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COMMENTARY

Benefits of a basic income for employees experiencing a mental health condition

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Although Hüffmeier and Zacher (2021) acknowledged the potential implications of a basic income for a variety of employee issues, they overlooked the possible positive benefits for employees who are experiencing a mental health condition. A mental health condition is defined as "both mental illness and symptoms of mental illness that may not be severe enough to warrant the diagnosis of a mental illness" (Kitchener et al., 2017, p. 4). Mental health conditions affect 20% of working aged adults in any given year and up to 50% in their lifetime. Mental health conditions can arise from both genetic and psychosocial factors and may be temporary or lifelong. Research has demonstrated the rate of mental health conditions is increasing and has been accelerated by the global pandemic (Pierce et al., 2020). Employee mental health conditions are associated with decreased productivity as well as increased absenteeism, presenteeism, and turnover (Kitchener et al., 2017). With this being said, work is a major determinant of mental health and plays an important role in recovery (Stuart, 2006).

Considering the prevalence and implications of mental health conditions for employees' quality of life and work outcomes, I argue that the provision of a basic income may benefit employees with a mental health condition by attenuating the significant personal, organizational, and societal barriers that are associated with mental health conditions in the workplace. I discuss three implications for why this might be the case. First, a basic income may reduce financial barriers that prevent working adults from seeking help. Financial barriers include the direct cost of treatment itself such as talk and pharmaceutical therapies as well as indirect costs including insurance premiums. Second, a basic income may have implications for alternative work arrangements and return-to-work practices such as extended unpaid leave and gradual return to work. Third, a basic income may help attenuate the risk associated with disclosing a mental health condition. Due to deeply ingrained societal stigma, employees with a mental health condition experience both formal and interpersonal discrimination (Follmer & Jones, 2018). A basic income would attenuate some of the negative financial effects by compensating for wage discrimination. A basic income also provides increased mobility and control if the employee experiences interpersonal discrimination by providing a financial buffer while searching for new employment.

Implication 1: Diminish direct and indirect financial barriers

Given the ever-growing disparity between high- and low-income earners (Dickman et al., 2017), financial barriers to help seeking among employees who are experiencing a mental health condition is an important extension of Hüffmeier and Zacher's (2021) arguments. Research suggests that financial barriers are one of the most salient factors that inhibit help seeking, particularly for low-income earners, young adults, and minorities (Cronin et al., 2021). Furthermore, financial barriers account for 25% of treatment dropouts, suggesting that it is a barrier not only to seeking

help but also to maintaining treatment (Andrade et al., 2014). Given that low and middle earners pay a significantly larger proportion of their incomes for health care and cover than do high earners (Dickman et al., 2017), a basic income may help reduce the inequalities in disposable income by assisting employees with both the direct and indirect costs associated with getting and maintaining help for their mental health condition.

Direct costs include medical practitioner visits, pharmaceutical, and other treatments. For example, my own research suggests that employees who are experiencing a mental health condition often seek help first from a general practitioner who then provides a referral to another mental health practitioner such as a psychologist or psychiatrist, and sometimes both, which can be a significant financial barrier (Carpini et al., 2020). In fact, in many medical systems around the world, a general practitioner referral is frequently a requirement to see a mental health specialist. The cost of treatment is further compounded by the fact that many insurance companies provide lower reimbursements for mental health consultations compared with those for other medical and surgical specialists (Melek et al., 2019). The COVID-19 pandemic saw the innovation of telehealth and teletherapy, which were lauded as cost-effective solutions to expensive consultations. This being said, an average teletherapy session costs between $60 and $90 USD a week, which is still beyond the financial ability of many employees (Melek et al., 2019). To put this into context, the weekly cost of teletherapy alone would represent between 12% and 30% of proposed basic income amounts (Hüffmeier & Zacher, 2021). In addition, the direct cost of pharmaceuticals and other treatments is often substantial for both the insured and uninsured (Dickman et al., 2017). The provision of a basic income could be a useful tool in overcoming the direct costs associated with seeking help.

