



MINISTRY OF
SOCIAL DEVELOPMENT
Te Manatū Whakahiato Ora



Dunedin Multidisciplinary Health
and Development Study



Lifecourse factors associated with time spent receiving benefit in young adulthood:

A note on early findings

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Prepared for
Social Services Policy
Ministry of Social Development

July 2010

ISBN 978-0-478-32365-8 (online)

Acknowledgements

This research was based on the experiences of members of the Dunedin Multidisciplinary Health and Development Study (the Dunedin Study) who participated in the Dunedin Study age 32 assessment and at that assessment consented to the integration of the Ministry of Social Development's data on their benefit histories. Funding for the Dunedin Study from the Health Research Council of New Zealand and the contribution of study members is gratefully acknowledged. Daniel Campbell, Professor Richie Poulton, John Jensen, Dr Debbie McLeod and Ross MacKay made helpful comments on an earlier draft of this note. We are grateful to Chungui Qiao for carefully checking tables and figures.

Disclaimer

Any errors or omissions remain the responsibility of the authors. The views expressed do not necessarily reflect the views of the Ministry of Social Development or the Dunedin Study.

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Executive summary

This note summarises the initial findings from research that draws on the Ministry of Social Development's benefit administration data which has been integrated into the Dunedin Multidisciplinary Health and Development Study (the Dunedin Study), a longitudinal study of a cohort born in 1972/1973.

The integrated data permits the examination of the amount of time 940 Dunedin Study members received benefit between 1 January 1993 (when most were aged 20 and a few were still 19) and their age 32 assessment (which usually occurred at around their 32nd birthday).

Patterns of benefit receipt for the Dunedin Study members over this period were broadly similar to those for the same age cohort nationally, in spite of the lower than average representation of Māori and Pacific young people in the Dunedin cohort.

In this analysis, associations were examined between the total time study members received benefit and a selection of measures of their early life experiences, their transition to adulthood, and their outcomes in other areas of life at age 32.

The associations found should be interpreted with care, and not taken as necessarily indicative of causal relationships. No attempt has been made to control for potential confounding factors.

Longer time spent receiving benefit had statistically significant associations with:

- a range of measures of childhood experiences including lower family occupational status, having a mother who was young when she first became a parent, low parental education, time in a sole-parent family, multiple caregiver or residential changes, low family cohesion and high family conflict, physical abuse and sexual abuse
- individual characteristics including socialised aggression, inattention, hyperactivity, conduct disorder, anxiety, antisocial behaviour, lower IQ, mental health problems, and lower self-esteem
- experiences in the transition to adulthood including longer periods of youth unemployment and becoming a parent early.

The time Dunedin Study members spent on benefit in young adulthood was also associated with a range of age 32 outcomes. Longer periods of benefit receipt were associated with lower occupational status, lower income, lower qualifications, poorer mental health, and higher rates of substance abuse and smoking.

From this initial analysis, we are unable to say whether the associations reflect a causal adverse effect of longer-term benefit receipt on outcomes.

It is likely that what distinguishes people who have a high risk of longer-term benefit receipt is an accumulation of disadvantages over their lifetime that combine to increase the likelihood of problems across a number of areas of life in adulthood.

While high levels of the risk factors examined were associated with longer-term benefit receipt, on average, short-term benefit recipients tended to have experienced less childhood adversity and better outcomes in adulthood than either those who did not receive benefits or those who received benefits for longer periods.

Introduction

While the Ministry of Social Development (MSD) maintains administrative data information on people while they receive benefits, it has little information about early lifecourse precursors of benefit receipt, or the wider life experiences that accompany or follow it.

This note summarises the initial findings from research aimed at building our knowledge in this area. The research draws on the MSD's benefit administration data which has been integrated into the Dunedin Multidisciplinary Health and Development Study (the Dunedin Study).¹

The analysis suggests that, for Dunedin Study members, an increasing time spent receiving benefit was associated with a range of difficulties in both adulthood and in childhood, and that persisting problems with mental health were common for those who had longer periods of benefit receipt in young adulthood.

These basic findings about associations between lifecourse factors and the length of time spent receiving benefit are intended to stimulate and inform further hypothesis-driven research.

The Dunedin Study and the integrated MSD data

The Dunedin Study is a longitudinal study of a birth cohort of over 1,000 people born in Dunedin, New Zealand in 1972/1973.

Of study members who were assessed at age three and formed the base study population, 96 percent participated in the age 32 assessment in 2004/2005. At this assessment, 97 percent consented to the MSD's data on their receipt of benefits being integrated into the study database.

