a service that over-rode ICS service (for example, Youth Service).



## Demographic and benefit characteristics

---

### **Demographic characteristics are similar for treatment and control groups, for ICS-X trial clients overall and Māori ICS-X trial clients**

In total, 4,990 clients were selected to the ICS-X trial up to 24 months. The 1:1 ratio meant 2,495 were allocated to the treatment group (who received the ICS service) and the other 2,495 were allocated to the control group (who continued to receive other business-as-usual services).

A high-level summary of demographic characteristics at 24 months shows that:

- overall, Māori were the largest ethnic group (55.0%), followed by NZ European (30.9%) and Pacific peoples (6.4%).<sup>19</sup>
- on average, clients in the younger cohorts were selected to the trial at 26.9 years old, while clients in the older cohorts were 34.6 years old for both ICS-X trial clients and for Māori ICS-X trial clients.
- gender was roughly split 40% female and 60% male for ICS-X trial clients, though the portion of females was slightly higher for Māori ICS-X trial clients (around 42%).
- overall, most ICS-X trial clients and Māori ICS-X trial clients fell into two groups regarding highest qualification, where around 40% had NQF Level 1 or less and 43% had NQF Level 4 or above.

As all clients met the same eligibility criteria and were randomly allocated to either the treatment or control group, the statistical assumption is that demographic characteristics for both groups should be similar prior to being selected to the ICS-X trial. If these demographic characteristics match, it would indicate that the treatment and control groups were a good match to compare outcomes from the trial.

Statistical testing between the treatment and control groups found there was no statistically significant difference for most demographic characteristics for ICS-X trial clients and Māori ICS-X trial clients.

The demographic characteristics where there was a statistically significant difference were, in the:

- ICS-X trial overall (across both analysis periods), the treatment group had a higher proportion of Māori and Pacific Island clients, and the control group had a higher proportion of NZ European clients
- younger JS HCD treatment clients were more likely to have a higher education qualification level than control clients for both analysis periods

---

<sup>19</sup> This is prioritised ethnicity reporting. 'Prioritised ethnicity' means that we allocate people to a single ethnic group in an order of priority, even if they identify with more than one ethnicity. The priority used in this report is Māori, Pacific Peoples, NZ European and Other ethnicities.



- younger Māori JS HCD treatment clients were also more likely to have a higher education qualification level than Māori control clients at 12 months.

Statistically significant findings from ethnicity, gender and educational characteristics include:

- The difference in prioritised ethnicity distribution between the treatment and control groups was statistically significant at both analysis periods for the ICS-X trial overall, but not for the four cohorts.
- Overall, Māori ICS-X trial clients had a slightly higher percentage of females than for the ICS-X trial overall at 12 months (41.8% and 39.9% respectively) and at 24 months (42.6% versus 40.4%).
- The difference in distribution of education qualification level between treatment and control clients was statistically significant for the younger JS HCD cohort at both analysis periods.
- The difference in education qualification level between treatment and control clients was also statistically significant for the younger Māori JS HCD cohort at 12 months.

## **Benefit history prior to ICS-X trial selection**

Like demographic characteristics, we also compared benefit characteristics of treatment and control clients prior their ICS-X trial selection.

A larger percentage of older clients were excluded from analysis pertaining to the first benefit they received, due to lack of pre-1996 data. Any observed differences between age groups for variables based on this data must be viewed within this context.

A high-level summary of benefit characteristics (prior to ICS-X trial) at 24 months shows that<sup>20</sup>:

- on average, clients received their first main benefit (excluding student hardship) between their 17<sup>th</sup> and 18<sup>th</sup> birthday, though it was slightly earlier for Māori ICS-X clients than for ICS-X trial clients overall.
- clients in the older cohorts spent more years on benefit than the younger cohort clients (due to the age difference) – though this difference was reduced when converted to percentage of time and paired by benefit type (for example, younger JS WR versus older JS WR).
- Māori ICS-X trial clients (except for the younger JS HCD control clients) spent a higher percentage of time on benefit than the ICS-X trial clients.
- about half of clients spent at least 60% of their life on benefit since receiving their first main benefit – the proportion was a little higher for Māori ICS-X trial clients than for ICS-X trial clients.

Similar benefit histories between the two groups gives further confidence that the treatment and control groups are a pretty good match for comparing trial outcomes (for example, percentage of time off benefit during the ICS-X trial).

---

<sup>20</sup> Due to a data issue pertaining to first main benefit, these findings related to that data should be taken with caution.



## Age difference rather than entrenchment explains years on benefit

The ICS service and the ICS-X trial were designed based on research by Taylor Fry (2012) that found clients who entered the benefit system before age 20 often spent more time on benefit. MSD therefore assumed that all ICS-X trial clients were 'entrenched' in the benefit system. Investigation showed this assumption was not true for all ICS-X trial clients.

As is expected, older cohorts spent more time on benefit (9.8 years) than the younger cohorts (5.4 years).

Although the average time (in years) and difference between treatment and control clients in the younger JS HCD cohort were the same across both analysis periods, the difference was only statistically significant at 24 months due to more precise measurement of a larger sample group.

In general, Māori ICS-X trial clients spent more time on benefit than the ICS-X trial clients. We observed the same patterns that older Māori cohorts spent more time on benefit than the younger cohorts (10.1 versus 5.6 years at 12 months, 10.0 versus 5.5 years at 24 months).

There was a statistically significant difference between treatment and control for the younger Māori JS HCD cohort at both analysis periods.

A better way to compare clients was to calculate the percentage of time that clients spent on benefit between when they received their first main benefit and when they were selected to the ICS-X trial (the pre-trial benefit period). This method standardised the metric across age groups.

When comparing age groups based on the percentage of time spent on benefit, the difference was reduced when groups were matched by the same benefit type (for example, younger JS WR versus older JS WR).

Figure 2 shows that JS HCD cohorts spent a greater percentage of their pre-trial benefit period on benefit than the JS WR cohorts, particularly the younger JS HCD treatment clients. On average at 24 months, it was 60.7% versus 56.6% for the treatment clients and 58.5% versus 55.1% for the control clients.

How the difference (+) between two percentages is interpreted is important. At 12 months, the difference of (+2.1) between the ICS-X overall treatment group (59.1%) and the ICS-X overall control group (57.1%) should be read as a difference of 2.1 percentage points. It is not a difference of 2.1%.<sup>21</sup>

For the ICS-X trial overall, treatment clients spent statistically significantly more time on benefit than the control clients across both analysis periods. The same was also true for the younger JS HCD cohort at the 24-month mark.

---

<sup>21</sup> A percentage change refers to the rate of change, whereas a percentage point change measures the actual amount of change. See <https://sciencing.com/difference-between-percent-percentage-point-8409115.html> for a more detailed explanation.