The indirect costs of mental health treatment are also substantial. Of the various indirect costs, insurance premiums are often identified as a structural barrier to help seeking (Andrade et al., 2014). The rising cost of insurance premiums outpaces wage increases and further compounds inequities in access to health care and treatment (Dickman et al., 2017), resulting in a greater proportion of individuals forfeiting insurance all together (Melek et al., 2019). The cost of health insurance itself represents a significant barrier, let alone for those who go without insurance and then must absorb the full cost of mental-health-related consultations and treatments. A basic income would also help alleviate wage compression that arises from employer-sponsored insurance schemes that see a growing proportion of salaries siphoned to growing insurance costs (Anand, 2017).

Implication 2: Leave and return-to-work policies and practices

A basic income may also have implications for leave and return-to-work policies and practices because the supplemental income may reduce experiences of stress that are associated with missing work and a reduction in working hours. Employers frequently use planned absences and gradual return-to-work practices to support employees with mental health conditions (Stuart, 2006). Indeed, in a study examining the policies and practices of 170 employers, researchers found reducing working hours (51% of respondents) and gradual return to work (43%) were the most common workplace accommodations following depression-related leave (Bastien & Corbière, 2019). Research suggests that planned absence and gradual return-to-work practices can be effective in reengaging employees in the workforce following a mental health condition (Kitchener et al., 2017). Although a useful strategy, employees may experience stress due to losses of income and perceived job security that sometimes motivates a premature return to work or a reduction in planned absenteeism (Corbière et al., 2018). This is likely because a large proportion of those experiencing a mental health condition are employed on part-time and casual bases that do not afford them the same employment privileges as their full-time peers (Melek et al., 2019). Thus, the provision of a basic income may support employees in using available planned absence

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and gradual return-to-work policies by attenuating stress that is related to wage loss as well as avoiding compounding a reduction in working hours with financial barriers to seeking and maintaining treatment.

Implication 3: Attenuating negative consequences of discrimination at work

Formal and interpersonal discrimination are among the most frequent experiences of employees with a mental health condition, contributing to diminished career opportunities, social isolation, and marginalization (Follmer & Jones, 2018; Stuart, 2006). Interpersonal discrimination refers to verbal and nonverbal behaviors making up an interaction, whereas formal discrimination refers to "discrimination in hiring, promotions, access, and resource distribution." (Hebl et al., 2002, p. 816). A basic income would have implications for both formal and interpersonal workplace discrimination by attenuating the negative consequences of formal discrimination and giving employees greater control over employment decisions and their exposure to interpersonal discrimination.

Although formal discrimination based on a mental health condition is *technically* illegal in many countries including the United States (Americans with Disability Act), Canada (Canadian Human Rights Act), and Australia (Disability Discrimination Act), research suggests that it still occurs. Discrimination is often due to negative stereotypes that are associated with mental health conditions such as being incompetent, emotionally unstable, uncooperative, and even dangerous—all of which are in stark contrast to the stereotypes of a desirable employee (Follmer & Jones, 2018). These stereotypes create perceptions of misfit between the attributes of employees with a mental health condition and those of the "ideal" employee, with profound career implications. For example, Baldwin and Marcus (2007) found that those with a mental health condition had an average of 7.5% lower hourly wage compared with those without, with those reporting an anxiety condition experiencing the worst discrepancy at 14.8%. Additionally, those with a mental health condition are also perceived as less promotable (Stuart, 2006). Together, this research demonstrates the influence of formal discrimination on the career outcomes of employees with mental health conditions. Therefore, a basic income would at least attenuate the financial burden that is associated with their diminished work opportunity and lower hourly wages and reduce some financial strain.

In additional to formal discrimination, employees with a mental health condition are also subjected to interpersonal discrimination that has an equally negative, if not worse, effect on their mental health (Follmer & Jones, 2018). Experiences such as increased supervision, work deskilling (Bastien & Corbière, 2019), social isolation, and rude and demeaning comments from coworkers are common (Kitchener et al., 2017). Many simply accept these experiences of interpersonal discrimination because they feel powerless to change their work contexts (Stuart, 2006), often motivated by difficulties with obtaining initial employment (Baldwin & Marcus, 2007). This being said, a basic income may decrease the financial risk of leaving a toxic work environment by providing financial support while searching for new employment (Hüffmeier & Zacher, 2021). This non-work-contingent income would afford a greater sense of control over where and with whom employees with a mental health condition work that can bolster their self-confidence and offer new opportunities for social integration.