The integrated data permits the examination of the amount of time 940 study members spent in receipt of main benefits of different types² between 1 January 1993 (when most were aged 20 and a few were still 19) and their age 32 assessment (which usually occurred at around their 32nd birthday).

Patterns of benefit receipt

The Dunedin Study members entered adulthood at a time when the proportion of the New Zealand population supported by benefits was very high. Unemployment rates peaked in the early 1990s when study members were in their late teens and moving into their 20s. They were especially high for this cohort due to their relative youth and consequent lack of an established position in the labour market.

¹ A more detailed technical report is available on request.

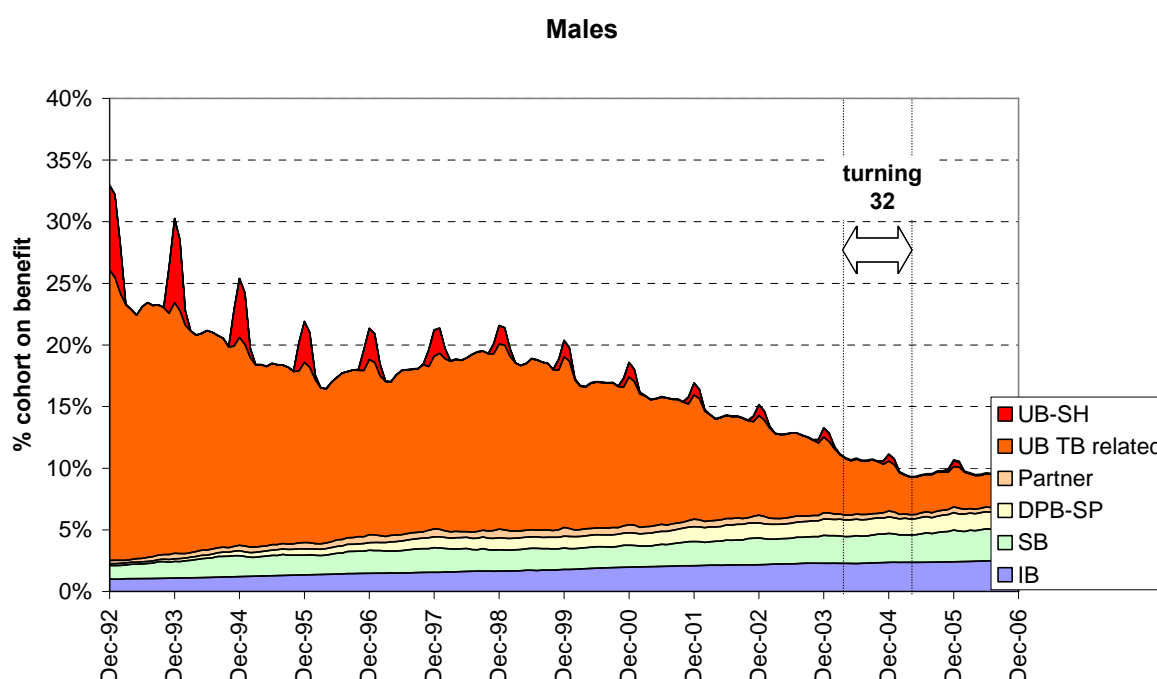
² These include main working-age benefits such as the Unemployment, Sickness, Invalid's and Domestic Purposes Benefits (mainly paid to sole parents). They exclude non-taxable payments such as the Accommodation Supplement, Disability Allowances and Childcare Assistance. They also exclude government transfers made to low and middle income families by way of family tax credits.

This group was also affected by the rapid growth in rates of sole parenthood in the 1990s. Growth in rates of sole parenthood may have partly reflected the effects of the difficult economic circumstances on patterns of family formation and dissolution.

Figure 1 shows that more than one in five men in the national cohort born in the same year as the Dunedin Study members received benefit at any point in time in the early 1990s. This was usually an unemployment or training related benefit, with rates above this level in the summer months as students took up the Unemployment Benefit–Student Hardship.³

As men in the national cohort turned 32, the proportion receiving benefit had fallen to around one in 10, and close to half of the receipt was associated with a Sickness or Invalid’s Benefit.