**Figure 2: Average percentage of time on a main benefit prior to trial selection at analysis period, by cohort and allocation group**

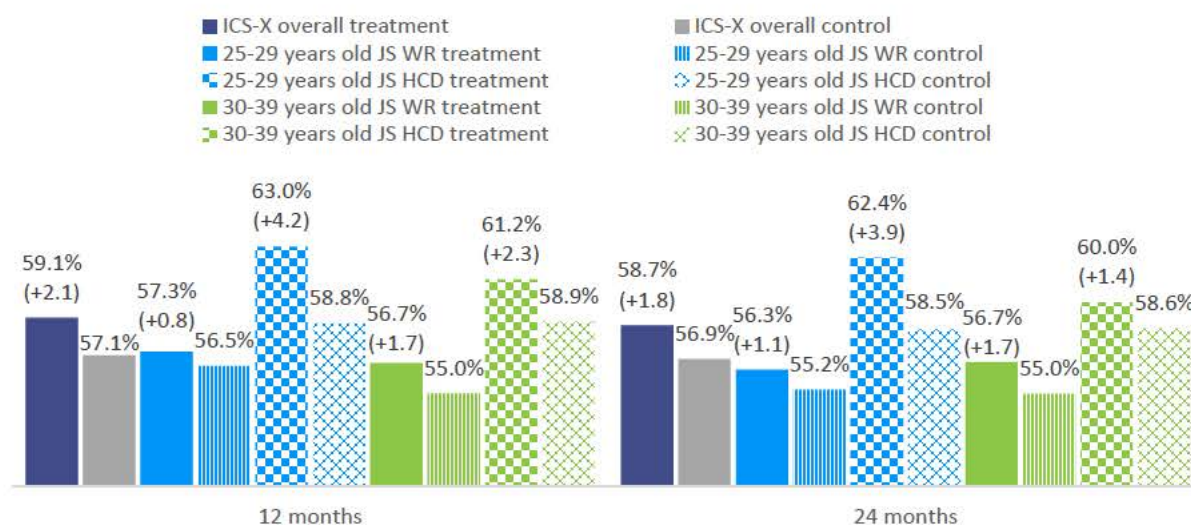
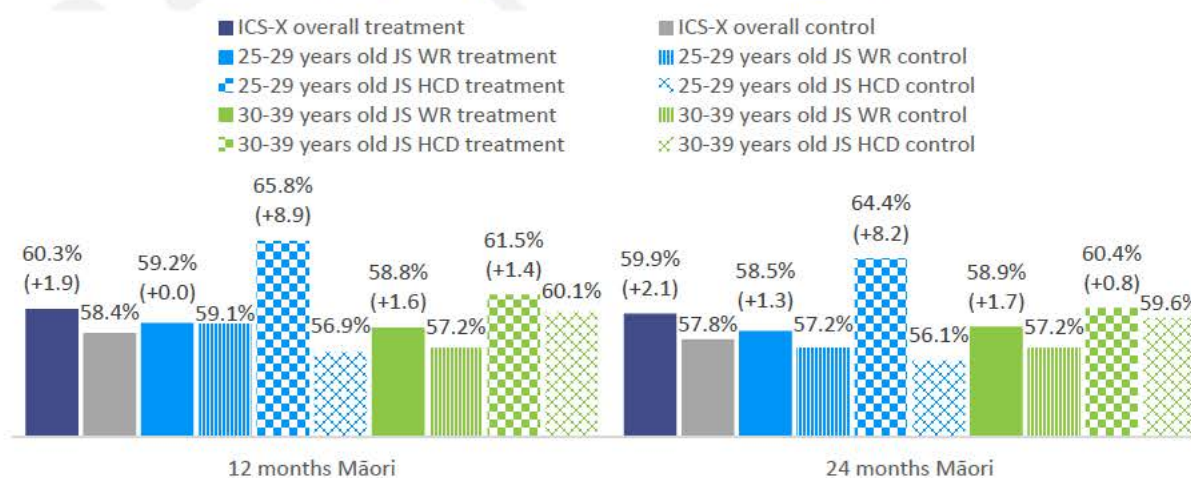


Figure 3 shows Māori ICS-X trial clients, except for younger JS HCD control clients, spent a higher percentage of their time on benefit during the pre-trial benefit period than the ICS-X trial clients. On average at 24 months, the percentage of time spent on benefit for Māori JS HCD clients compared with Māori JS WR clients was 61.5% to 58.7% for treatment clients and 58.7% to 57.2% for control clients. The percentage of time spent on benefit for Māori ICS-X trial clients across each group increased or decreased by up to 1.5 percentage points between the 12-month and 24-month mark.

Across both analysis periods, there was a statistically significant difference between treatment and control for the Māori ICS-X trial clients overall and for the younger Māori JS HCD cohort.

**Figure 3: Māori ICS-X trial clients - Average percentage of time on a main benefit prior to trial selection at analysis period, by cohort and allocation group**





## Treatment clients received more intensive support than control clients

---

ICS service was designed to give long-term support to treatment clients and be more intensive than other business-as-usual services. This section looked at factors that gave an “average” overview of what treatment and control clients experienced during the trial period to see if ICS service achieved those goals.

We found strong evidence that ICS service met those design goals:

- A growing percentage of treatment clients have successfully returned to ICS service over time.
- Based on the average percentage of time that clients spent in different services, treatment and control clients had vastly different experiences during the ICS-X trial.
- Treatment and control clients spent a similar percentage of time off benefit.
- Treatment clients received more intensive service than control clients, on average.
- Treatment clients spent more time with frontline staff (on average), though the difference was getting smaller at 24 months. This was due the control group gaining time with frontline staff relative to the treatment group between 12 and 24 months. The exception was the older JS HCD cohort (for both ICS-X and Māori), with the difference increasing over time for this group for the treatment group relative to the control group.

Looking at a broader view:

- Frontline staff spent more time with JS WR clients than JS HCD clients, for treatment and control. The exception was the older Māori JS HCD treatment clients who spent more time with frontline staff than the older Māori JS WR treatment clients, with the difference increasing at 24 months.
- During the ICS-X trial, MSD made an organisational change of reducing service capacity for WFCM GEN and WSS to increase capacity for GCM service. This was evident by an increase in percentage of time that clients spent in GCM service, particularly for the control clients.

The difference between treatment and control clients was statistically significant for:

- percentage of time spent in each of the following services for all cohorts across both analysis periods for ICS-X trial clients and Māori ICS-X trial clients:
  - ICS service (only available to treatment clients<sup>22</sup>)
  - Other intensive services<sup>23</sup> (the business-as-usual version of intensive service)

---

<sup>22</sup> Though a small number of control clients did receive ICS service at some point as the partner of a treatment client

<sup>23</sup> Other intensive services include: WFCM GEN, WFCM HCD, WFCM IS and Supporting Offenders into Employment.



