

Measures on prevention of disability benefit dependency and activation of young persons

United Kingdom: Young persons with Health Problems and Employment

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Introduction to the national report

In 2016 the Swiss Law on Invalidity Insurance (IVG) is being revised and this also involves discussions on options for revision. Regarding the increased inflow of young persons into the Swiss scheme (in particular young persons with mental health related problems), some experts have proposed the introduction of a higher minimum age for eligibility to invalidity pensions. However also other measures can be taken to prevent disability pension dependency and improve labour market participation of the young. E.g.: specific benefits and support programmes for young persons with health restrictions or disabilities ,

The Federal Office of Social Insurance (FSIO/BSV) was very interested to know about reforms in other countries which focused on measures to prevent disability and disability pension dependency in young persons. In particular, information was needed (“facts and figures”) about the backgrounds of the measures taken, how these measures have been conceptualized, what specific programmes or arrangements have been made, how they were implemented, what the reactions of different actors concerned were, and what implications the measures had. The inquiry should be mainly descriptive and not include recommendations but rather give pros and cons in a “neutral” manner and considering the national contexts.

Specific reforms have been described for five countries, namely, Austria, Denmark, Netherlands, Sweden and the United Kingdom. The focus is on nationwide reforms, which actually have been implemented. Pilot projects and experiments fall out of the scope of the study, except when relevant as an example of “ongoing developments” after the reform has been described.

For each country a national expert collected literature and used – where necessary - additional sources. The project was coordinated by Rienk Prins Consultancy (Netherlands).

Depending on the national context, “evaluation culture” and implementation year of the reforms, national experts used multiple sources:

- Reports, policy papers, guidelines, etc., both official and “grey literature”.
- When available: elementary statistics on the situation before and after the reform;
- Research reports on evaluative studies carried out, position papers, etc.;
- (Telephone or face to face) interviews and email correspondence for those aspects where documentation was poor or not recent.

In its structure and terminology this national report reflects the questionnaire that has been used for each country to unify data collection. The report should be considered as a “working paper” which reflects the situation as in Summer 2016. Its content has been used for the comparative (final) report.

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Abbreviations

AtW	Access to Work
AFCS	Armed Forces Compensation Scheme
CRPD	Convention on the Rights of Persons with Disabilities
DWP	Department for Work and Pensions
ESA	Employment and Support Allowance
FSF	Flexible Support Fund
NEET	Not in Employment, Education or Training
OSP	Occupational Sick Pay
TUC	Trades Union Congress
PIP	Personal Independence Payment
UK	United Kingdom of Great Britain and Northern Ireland
UN	United Nations
WCA	Work Capability Assessment

Summary

This report discusses a selected number of key welfare initiatives in the United Kingdom (UK) that aim to address a situation where only around four in ten people with mental health conditions are employed. Attention is drawn to increasingly tight eligibility conditions that characterise state welfare benefit provision. However, this report also concentrates on developments such as the Access to Work and Work Choice programmes that expressly aim to support disabled people in returning to and staying in employment. It also points to future developments of particular relevance to young people with mental health conditions such as health interventions and Individual Placement and Support.

Recent decades have seen a clear focus on the activation of disabled people in relation to work and increased conditionality of welfare benefits. Austerity measures have been the catalyst for a large number of welfare benefit reforms in recent years. Policies include specific measures aimed at people with mental health conditions and although UK policy has few return to work / employment reforms that are aimed specifically at young people, they are usually included in measures aimed at adults. The implications for young people with mental health conditions will be drawn out wherever possible and discussed in this report.

Greater links between health and employment services have also been put in place, bridging to some extent a traditional divide between health and employment services. Notably, psychological therapies have been made available to both job seekers and people in work. For health services, there is a separation between children and adolescent mental health services (CAMHS) and adult services. As with employment and return to work, young people of working age primarily come under adult services. From a legal perspective, people with mental health conditions are defined as disabled under the Disability Discrimination Act 1995 and Equality Act 2010, so reference to disabled people in this report also includes people with mental health conditions.

Mental ill-health is highly correlated with labour market exclusion in the United Kingdom. The OECD has reported that in 2012 there were roughly a million people with mental health conditions in the UK and their employment rate was under 15%. People with mental health conditions represent over 40% of the total disability benefit caseload and they make 38% of new claims. The unemployment rate is double the overall general rate for those with a moderate mental health condition and four times the overall rate for those with a severe mental health condition. However, they are under-represented as users of support services.