References

Anand, P. (2017). Health insurance costs and employee compensation: Evidence from the National Compensation Survey. *Health Economics (United Kingdom)*, **26**(12), 1601–1616. https://doi.org/10.1002/hec.3452

Andrade, L. H., Alonso, J., Mneimneh, Z., Wells, J. E., Al-Hamzawi, A., Borges, G., Bromet, E., Bruffaerts, R., De Girolamo, G., De Graaf, R., Florescu, S., Gureje, O., Hinkov, H. R., Hu, C., Huang, Y., Hwang, I., Jin, R., Karam, E. G., Kovess-Masfety, V., … **Kessler, R. C.** (2014). Barriers to mental health treatment: Results from the

https://doi.org/10.1017/iop.2021.106 Published online by Cambridge University Press

WHO World Mental Health surveys. *Psychological Medicine*, **44**(6), 1303–1317. https://doi.org/10.1017/S0033291713001943

Baldwin, M. L., & Marcus, S. C. (2007). Labor market outcomes of persons with mental disorders. *Industrial Relations*, **46**(3), 481–510. https://doi.org/10.1111/j.1468-232X.2007.00478.x

Bastien, M. F., & Corbière, M. (2019). Return-to-work following depression: What work accommodations do employers and human resources directors put in place? *Journal of Occupational Rehabilitation*, **29**(2), 423–432. https://doi.org/10.1007/s10926-018-9801y

Carpini, J. A., Chandra, J., Lin, J., Teo, R., Truong, N., Boyne, E., Wylde, T., Clifford, R., & Ashoorian, D. (2020). Mental health first aid by Australian tertiary staff: Application rates, modes, content, and outcomes. *Early Intervention in Psychiatry*, *October*, 1–9. https://doi.org/10.1111/eip.13072

Corbière, M., Bergeron, G., Negrini, A., Coutu, M. F., Samson, E., Sauvé, G., & Lecomte, T. (2018). Employee perceptions about factors influencing their return to work after a sick-leave due to depression. *Journal of Rehabilitation*, **84**(3), 3–13.

Cronin, T. J., Pepping, C. A., Halford, W. K., & Lyons, A. (2021). Mental health help-seeking and barriers to service access among lesbian, gay, and bisexual Australians. *Australian Psychologist*, **56**(1), 46–60. https://doi.org/10.1080/00050067.2021.1890981

Dickman, S. L., Himmelstein, D. U., & Woolhandler, S. (2017). Inequality and the health-care system in the USA. *Lancet*, **389**(10077), 1431–1441. https://doi.org/10.1016/S0140-6736(17)30398-7

Follmer, K. B., & Jones, K. S. (2018). Mental illness in the workplace: An interdisciplinary review and organizational research agenda. *Journal of Management*, **44**(1), 325–351. https://doi.org/10.1177/0149206317741194

Hebl, M. R., Foster, J. B., Mannix, L. M., & Dovidio, J. F. (2002). Formal and interpersonal discrimination: A field study of bias toward homosexual applicants. *Personality and Social Psychology Bulletin*, **28**(July), 815–825. https://doi.org/10.1177/0146167202289010

Hüffmeier, J., & Zacher, H. (2021). The basic income: Initiating the needed discussion in industrial, work, and organizational psychology. *Industrial and Organizational Psychology: Perspectives on Science and Practice*, **14**(4), 531–562.

Kitchener, B. A., Jorm, A. F., & Kelly, C. M. (2017). *Mental health first aid: Standard* (4th ed.). Mental Health First Aid Australia.

Melek, S., Davenport, S., & Gray, T. (2019). *Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement. A deeper analytical dive and updated results through 2017*. Milliman. http://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf

Pierce, M., Hope, H., Ford, T., Hatch, S., Hotopf, M., John, A., Kontopantelis, E., Webb, R., Wessely, S., McManus, S., & Abel, K. M. (2020). Mental health before and during the COVID-19 pandemic: A longitudinal probability sample survey of the UK population. *Lancet Psychiatry*, **7**(10), 883–892. https://doi.org/10.1016/S2215-0366(20)30308-4

Stuart, H. (2006). Mental illness and employment discrimination. *Current Opinion in Psychiatry*, **19**(5), 522–526. https://doi.org/10.1097/01.yco.0000238482.27270.5d

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