- WSS service<sup>24</sup>
- GCM service.
- Māori control clients in the younger JS HCD cohort spent statistically significant more time off benefit than the treatment clients (19.1% versus 10.3%) at 12 months
- average service intensity score (based on percentage of time spent in each service) for all cohorts across both analysis periods for ICS-X trial clients and Māori ICS-X trial clients
- for ICS-X trial clients, average time spent with frontline staff for all cohorts at 12 months, plus ICS-X trial overall and older JS HCD cohort at 24 months
- for Māori ICS-X trial clients, average time spent with frontline staff for ICS-X trial overall and both older cohorts at 12 months.

## **Treatment and control clients received vastly different services**

For ICS-X trial clients at the 12-month mark, we see the following (on average):

- treatment clients in the JS HCD group spent a higher percentage of their time in ICS service (70.7% versus 62.2%) and GCM service (15.6% over 11.1%) than those in the JS WR group
- for both treatment and control, JS WR clients spent more time off benefit than JS HCD clients (21.6% and 11.8% respectively)
- the percentage of time that control clients spent in other intensive services was similar across each group (35.4% on average)
- control clients in the JS HCD group spent their remaining time in GCM service (53.5%), while those in the JS WR group split it between WSS service (17.0%) and GCM service (24.8%).

We see a similar pattern at the 24-month mark, although groups spent less time on ICS, WSS, and other intensive services and more time on either GCM service or off benefit:

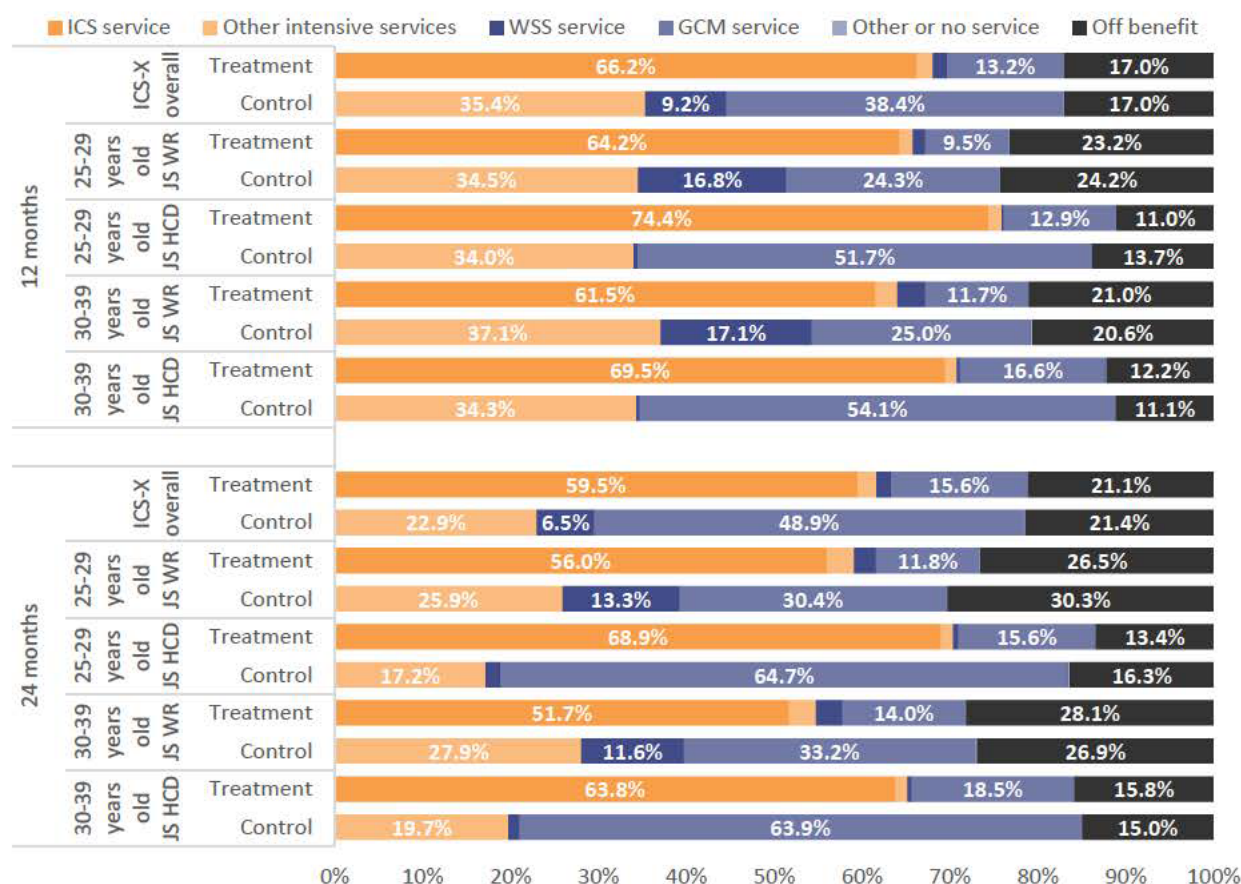
- treatment clients in the JS HCD group spent more of their time in ICS service (65.2% versus 53.2%) and GCM service (17.7% versus 13.3%) than those in the JS WR group
- for both treatment and control, JS WR clients spent more time off benefit than JS HCD clients (27.8% and 15.3% respectively)
- for control clients, the percentage of time spent in other intensive services was higher for the JS WR group than the JS HCD group (27.2% versus 19.0%)
- control clients in the JS HCD group spent their remaining time in GCM service (64.1%), while those in the JS WR group split it between WSS service (12.2%) and GCM service (32.2%).

---

<sup>24</sup> Difference in WSS service was not significant for both ICS-X JS HCD cohorts at 12 months and the older Māori JS HCD cohort at 12 months.



**Figure 4: Percentage of time spent in each service during the ICS-X trial period at analysis period, by cohort and allocation group**



The difference in the percentage of time spent in ICS service, other intensive services and GCM service was statistically significant between treatment and control clients across all groups for both analysis periods.<sup>25</sup> The pattern also held true for WSS service, except for JS HCD cohorts at the 12-month mark.

The patterns were similar for Māori ICS-X trial clients. At the 12-month mark, we saw the following (on average):

- treatment clients in the JS HCD group spent more of their time in ICS service (67.8% versus 61.5%) and GCM service (17.3% versus 12.2%) than those in the JS WR group
- for both treatment and control, JS WR clients spent more time off benefit than JS HCD clients (21.4% and 13.3% respectively)
- while there was more variation in percentage of time that control clients spent in other intensive services (33.2% on average), there was no discernible pattern between groups

<sup>25</sup> In general, control clients spent a higher percentage of time in GCM service at 24 months than at 12 months. This was due to an MSD organisational change.