Annual mental health – related costs are estimated at £70 billion, which is equivalent to 4.5% of GDP: this being through lost productivity, cost of social benefits and health care. However mental health conditions are also widespread among workers, unemployed people and those receiving other social benefits, especially income support and housing benefit.

Taken together these labour market disadvantages translate into in very high income poverty risks for people with mental health conditions. There are also wide equality gaps for disabled

people generally, in household poverty risk, especially for people who are of working age, including those in work.

As stated, from 2008 in particular, welfare reform and activation have been characterised by increasing conditionality. While there have been differences in emphasis between different regimes, the assumption behind current policies is that restricting benefits will encourage people to move into work. However there is also evidence that reforms are increasing the incidence of poverty. There is now widespread national and international concern about the disproportionate consequences of austerity policies for disabled people in the UK. For example, the Centre for Welfare Reform¹ indicates that cuts affecting disabled people in the UK are 9 times higher than those affecting most other citizens and that disabled people as a whole, 8% of the population, experience 29% of cuts. The Joseph Rowntree Foundation reports that an estimated 668,000 households, containing 1,252,000 people, of whom 312,000 were children, were destitute in 2015.² Internationally, the Committee of the International Covenant on Economic, Social and Cultural Rights has issued wide-ranging criticism of the UK for its austerity measures and their effects³.

It is now more widely recognised in the UK that most young people with mental health conditions want to work and that work can alleviate the negative effects of unemployment on mental health. Conversely, however, there is also evidence that increased demands from workplaces and insecure employment (such as zero hours contracts) can cause stress, which can then become harmful and lead to further mental health issues. The relationship between mental health and work is therefore not a straightforward matter in the UK.

Young people with mental health conditions are often absent from policies, support programmes and research. A more explicit focus on support into well suited employment as well as wider life issues is needed if their situation is to be adequately addressed. Successful programmes include Access to Work and Work Choice (the latter in its more recent version). However there are problems with availability in that provision is rationed and the most successful employment support models have not yet been fully implemented.

Recent benefit reforms are too extensive to be described adequately in a report of this length. More extensive information on the specific welfare benefit measures in general is available by following up information in the endnotes to this report, in a forthcoming report on UK social protection systems for the Academic Network of European Disability Experts⁴ and elsewhere.

1. Background and context

In the late 1980s high state expenditure on sickness and disability benefits arose from a profound restructuring of the labour market in the UK. Decline in traditional manufacturing and heavy industry was accompanied by government support for free trade, the financial sector and allied service industries in a context of globalisation. As manufacturing jobs were transferred abroad many now unemployed people were placed on disability benefits and commentators agree that the expansion of numbers receiving disability benefits represented hidden unemployment rather than an increase in impairment or sickness.⁵ Developments were accompanied by a weakening in the rights of workers, diminishing trade union representation and a rise in part – time, temporary and precarious employment that has continued and deepened to the present day.⁶ High levels of poverty were, and continue to be, reported, together with growing inequality.⁷

This report will focus on a few key measures, originating from the late 1990s to the present day, involving a shift from passive provision of benefits to a more active approach emphasising the conditionality of state support. The main direction of policy has remained constant during this period, despite changes in government and periods of growth and recession. Key times of reform, especially for income replacement benefits, are the late 1990s, 2008 and the present day.

Overall, welfare benefits for sick and disabled people may be grouped as follows⁸:

Compensatory benefits: for people who have become incapacitated as a result of combat or occupational work. E.g. Industrial Injuries Disablement Benefit and War Disability Pension (now War Disablement Pension and Armed Forces Compensation Scheme (AFCS))

Earnings Replacement Benefits: either short or long – term and tied or not tied to employment. They were originally tax – free (this later changed). While not means tested, they were taken into account in relation to other benefits that *were* means tested. Examples included: Sickness Benefit (now Statutory Sick Pay), Invalidity Benefit (replaced by Incapacity Benefit and later Employment and Support Allowance (ESA)), and Non-Contributory Invalidity Pension (replaced by Severe Disablement Allowance).