Figure 1: Estimated percentage of males in the national cohort born in the year to March 1973 receiving benefit at month ends, by benefit type



Key: UB-SH is Unemployment Benefit–Student Hardship
 UB TB related includes unemployment and training related benefits
 Partner refers to receipt of any main benefit as a partner of the primary benefit recipient
 DPB-SP includes Domestic Purposes Benefit–Sole Parent and Emergency Maintenance Allowance
 SB includes Sickness Benefit and Sickness Benefit–Hardship
 IB is Invalid’s Benefit

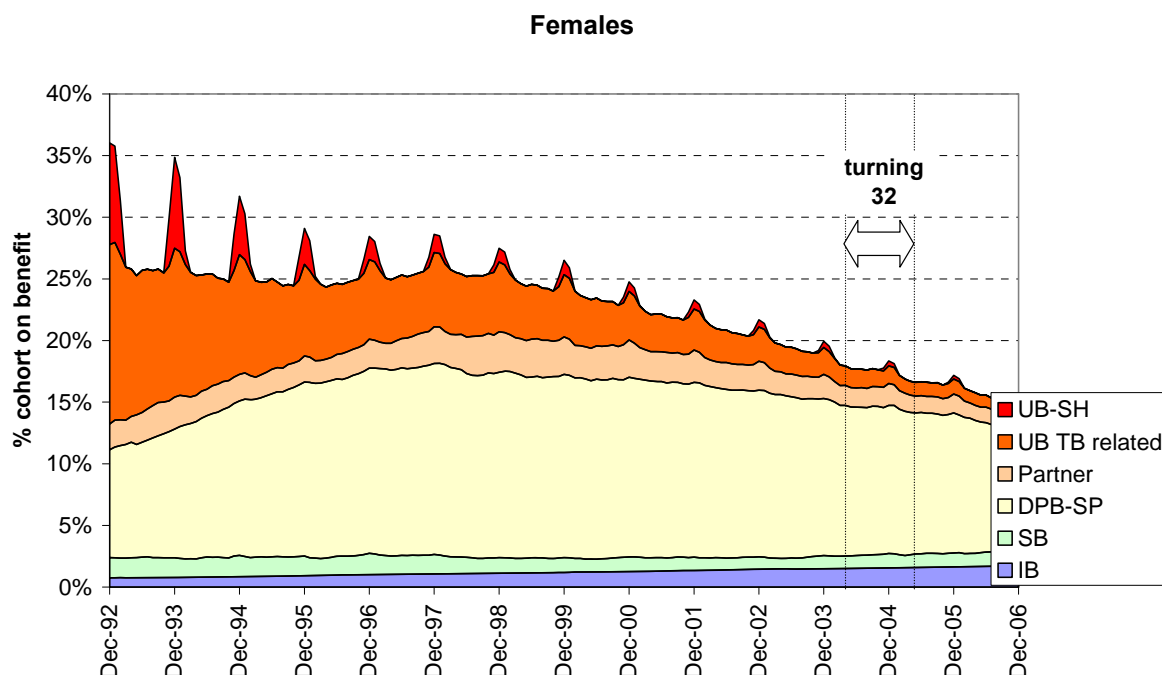
Note: Population estimates are used to obtain an estimate of the resident population in the cohort as at March each year. Linear interpolation is used to obtain estimates for the intervening months.

Sources: MSD’s Benefit Dynamics Data Set; Statistics New Zealand, Estimated Resident Population by Age

³ Sources: MSD’s Benefit Dynamics Data Set; Statistics New Zealand, Estimated Resident Population by Age.

Figure 2 shows that the proportion of women in the national cohort receiving benefit at any point was around one in four for most of the 1990s, but declined between 1998 and 2007. By the mid-1990s, as the cohort entered their mid-20s, most of those in receipt of benefit received Domestic Purposes Benefit–Sole Parent. Around 18 percent of women in the national cohort received a benefit as they turned 32. An estimated 12 percent of women in the national cohort were sole parents receiving Domestic Purposes Benefit at that age.

Figure 2: Estimated percentage of females in the national cohort born in the year to March 1973 receiving benefit at month ends, by benefit type



Key: UB-SH is Unemployment Benefit–Student Hardship
 UB TB related includes unemployment and training related benefits
 Partner refers to receipt of any main benefit as a partner of the primary benefit recipient
 DPB-SP includes Domestic Purposes Benefit–Sole Parent and Emergency Maintenance Allowance
 SB includes Sickness Benefit and Sickness Benefit–Hardship
 IB is Invalid’s Benefit

Note: Population estimates are used to obtain an estimate of the resident population in the cohort as at March each year. Linear interpolation is used to obtain estimates for the intervening months.

Sources: MSD’s Benefit Dynamics Data Set; Statistics New Zealand, Estimated Resident Population by Age

We compared several measures of benefit receipt for study members over this period with those for the national cohort born in the same year. These measures were broadly similar, in spite of the lower than average representation of Māori and Pacific young people in the Dunedin cohort.

