



Pathways to Work and claimants with mental health problems - the story so far

Bob Grove PhD

Pathways to Work – the problem

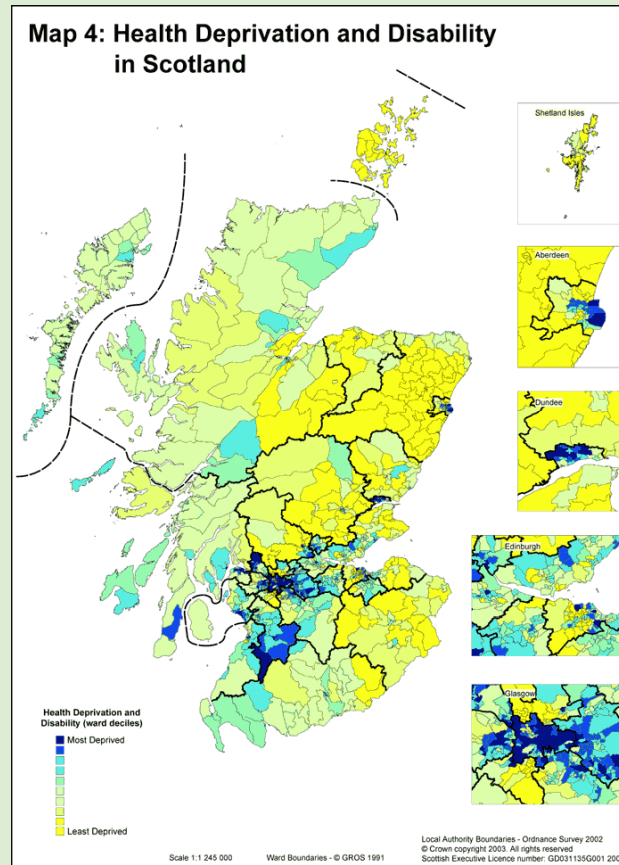
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- Numbers on long term sickness and disability benefits rose from 1m in 1980 to 2.7 m in 1997. However declining since 2004 to under 2.6 m in May 08
- Mostly common health problems in 1997 – 35% mental ill health, 22% musculo-skeletal, 10% coronary-respiratory
- Proportion of claimants with mental health problems has risen steadily since 1997 to over 40%

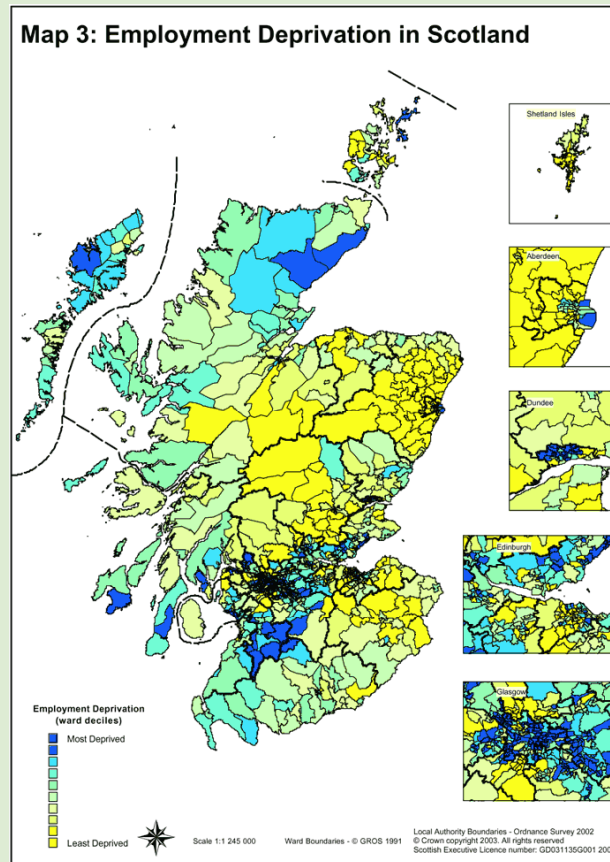
Ill health and disability in Scotland

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Employment deprivation in Scotland

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Pathways to Work – the pilots

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- 7 pilot areas covering 10% of claimant population started in 2003
- Distributed across 5 areas with high claimant count, including RIAB.
- Immediate increase in off-flow from the benefits and entry into employment prompted phased national roll out

Pathways to Work – the expansion

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- ❑ Extended to new high claim areas from 2005 covering 42% of claimant population by end of 2006
- ❑ Extended to existing claimants in pilot areas with more limited mandatory requirements
- ❑ Rolled out to the remainder of the country for new claimants only, using private and voluntary sector contractors in 2007/8
- ❑ Further changes to benefit system and programme, including new entry process and extra conditionality from October 2008

Pathways to Work – the evaluation

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- 4 impact studies using “difference in differences” methodology with survey and administrative data (Expansion areas due Dec 2008; Choices Feb 2009)
- 12 further research reports using both qualitative and quantitative methodology looking at costs and benefits, the experiences of customers and frontline staff, the different components of the Choices programme and the sanctions regime
- Synthesis report (DWP Research Report 525) summarizing findings from pilot areas only

Summary chart of impacts of Pathways to Work Programme

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	Incapacity benefits receipt		JSA receipt		Employment
	Peak IB off-flow impact	Longer term IB off-flow impacts	Peak impact	Longer term impacts	After about a year and a half
Pilot areas - Bewley et al (2007)	6.3 ppt increase at 5 months**	1.5 ppt increase at 18 months*	Not analysed	Not analysed	7.4 ppt increase (from base of 28%)*
October 2005 expansion areas	6.0 ppt increase at 5 months**	2.4 ppt increase at 9 months**; 0.5 ppt increase at 14 months	2.6 ppt increase at 4 months**	1.6 ppt reduction at 11 months**; 0.7 ppt reduction at 14 months	Not analysed
April 2006 expansion areas	6.5 ppt increase at 6 months**	4.0 ppt increase at 8 months**	2.5 ppt increase at 5 months**	0.4 ppt reduction at 8 months	Future analysis planned
October 2006 expansion areas	Not analysed	Not analysed	Not analysed	Not analysed	Not analysed

Key: ppt = percentage points; **=statistically significant at the 5 per cent level or better; *=statistically significant at the 10 per cent level. All other impact estimates are statistically insignificant at the 10 per cent level. Benefit impacts are based on administrative data, whilst the employment impacts are based on survey data.

Pathways to Work – evaluation findings (mental health) RRs 525 & 548

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- Evidence on effectiveness positive in 4 out of 5 impact measures
- Significant off-flow in pilot areas but no impact on employment rates of new claimants
- Significant off-flow and employment impact for existing claimants (albeit from low base)
- More significant off-flow rates for people with mhc in expansion areas than other conditions for new claimants (employment impacts due Jan 09)

Pathways to Work- Key support factors for claimants with mhc

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- ❑ Condition Management Programmes a key factor for this group
- ❑ Social and psychological support very important
- ❑ Ways found to overcome or get round the stigma of mental ill health
- ❑ Training IBPAs to feel more confident in dealing with mhc has been a major focus

Pathways to Work – costs and benefits

RR 498

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- Assuming impacts last 70 weeks PtW in the pilot areas showed a return on investment of
 - £1.50 for every £1 pound invested to the Exchequer
 - £3 for every £1 invested to society as a whole
 - This excludes putting monetary value on health/quality of life benefits and reduced use of services

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Thank you

For further information contact: bob.grove@scmh.org.uk