Extra Costs Benefits: These tax-free and non-means tested benefits were paid in recognition of the higher costs of living with disability and impairment. Attendance Allowance, Mobility Allowance and later, Disability Living Allowance (currently being replaced by Personal Independence Payments) are examples.

Means tested benefits: to top up benefit levels to a minimum level. Although not sickness / disability benefits, many disabled people received these. Examples at the time were Housing Benefit, Council Tax Benefit, and Disability Working Allowance (now replaced by ESA) for disabled people in employment.

Sickness Benefits: Through the 1980s short term sickness benefits became flat-rate (losing their previous earnings-related element) and responsibility for them was gradually passed to employers.

In Law, the first UK disability equality legislation was the Disability Discrimination Act 1995⁹ (DDA), which made it illegal to discriminate against disabled people in respect of employment, access to goods and services, education and transport. The DDA imposed a

duty on employers to make reasonable adjustments where needed. This law, while it still applies in Northern Ireland, has been replaced by the Equality Act 2010¹⁰ (see below) in other parts of the UK.

A number of Tables are presented in Appendix 1 to show trends in welfare claimants over this time: please see Tables 1 – 4.

2. Contents and organisation of reform measures

2.1 Target group: young persons with health problems who are in Employment

Following a description of relevant legal measures, this section will primarily discuss the Access to Work scheme, which is the main measure through which support at work for disabled people is organised. Personal Independence Payments are also mentioned, together with other relevant measures where appropriate.

2.1.1. Legal features

The Disability Discrimination Act 1995 has been repealed and superseded in England, Scotland and Wales by the Equality Act 2010¹¹, which covers six protected characteristics including disability. The Public Sector Equality Duty (PSED)¹² also applies. In Northern Ireland similar rights are provided by Disability Discrimination Act 1995 (amended by secondary legislation), which prohibits discrimination against disabled people and the duty of public authorities to promote equality is reflected in the Disability Discrimination (Northern Ireland) Order 2006¹³. Under the Equality Act there remains a requirement for employers to make 'reasonable adjustments' for disabled people.

Having signed (2007) and ratified (2009) the UN Convention on the Rights of Persons with Disabilities¹⁴, including the Optional Protocol, the UK government is also bound by international law, including Article 28 on adequate standard of living and access to social protection. The UK is also a signatory to the UN International Covenant on Economic, Social and Cultural Rights¹⁵.

While there is a large amount of legislation concerned with benefit reform, two recent Acts may be mentioned. The Welfare Reform Act 2012¹⁶ allows for the introduction of Universal Credit to replace six welfare benefits with a single payment. Second, the Welfare Reform and Work Act 2016¹⁷ (not yet in force at the time of writing) provides for a freeze on levels of payments to benefit recipients for several welfare measures.

Regarding legal responsibilities, as noted by Frost and Black (2011)¹⁸ Great Britain has a mixed approach to sickness absence. Payment of Statutory Sick Pay (SSP) is borne by employers for 28 weeks before other benefits must be applied for. However the cost of SSP, at £88.45 per week in 2016, down from £115 in 2015 is not very high. Barriers to dismissal are fairly minor, (although it is illegal to dismiss an employee in order to avoid paying SSP). Therefore employers are required to bear little cost or to be accountable for sickness absence, although many employers choose to pay more in occupational sick pay¹⁹ (OSP) than they are legally obliged to do.

2.1.2. Programme(s) / Interventions

The Access to Work (AtW)²⁰ programme provides practical support in the workplace for disabled people (including personal assistance, equipment and adaptations) with the aim of job retention or self - employment. Grants to pay for additional help needed by disabled people in the workplace are made by the Department of Work and Pensions (DWP), agreed with the employer and employee. To this end, assessors determine what is required through a workplace visit and where applicable subcontracting arrangements are made with service providers. The programme began in 1994 and a re-organisation in 2010 made it a requirement for large employers to increase their contribution where aids, equipment and adaptations to premises were required.

Within the Access to Work programme a specific scheme targets people with mental health conditions²¹. This service operates assessment by phone and support in person to employees, followed by referral on to other support services if needed. It is administered by Remploy, the former sheltered workshop provider.