In both the Dunedin Study and nationally:

- approximately half the cohort received some income from a benefit in the 11–12 year period
- a large proportion of those who received benefits did so for only a short time – just under three-quarters spent either no time or less than a tenth of their time on benefit in the period
- the small proportion with the longest benefit durations accounted for the majority of the total weeks that cohort members spent on benefit (for example the 10 percent of the cohort who spent the largest share of their time on benefit accounted for around 60 percent of all the weeks cohort members spent on benefit in the 11–12 year period)
- women were more likely than men to spend longer periods on benefit
- on average, for most of the time that men received benefits they were in receipt of unemployment and training related benefits - for men with longer benefit durations, the average share of time spent on incapacity benefits was higher
- on average, for just over half the time that women received benefits they were in receipt of Domestic Purposes Benefit as a sole parent - for women with longer benefit durations, the average share of time spent on Domestic Purposes Benefit was higher.

Associations with other lifecourse experiences

When childhood experiences and indicators of the transition to adulthood were examined, longer periods of benefit receipt in young adulthood had statistically significant associations with:

- low parental occupational status in childhood, having a mother who had children at a young age, low maternal educational qualifications, spending time in a sole-parent family and having multiple changes in caregiver or changes in residence
- having a family life that was characterised by less cohesion and more conflict and aggression than average and having a mother with emotional problems
- being sexually abused as a child and, for males, being physically abused
- having behavioural problems as a child, including hyperactivity and antisocial behaviour, and having low measured IQ and low self-esteem
- having a diagnosable mental health condition at age 15.⁴
- becoming a parent at a young age

⁴ One in 10 study members spent more than five years on benefit over the 11–12 years of the study. Of these study members, 46 percent had a diagnosable mental health disorder in the 12 months to their age 15 assessment, with 24 percent being diagnosed as having conduct disorder. In comparison, 20 percent of study members who spent no time on benefit in the period had a diagnosable disorder in the 12 months to their age 15 assessment, with 7 percent diagnosed as having conduct disorder.

- spending a lot of time unemployed between leaving school and age 21 (the beginning of our analysis period).

While high levels of the risk factors examined were associated with longer-term benefit receipt, on average, short-term benefit recipients tended to have experienced less childhood adversity than either those who did not receive benefits or those who received benefits for longer periods. In other words, these were risk factors for longer-term benefit receipt, but not always risk factors for any benefit receipt.

In common with other studies, the effect of individual risk and protective factors in isolation appeared modest. Often what distinguishes those who have a high risk of poor outcomes is an accumulation of disadvantages (Fergusson and Horwood, 2003; Fergusson et al, 2003; Melchior et al, 2007).

Spending longer periods in receipt of benefit was also associated with:

- low educational attainment and very low personal income levels at age 32
- mental health difficulties at age 32⁵
- smoking.⁶

There was no association between time on benefit and several physical health measures (Body Mass Index for example) in simple bi-variate analyses.

The associations should be interpreted with care, and not taken as necessarily indicative of causal relationships. We are unable to say whether associations between longer-term benefit receipt and poor age 32 outcomes are caused by longer-term benefit receipt itself.

The associations found in this initial examination of the data may simply reflect systematic, pre-existing differences between the people who spent longer and shorter periods receiving benefit.

A full report on the analysis provides details of the associations found.

Relevance to younger cohorts

Up until 2007, rates of benefit receipt were lower for younger cohorts entering adulthood than they were for the Dunedin cohort. Falling unemployment led to much lower rates of receipt for young men especially. In addition, women in younger cohorts tended to have their children later, appeared to be less likely to parent alone and, where they did parent alone, were more likely to work full-time.

⁵ For example, 55 percent of those who spent more than five years on benefit over the 11–12 years of the study had a diagnosable mental health condition in the 12 months to their age 32 assessment, with 38 percent having an anxiety disorder and 28 percent having a substance use disorder (this excludes tobacco use). In comparison, of those who spent no time on benefit, 31 percent had a diagnosable mental health condition in the 12 months to their age 32 assessment, with 20 percent having an anxiety disorder and 9 percent having a substance use disorder.

⁶ Of those who received benefit for more than five years, 74 percent were smokers at age 32 compared with 27 percent of those with no benefit receipt.

While the level of benefit receipt may vary, it is reasonable to suppose that the factors identified by this report would tend to predict the risk of longer periods of benefit receipt in any socio-economic context. For example, for the cohorts who entered the labour market in the recessionary conditions prevailing in 2009, these early findings may indicate who is most at risk of longer-term benefit receipt.