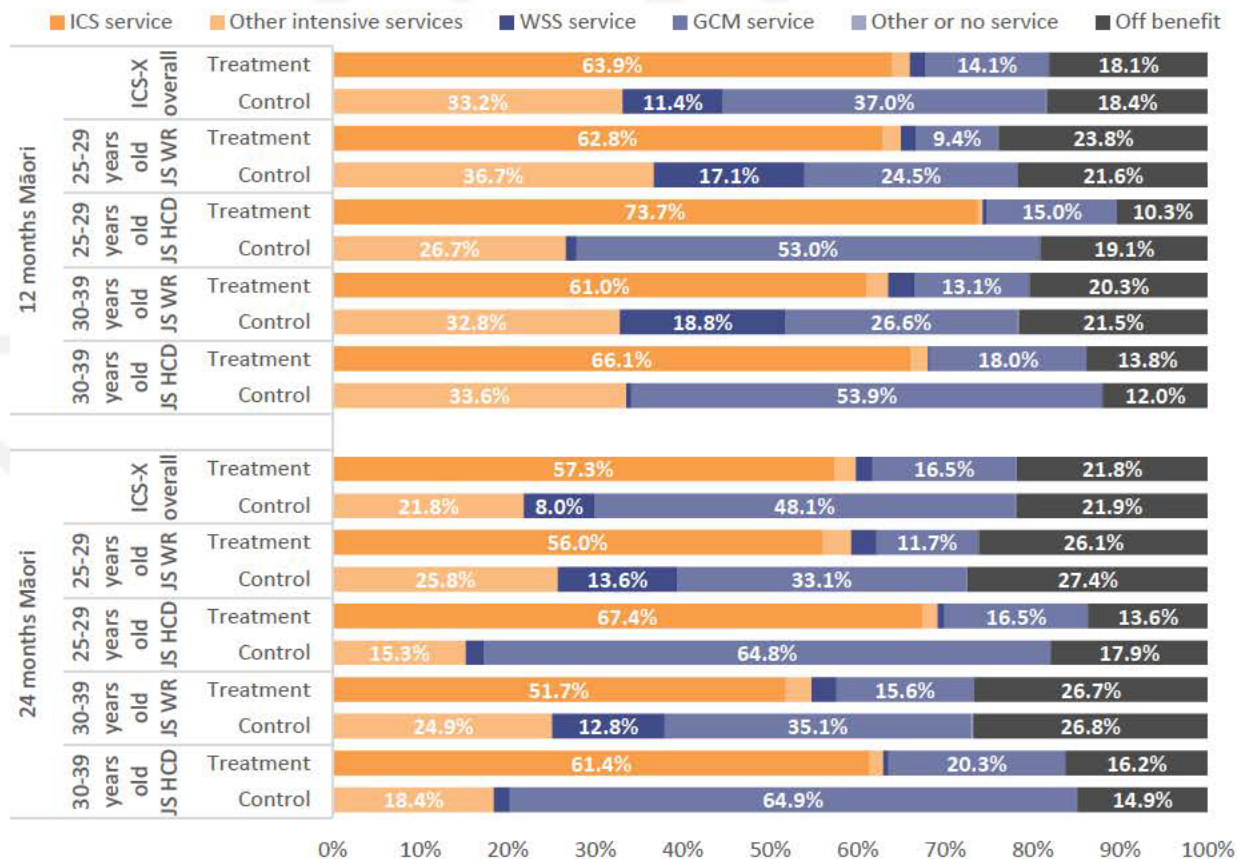
- control clients in the JS HCD group spent their remaining time in GCM service (53.7%), while those in the JS WR group split it between WSS service (18.4%) and GCM service (26.0%).

At the 24-month mark, we see the following (on average):

- treatment clients in the JS HCD group spent more of their time in ICS service (62.8% versus 53.1%) and GCM service (19.3% versus 14.4%) than those in the JS WR group
- for both treatment and control, JS WR clients spent more time off benefit than JS HCD clients (26.7% and 15.6% respectively)
- for control clients, the percentage of time spent in other intensive services was higher for the JS WR group than the JS HCD group (25.2% versus 17.7%)
- control clients in the JS HCD group spent their remaining time in GCM service (64.9%), while those in the JS WR group split it between WSS service (13.1%) and GCM service (34.4%).

There was also a statistically significant disproportion between the time that Māori treatment and Māori control clients spent in ICS service, other intensive services and GCM service across the board. Trends were similar for WSS service, except for both JS HCD cohorts at 12 months and the younger JS HCD cohort at 24 months. Māori treatment clients in the younger JS HCD cohort spent statistically significantly less time off benefit than their control counterparts (10.3% versus 19.1%) at 12 months.

**Figure 5: Māori ICS-X trial clients – Percentage of time spent in each service during the ICS-X trial period at analysis period, by cohort and allocation group**





## **Frontline staff spent more time working with treatment clients**

As clients can go on and off benefit or have a short period with lots of support to deal with an emergency and then no contact for weeks, we needed to standardise how we measured the amount of time that clients spend with MSD frontline staff. Our method added up the total time that staff spent with each client from the day they were selected for the ICS-X trial up to a specified analysis date (for example, 12 or 24 months after the trial started), then divide that total by the number of days the client was on benefit for a standardised measure of staff minutes per benefit day.

Overall, clients in the treatment group (receiving ICS service) spent more time with MSD frontline staff than those in the control group (receiving other business-as-usual services), 4.8 versus 3.0 minutes per benefit day at 12 months and 4.8 versus 3.5 minutes per benefit day at 24 months.

Treatment clients spent statistically significantly more time with frontline staff than control clients across all groups at 12 months. At the 24-month mark, it was only true for ICS-X trial overall and the older JS HCD cohort.

Māori treatment clients spent more time with MSD frontline staff than Māori control clients across all groups as expected. While Māori ICS-X trial clients spent more time with frontline staff at the 24-month mark than at 12-months, the increase was larger for control clients which resulted in a smaller difference (+) across groups, except for the 30-39 years old JS HCD cohort.

The difference in staff time was only statistically significant for Māori ICS-X trial clients in the ICS-X trial overall and for both JS HCD cohorts at the 12-month mark.

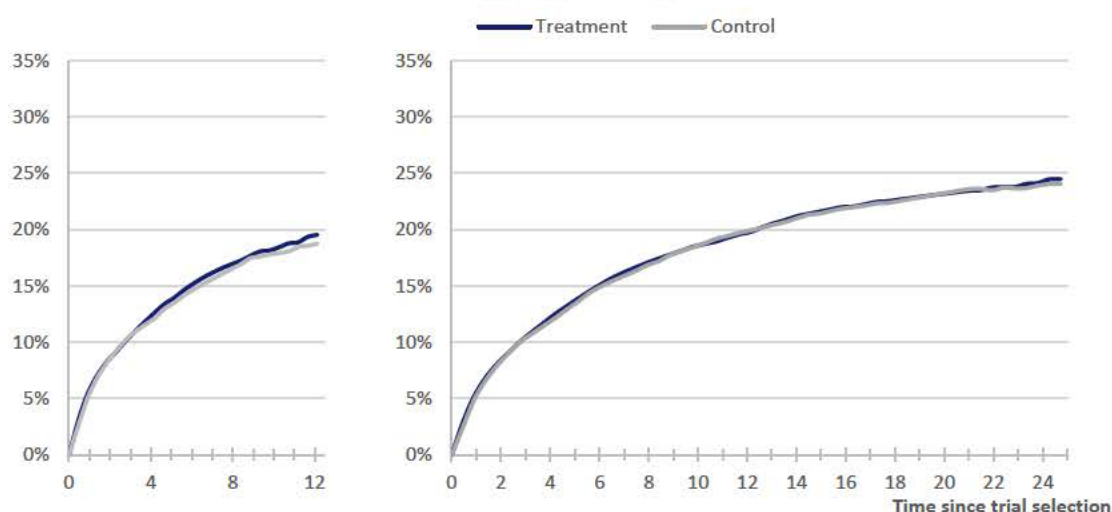
## ICS-X trial results showed few differences, with some notable exceptions

---

### There was little difference overall between treatment and control ICS-X trial clients with respects to time off benefit.