Stakeholders involved are eligible job applicants, the Department of Work and Pensions (the funders), employers and other workers at the place of employment. Access to Work can meet 100% of the costs where the need is assessed as eligible (although the size of the company is relevant to the award its financial worth is not assessed explicitly). Anyone over the age of 16 is eligible for the fund if their employment is in England, Scotland or Wales, and as long as they are not in receipt of certain out of work benefits²². Northern Ireland operates a separate system²³.

Access to Work may be used to fund a range of different services. Those that may be most useful to young people with mental health conditions include: adaptations to equipment and special equipment, fares to work, a support worker or job coach, a support service if absent from work or finding it difficult to work and disability awareness training for colleagues. The grants have been capped at £40,800 per year for all new grants awarded from 1 October 2015. This also applies from 1 April 2018 for all grants that were awarded before 1 October 2015.

Personal Independence Payments (PIPs)²⁴ are replacing Disability Living Allowance as the main benefit to compensate for the additional costs of living with disability. A national programme of reassessment is accompanying this process (see also below). Although not an allowance that is connected to work, receipt of PIP can enable many disabled people to remain in or take up work by supporting people in everyday living. The payment is not means tested in the sense of taking earnings and savings into account and payments are not dependent on insurance contributions.

People aged 16-64 who have an impairment or health condition that is long-term or terminal are eligible for PIP, and people need to be resident in Great Britain (although there are some exceptions). There are two components: for 'daily living' and 'mobility' and each may be paid at either a standard or higher rate. Eligibility is based on a score-based functional

assessment and additional evidence of need is required, established by an assessment agency and/or case managers in the government Department of Work and Pensions.

Regarding some further measures, funding for sheltered workshops, notably Remploy, was withdrawn in 2012 and social enterprises have been promoted by the government instead. Many factories have since closed and former staff have been tasked with assisting disabled people into work. Remploy also runs the support scheme Workplace Mental Health Support Service (WMHSS) as part of Access to Work and also the apprenticeship support (discussed further below).

The Disability Confident Campaign²⁵ is a government-backed initiative, through which employers can commit to employing and retaining disabled people and people with health conditions.

2.1.3. Changes in social insurance programmes

The Access to Work programme is being developed in recent years in response to the criticism that it is only available to a limited number of people. The Work and Pensions Committee has stated that there is a misperception that the fund only supports people with physical and sensory impairments and that:

“Its priority should be supporting a much greater number of people with mental health problems, and intellectual, cognitive and developmental impairments, including learning disabilities and autism spectrum disorders. Information about AtW, including on its webpages, should make it much clearer that AtW is as relevant to people with mental, intellectual, cognitive and behavioural impairmentsDWP should also develop a range of AtW mental health provision, in addition to the existing Workplace Mental Health Support Service.”²⁶

In 2010, larger employers were required to accept greater responsibility for meeting the costs of some aids and adaptations. This, as well as other funding limitations are indications that the aim is to stretch the existing budget further rather than to increase the overall available funding.

Access to Work may be seen as part of the shift from provision of sheltered employment (and especially state sponsored sheltered employment), to supporting individuals in open employment with tailored help. Implications are discussed further in the following sections.

2.1.4. New elements in other domains

Health support for young (and older) people with mental health conditions (e.g. depression, anxiety and other common conditions) has been expanded with the development of the Improving Access to Psychological Therapies (IAPT)²⁷ programme. As a short course of cognitive behaviour therapy that encourages participants to reframe problems in a more positive light, it aims to offer support to people who are in work as well as those seeking work. The programme was established in 2007 to support the NHS in delivering the intervention.

In 2009 an Employment Adviser (EA) pilot programme was added in 11 areas in England (later on sites were added in Scotland and Wales), with the aim of testing the added value of providing employment advice as well as psychological therapy to employed IAPT clients to help them remain at work or return to work if on sick leave. An evaluation of this service is discussed in the following section. There is also an IAPT programme aimed at children and young people,²⁸ which is part of the Child and Adolescent Mental Health Services (CAMHS) National Health Service (NHS) provision.

Another discontinued programme (in England although not in other parts of the UK) is the Education Maintenance Allowance (EMA).²⁹ EMA is a grant to enable students on low incomes to study.