What is less clear is how the prevalence of the factors identified is changing.

Compared to the 1972 birth cohort, children now are in some respects more likely to have had experiences that enhance outcomes, but in other respects are more likely to have had experiences that pose a risk to outcomes.

Participation in early childhood education, in particular, has increased substantially since the 1970s, as have efforts to promote the quality of early childhood education. On the other hand, persistent low income associated with long-term benefit receipt by their carers is a much more common childhood experience now than in the 1970s.

One limitation of the current study is the lower than average representation of Māori, Pacific and other ethnic groups in the Dunedin Study. These population groups make up a growing proportion of young people, and Māori especially are over-represented in benefit uptake. It is possible that there are risk and protective factors that are particular to these groups, or that those factors identified in this study may operate in different ways for them.

Possible directions for further research

The integration of benefit data into the Dunedin Study has the potential to provide new knowledge to inform a number of areas of policy development and service delivery.

Research that can support the design and delivery of early intervention

The childhood risk and protective factors examined in this study often co-occur and tend to be interrelated, making it difficult to isolate those that have a causal influence on outcomes (Fergusson et al, 2003; Melchior et al, 2007).

When seeking to identify or prioritise for services those children or young people most likely to become long-term benefit recipients or have other negative outcomes, it does not matter whether a factor is causal or not. However, for the purposes of identifying points at which interventions could make a difference, knowing which factors are causal is important.

There is a general consensus in the literature that improved family incomes, effective early years interventions, high quality early childhood education, the prevention of child abuse and family violence and effective interventions for conduct disorder/severe antisocial behaviour can have a positive causal influence on outcomes, and this informs many of the Ministry's current areas of focus. The early findings from this study suggest that, where these programmes are successful, people may spend less time on benefit.

Further research on the causal paths that lead to long-term benefit receipt using the integrated data could strengthen the evidence base for the design and delivery of early intervention and prevention.

Research that can support the targeting of more intensive services to benefit recipients with a high risk of longer-term benefit receipt

The findings in this report highlight the important role that the benefit system performs in providing a short-term safety net which, for this cohort, was accessed by a broad cross-section of young people.

Short-term benefit recipients tended to have experienced less childhood adversity and better outcomes in adulthood than either those who did not receive benefits or those who received benefits for longer periods. Not all benefit recipients need intensive services.

The associations highlighted here could be investigated further to provide information that might help in directing more intensive services early in a person's benefit history to those most at risk of longer-term benefit receipt.

Research that can support the development of integrated services for benefit recipients and their families

The findings demonstrate that there are interrelationships between longer-term benefit receipt and other adverse outcomes in young adulthood. These outcomes include educational disadvantage, economic adversity, poor mental health, high rates of substance abuse and health risk behaviours such as smoking.

What distinguishes many people who experience long periods of benefit receipt is likely to be an accumulation of risk over their lifetime that combines to increase the likelihood of problems across a number of areas of life in adulthood.

In recent years, longer-term recipients have made up a high proportion of the cross-section of people receiving benefit on a given date. Of those born in the same year as the Dunedin cohort who were receiving benefits at age 32, for example, two-thirds had spent more than half their time on benefits since 1993.

The findings reported here highlight the difficulties that some longer-term benefit recipients face, and suggest that policies focused on speeding the transition to work or improving work incentives may not be sufficient to address these difficulties.

The findings provide support for policies that seek to use contact in the process of benefit administration to address wider needs, but they also highlight the inherent difficulties in doing this. These difficulties include the need for skilled and sensitive engagement, the need for time to begin and maintain conversations, and the need to integrate services that potentially span mental health, drug and alcohol rehabilitation, education, justice and social services and link back to local communities.

Because most longer-term benefit recipients in the Dunedin cohort were parents by age 32, their experiences are now shaping the lives of their children. Some of their circumstances that have been highlighted in this initial research (for example their relatively high rates of conduct disorder in adolescence, early childbearing, low education, low income, and poor mental health) suggest that their children, in turn, will be among those in younger cohorts with an elevated risk of poor outcomes in adulthood (see Jaffee et al, 2006). This highlights the potential for gains in reducing the intergenerational transmission of disadvantage that can be made from working effectively with this group.

Further investigation of how the accumulation of risk over the lifetime combines to increase the likelihood of multiple problems for this cohort, and the investigation of

associations between their experiences and those of their children (which could potentially draw on assessments of the offspring of study members), could strengthen the evidence base for integrated services that aim to improve outcomes for longer-term benefit recipients and their children.

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