Results for the ICS-X trial overall were similar, in that the curves for treatment and control clients often overlapped each other. Comparison of results at the 12-month mark (on the left-hand graph) and at the 24-month mark (on the right-hand graph) showed on average that the percentage of time off benefit for ICS-X trial clients increased from 19.1% to 24.3%, an increase of 5.1 percentage points. However, the difference between treatment and control clients never exceeded 1.0 percentage point.

**Figure 6: Percentage of time spent off a main benefit since trial selection at 12 months (left) and 24 months (right)<sup>26</sup>**



<sup>26</sup> Number of ICS-X trial clients overall (for treatment and control groups individually) at different operational time points: at go-live (n=962), prior to additional sites added (n=955), after additional sites added (n=1239), prior to waitlist (n=1451), after waitlist (n=1822), at 12 months analysis (n=2020) and at 24 months analysis (n=2499).

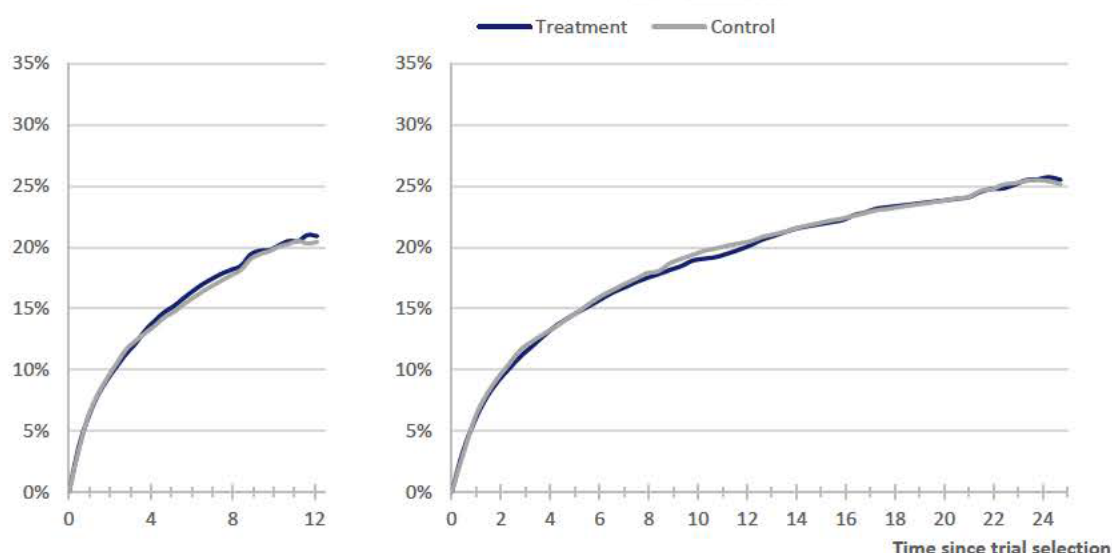


## There was little difference overall between Māori treatment and control ICS-X trial clients with respects to time off benefit.

Results for the Māori ICS-X trial treatment and control clients overall also overlapped. For Māori ICS-X trial clients, there was an average 4.7 percentage point increase from 20.7% at the 12-month mark (on the left-hand graph) to 25.3% at the 24-month mark (on the right-hand graph).

Māori ICS-X trial clients spent more time off benefit than ICS-X trial clients, ranging from 0.6 to 2.0 percentage points for the 12 months graph and ranging from 0.4 to 1.6 percentage points for the 24 months graph.

**Figure 7: Māori ICS-X trial clients - Percentage of time spent off a main benefit since trial selection at 12 months (left) and 24 months (right)<sup>27</sup>**



There was little difference over time between the Māori treatment and control clients, where the difference also never exceeded 1.0 percentage point. The confidence intervals were wider here due to Māori ICS-X trial clients being a smaller group.

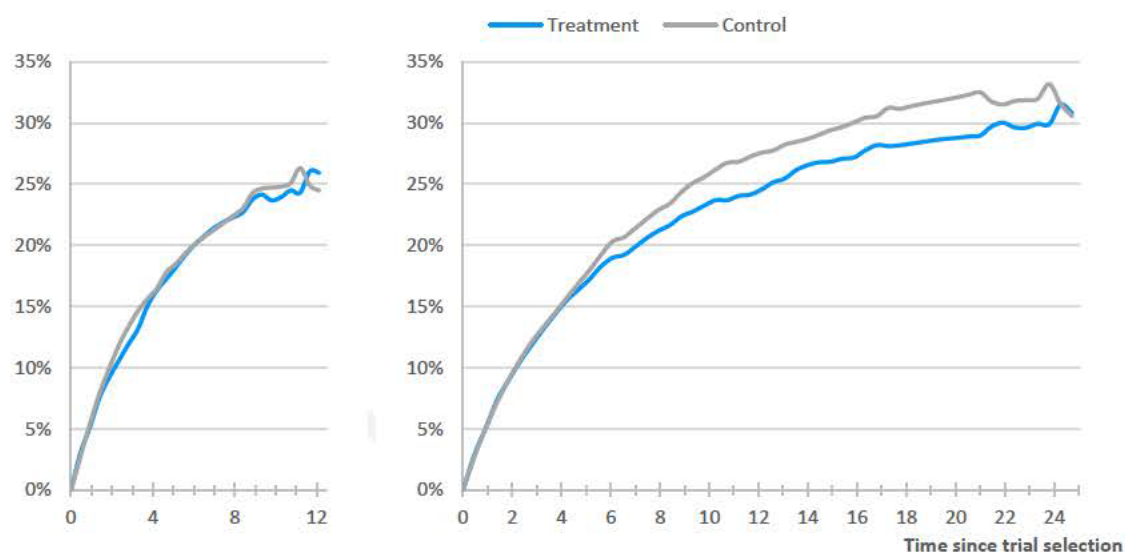
<sup>27</sup> Number of weight-adjusted Māori ICS-X trial clients overall (for treatment and control groups individually) at different operational time points: at go-live (n=524), prior to additional sites added (n=540), after additional sites added (n=701), prior to waitlist (n=815), after waitlist (n=1060), at 12 months analysis (n=1152) and at 24 months analysis (n=1384).

## There was a non-significant difference at some time points between younger JS WR treatment and control clients with respects to time off benefit

There was little difference in the percentage of time spent off benefit between the younger JS WR treatment and control clients for the 12 months analysis, with both groups ending around the 25% mark.

However, between six and 24 months in the 24 months analysis, results suggest that younger JS WR control clients were more likely to be off benefit than younger JS WR treatment clients. However, at no point was this difference significant.

**Figure 8: Younger JS WR cohort - Percentage of time spent off a main benefit since trial selection at 12 months (left) and 24 months (right)<sup>28</sup>**



Additionally, younger Māori JS WR control clients spent more time off benefit than the younger JS WR control clients overall up to month 5, then the opposite thereafter. The younger Māori JS WR treatment clients spent more time off benefit than the younger JS WR clients overall for most time points.

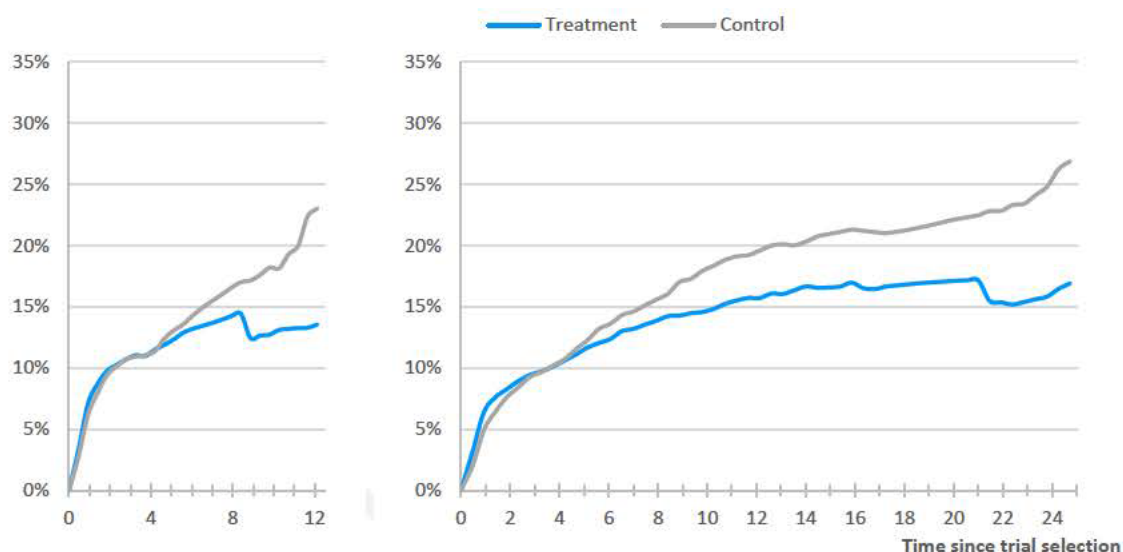
<sup>28</sup> Number of younger JS WR clients (for treatment and control groups individually) at different operational time points: at go-live (n=135), prior to additional sites added (n=139), after additional sites added (n=175), prior to waitlist (n=207), after waitlist (n=250), at 12 months analysis (n=295) and at 24 months analysis (n=410).



## Younger JS HCD control clients were more likely than their treatment counterparts to be off benefit from 21 months onwards

For clients in this cohort, there was an increasing difference between treatment and control groups from the fifth month of the trial. From month 11 in the 12 months analysis, and from month 21 in the 24 months analysis that the difference between the treatment and control groups was statistically significant.

**Figure 9: Younger JS HCD cohort - Percentage of time spent off a main benefit since trial selection at 12 months (left) and 24 months (right)<sup>29</sup>**



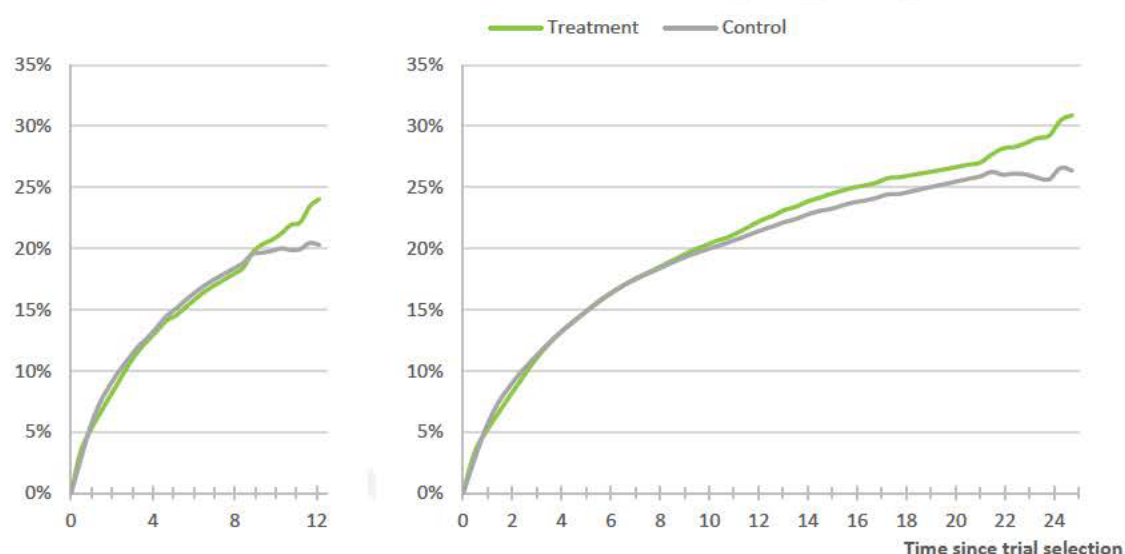
Additionally, younger Māori JS HCD control clients spent more time off benefit than younger JS HCD control clients overall. The opposite was true for the younger JS HCD treatment clients.

<sup>29</sup> Number of younger JS HCD clients (for treatment and control groups individually) at different operational time points: at go-live (n=108), prior to additional sites added (n=110), after additional sites added (n=132), prior to waitlist (n=161), after waitlist (n=200), at 12 months analysis (n=238) and at 24 months analysis (n=366).

## Older JS WR treatment clients selected on the first week of the trial were more likely to be off benefit than their control counterparts

For most of the 24 months there was no significant difference for older JS WR clients, except for those that had been in the trial since the very first week. For the older JS WR clients that had been in the trial since the first week, the 24-month analysis showed that treatment clients spent 4.5 percentage points more time off a benefit compared to control clients.

**Figure 10: Older JS WR cohort - Percentage of time spent off a main benefit since trial selection at 12 months (left) and 24 months (right)<sup>30</sup>**



Additionally, older Māori JS WR control clients spent more time off benefit than older JS WR control clients overall, whereas older Māori JS WR treatment clients spent less time off benefit than older JS WR treatment clients overall.

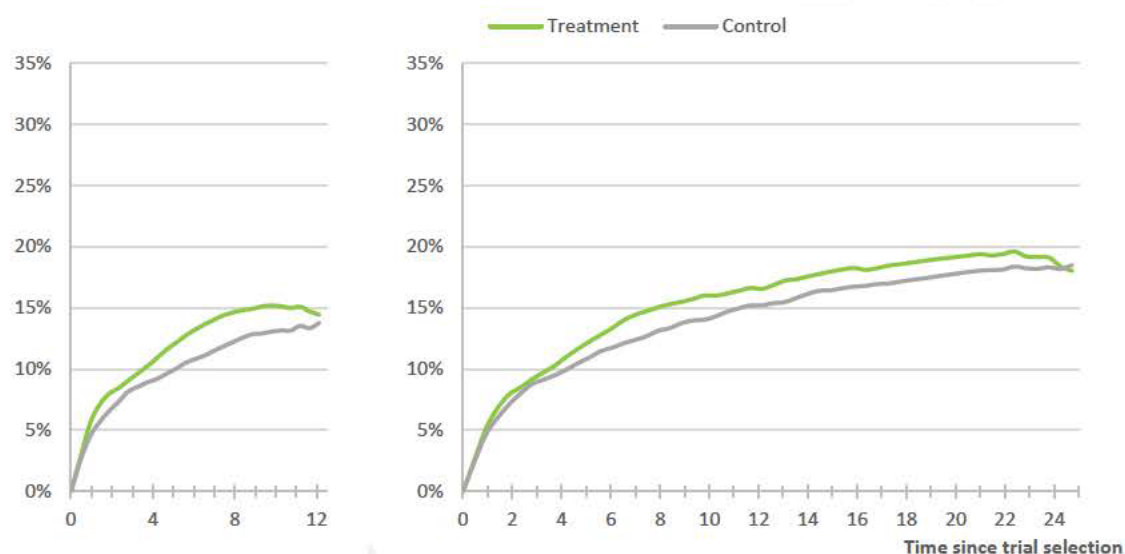
<sup>30</sup> Number of older JS WR clients (for treatment and control groups individually) at different operational time points: at go-live (n=359), prior to additional sites added (n=367), after additional sites added (n=472), prior to waitlist (n=544), after waitlist (n=714), at 12 months analysis (n=769) and at 24 months analysis (n=780).



## There was a non-significant difference at most time points between older JS HCD treatment and control clients with respects to time off benefit

The 24-month analysis showed that from the first month of the trial until the end of the 23<sup>rd</sup> month, there was a noticeable difference (though not statistically significant) between treatment and control groups for clients in the older JS HCD cohort.

**Figure 11: Older JS HCD cohort - Percentage of time spent off a main benefit since trial selection at 12 months (left) and 24 months (right)**<sup>31</sup>



Additionally, the older Māori JS HCD treatment and control clients spent more time off benefit, on average, than older JS HCD treatment and control clients overall.

<sup>31</sup> Number of older JS HCD clients (for treatment and control groups individually) at different operational time points: at go-live (n=360), prior to additional sites added (n=379), after additional sites added (n=460), prior to waitlist (n=539), after waitlist (n=658), at 12 months analysis (n=718) and at 24 months analysis (n=943).

## Conclusion

---

Because treatment clients were assigned to more intensive services and spent more time engaging with frontline staff during the trial, we expected the treatment group would spend more time off benefit and difference from the control group would be significant. However, this was not the case. For the most part, there was little difference between treatment and control.

For the 24 months analysis of the ICS-X trial:

- both treatment and control clients across all cohorts spent more time off benefit the longer they were involved in the trial
- for ICS-X trial clients overall and Māori ICS-X trial clients overall, the difference between treatment and control was minimal (never exceeded 1.0 percentage point) - Māori ICS-X trial clients spent a little more time off benefit than the ICS-X trial clients
- younger JS WR cohort of Māori treatment clients spent a little more time off benefit than the ICS-X trial treatment clients – the difference with their respective control clients was not significant
- there was a significant difference for the younger JS HCD cohort where the treatment group (for ICS-X trial clients and Māori ICS-X trial clients) spent more time on benefit than the control group. The difference between treatment and control was larger for Māori ICS-X trial clients
- ICS-X trial treatment clients in the older JS WR cohort spent a little more time off benefit than the Māori treatment clients – the difference with their respective control clients was not significant
- for the older JS HCD cohort, although the treatment group for both ICS-X trial clients and Māori ICS-X trial clients did spend more time off benefit than their control group the difference was not significant – Māori ICS-X trial clients (both treatment and control) spent a little more time off benefit than their ICS-X trial counterparts.

The ICS service and the ICS-X trial were designed with the hypothesis that clients who entered the benefit system before age 20 often spent more time on benefit, leading to 'entrenchment' in the benefit system. Investigation showed this assumption was not true for all ICS-X trial clients.

Unsurprisingly, older cohorts had spent more time on benefit (9.8 years) than younger cohorts (5.4 years). Older clients have lived longer and, therefore, had more years to possibly be on benefit.

A better way to compare clients was to calculate the percentage of time that clients spent on benefit between when they received their first main benefit and when they were selected to the ICS-X trial (the pre-trial benefit period). This method standardised the metric across age groups.

When comparing age groups based on percentage of time spent on benefit, the difference was reduced when matched by same benefit type.



It seems likely that the changing economic circumstances were at least partially responsible for the quantitative results. In addition, a service dependent on the relationship between client and ICSM relies on individuals within the trial, an element that we could not control for quantitatively. To look at this aspect of the ICS-X trial results, MSD commissioned qualitative research.

## **Overview of qualitative findings**

Profiles of interviewed clients and comments from ICSMs showed ICS service was reaching the intended group: clients with multiple challenges that affected their work readiness.

The key difference between ICS service and other BAU services was the intensive, holistic, and client-centred case management approach of ICS service. Clients receiving ICS service reported feeling treated more “like a person” than in their previous Work and Income experiences. The client-centred approach was facilitated by a smaller caseload of 60 clients and a single case manager. This allowed clients to build rapport with ICSMs. Greater levels of whānau involvement were also possible with ICS service. ICSMs reduced challenges to engaging with Work and Income by offering alternative ways to engage such as by phone, text, and email.

Almost all clients were affected by low confidence and self-esteem and often also had mental or physical health issues. Challenges included substance use and addiction, complex family issues, housing issues, challenges with reading and writing, a criminal history, low motivation to work, or attitudes and social issues that made it difficult to stay in work.

Clients’ previous negative experiences with Work and Income were often a challenge. ICSMs focussed initial sessions with clients on building rapport and trust. This included checking clients were receiving their full and correct entitlement and providing material goods such as food grants and whiteware if needed. ICSMs noted many JS-WR clients were potentially eligible for the JS-HCD benefit but were untreated or disengaged from the health system or had not shared their health issues with Work and Income.

The ‘staircasing’ approach where ICSMs worked with clients to build incremental progress towards the client’s goals always began with the client’s most pressing need and continued at the client’s pace. Early ‘staircasing’ steps tended to be wellbeing focussed including health-related steps. Improved management of health conditions contributed to increased self-esteem and confidence resulting in clients being better equipped to support whānau and make changes in their lives, such as moving to more sustainable housing and becoming work ready.

Later ‘staircasing’ took a greater work readiness focus. Success of the ‘staircasing’ approach with individual clients depended on a strong relationship between the ICSM and the client.

Positive changes for clients were consistent with a ‘staircasing’ approach to employment.

## Future areas of analysis

Other areas of analysis would provide additional insights about ICS service:

- Additional statistical testing would enable further comparison to answer the following evaluation questions:
  - Does the ICS-X trial achieve similar impact on JS HCD client outcomes as for the JS WR clients?
  - Does the ICS-X trial achieve similar impact on outcomes for younger clients as for older clients?
- Analysis using the Integrated Data Infrastructure (IDI) would verify how treatment and control clients spent their time off benefit (for example, in employment, in study, in prison, overseas) and whether the ICS-X trial was achieving its objective of getting clients into employment or training.
- Analysis using the IDI could also show how clients in the ICS-X trial treatment group fared relative to ICS-X control group clients across domains such as health and justice outcomes.
- Additional statistical analysis (such as logistic regression) outside of the IDI to identify and test if there were any key factors that would increase the likelihood of a client being off benefit in the future.
- Although the ICS-X trial showed little difference in percentage of off benefit between the treatment and control clients (within context of slowing economic conditions), there is qualitative evidence that suggests ICS service was still beneficial in helping clients 'staircase' towards work readiness and sustaining employment. A possible way to explore this idea is to do longitudinal impact analysis for the original ICS trial clients to see if the treatment clients continued to spend more time off benefit than control clients during these changes in economic conditions and through COVID-19.
- Analysis using a Kaupapa Māori approach would be better suited to exploring outcomes for Māori ICS-X trial clients, particularly in relation to Te Whare Tapa Whā.



# Bibliography

---

Durie, Mason. *Whaiora: Maori health development*. Auckland: Oxford University Press, 1998, pp. 68–74.

Gravitas Research and Strategy Limited. (2017). *Intensive Client Support (ICS): 24-month case studies evaluation*. Retrieved from Ministry of Social Development website: <https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/research/ics-qualitative-evaluation-2017/ics-24-month-case-studies-evaluation.pdf>.

Malatest International. (2019). *Intensive Client Support – Extension (ICS-X): 12-month process review and client case stories evaluation*. Retrieved from Ministry of Social Development website: <https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/research/ics-qualitative-evaluation-2017/12-month-process-review-and-case-studies-report.pdf>

Ministry of Social Development. (2006). *Ill Health, Disability, Benefit and Work: A Summary of Recent Research*. Retrieved from: <https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/journals-and-magazines/social-policy-journal/spj29/ill-health-disability-benefit-and-work-29-pages78-101.html>.

Ministry of Social Development. (2018). *Te Pae Tawhiti – Our Future*. Retrieved from: <https://www.msd.govt.nz/about-msd-and-our-work/about-msd/strategies/te-pae-tawhiti/index.html>.

Statistics New Zealand. (2019). *Employment gap for disabled people remains high*. Retrieved from: <https://www.stats.govt.nz/news/employment-gap-for-disabled-people-remains-high>

Taylor Fry. (2012). *Actuarial valuation of the Benefit System for Working-age Adults*. Retrieved from Ministry of Social Development website: <https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/evaluation/valuation-reports/valuation-benefit-system-working-age-adults-30-june-2012.pdf>.

# Report



MINISTRY OF SOCIAL  
DEVELOPMENT  
TE MANATŪ WHAKAHIAO ORA

**Date:** 29 April 2022

**Security  
Level:**

IN CONFIDENCE

**To:** Hon Carmel Sepuloni, Minister for Social Development and  
Employment

---

## New Employment and Social Outcomes Investment Strategy

### Purpose of the report

- 1 The purpose of this report is to engage with you and seek your feedback on the new *Ministry of Social Development Employment and Social Outcomes Investment Strategy* (the Strategy), which updates the *Employment and Social Outcomes Investment Strategy 2018 – 2021*. We plan to publish the Strategy on the Ministry of Social Development (MSD) website, subject to any feedback you may have.

### Recommended actions

It is recommended that you:

Out of scope





Out of scope

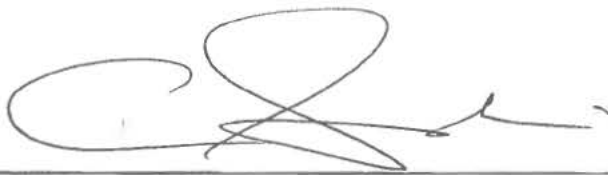
- 7 **note** that we intend to provide advice to you later in May on what work is underway to give effect to the Strategy, including supporting shifts in the overall investment mix (and reaching those who have been on benefit for longer duration), and the approach to specific programmes that have lower evaluated effectiveness (eg Youth Service).

Out of scope

Co-Director  
Strategic Issues & Investment

29/4/22

Date



Hon Carmel Sepuloni  
Minister for Social Development and  
Employment

1/5/22

Date

## Background

Out of scope



- 4 The purpose and focus of MSD's employment services, including how they support people at high or low risk of long-term benefit receipt, are policy matters determined by Government. The Strategy supports the implementation of Government policy, by informing decisions about how employment investment is used to purchase different programmes for eligible people.

Out of scope



---

Out of scope





- 17 In practice, this would mean that the relative focus on those at risk of long-term benefit receipt, those on benefit but at lower risk of long-term benefit receipt, and others who may be at risk of or are experiencing poor labour market outcomes, will be determined according to the policy parameters agreed by Cabinet. Decisions about how the investment in each of these groups is used to purchase different programmes will be informed by the Strategy, in line with the four shifts set out in the Strategy and the investment principles.
- 18 As clients at risk of long-term benefit receipt include those with longer duration on benefit, the Strategy can be expected to support a focus on this group. Some of the specific ways in which the Strategy does this is through:
- the Strategy's focus on work readiness (reflected in two investment shifts), which is likely to support those who have been on benefit for a longer duration due to their having increased barriers to work
  - the level of need of individuals who require support being a key consideration for investment decisions. The Strategy's investment principles include that each of our investment decisions should aim to apportion and target investment based on current evidence and information about the level and type of support that individuals need

- the focus on promoting equity for different population groups, which includes groups that have lower rates of exit from benefit (eg JS-HCD, SLP and older workers).

Out of scope




- 24 We also intend to provide advice to you later in May on what work is underway to give effect to the Strategy, including supporting shifts in the overall investment mix (and reaching those who have been on benefit for longer duration), and the approach to specific programmes that have lower evaluated effectiveness (eg Youth Service).

Out of scope



Author:  Principal Advisor, Strategic Issues & Investment

Responsible manager:  Co-Director, Strategic Issues & Investment