2.2. Target group: young people with health problems who are not in employment

There are again a very large number of programmes and measures concerned with people who are unemployed, including disabled people. The focus of this section will be on the Work Choice programme, which is more specifically aimed at disabled people who need additional help in work as well as help to find a job. It exists alongside the wider Work Programme, which aims to assist unemployed people more generally into work. Where possible the particular implications for young people will be pointed out.

2.2.1. Legal features

The same legal framework applies to people not in employment in the UK (Equality Act 2010, PSED) as discussed above in section 2.1.1. However, most discrimination cases for people in work are taken up on an individual basis and the legal measures do not provide a means of challenging the policies themselves. Alleged discrimination in respect of policies may instead be challenged using Article 14 of the European Convention on Human Rights (ECHR)³⁰ – which is directly actionable in UK courts under the Human Rights Act 1998³¹.

2.2.2. Programmes and interventions provided under the reform

There are two main Return to Work (RtW) programmes that offer training, with a view to helping unemployed people to enter employment:

- a) The Work Programme³²: a mainstream programme providing work experience, support and training for up to 2 years.
- b) The Work Choice Programme³³, offering specialist training for people recognised under the Equality Act 2010 as disabled. This assistance can include individually tailored supports, interview coaching and confidence building as well as further support.

Work Choice replaced three previous programmes: Work Preparation, WORKSTEP, and the Job Introduction Scheme, which were employment services aimed at disabled people and others. To be eligible for Work Choice, applicants must have a long-term health condition that affects their work capacity. They must be able to work at least sixteen hours per week (after receiving skills development support and advice); need support in work; and require the kind of support that cannot be provided by other government programmes and schemes, including from JCP, Access to Work and the Work Programme). Work Choice provides pre-employment advice and support followed by short to medium-term in-work support for the employee and employer for up to two years. There is open-ended help for the worker to make progress in their work and to become independent from the support system.

In part, Work Choice providers are paid according to outcomes achieved. However, this is a much smaller part of the commissioning model compared with Work Programme payments. More money in Work Choice is allocated at the start of the process, reflecting the greater costs and more intensive support that is usually needed by participants in getting employment. Organisations are paid 70% initially and a further 15% being allocated when a client moves into employment with support. Finally, 15% is paid when they move into a situation where no support is required (where this is sustained for at least six months).

Regarding social security or welfare payments, most UK allowances do not rely on social insurance but are financed from public taxation. As has been noted above in section 1, in the UK there are a range of benefits available to people who are not working, grouped into the following categories: compensatory benefits (for war injuries etc.), earnings replacement benefits (primarily ESA), extra costs benefits (primarily PIP) and a number of means tested benefits, (e.g. housing benefit etc.) Young people aged 16 – 18 generally may not receive allowances, except in particular circumstances, for example for lone parents. For those over 18, there are a number of assessments that may be made to determine eligibility for benefits. The main distinction to be made is whether an applicant is deemed fit for work. If judged fit for work, without significant savings and not in full-time education or working under 16 hours a week, applicants may receive Job Seekers Allowance (JSA)³⁴. With certain assumptions made, amounts paid at the time of writing this report in 2016 are £57.90 per week for young people under 25 years old and £73.10 for people over 25.

However, Employment and Support Allowance (ESA)³⁵, which replaced Incapacity Benefit, as the main income replacement benefit for disabled people, is linked to workers' national insurance contributions. It is available to people who are in work but on low wages, as well as those who are unemployed. ESA replaced Incapacity Benefit from 2008 onwards. Eligibility is determined via a Work Capability Assessment (see also below), which allocates applicants to one of three groups that then receive different treatment. People assessed may be placed in one of 3 groups. First they may be assessed as fit for work and placed on Job Seeker's Allowance³⁶. Second, they may be placed in the Work-Related Activity Group, meaning they are seen to be capable of working after some support. Or they may be allocated to the Support Group, for whom there is no conditionality.

In relation to job seekers with mental health conditions, the DWP is contracting with IAPT programme providers to extend talking therapies to job seekers³⁷. This is discussed further in following sections.

2.2.3. Changes in social insurance programmes

An important change in welfare benefits concerns the assessment organisation charged with conducting the Work Capability Assessments for ESA for the Department of Work and Pensions. The highly unpopular organisation ATOS³⁸ was originally contracted to re-assess disabled people but the work was taken over by Maximus³⁹ in 2015. These companies have both conducted very large scale reassessments of existing Incapacity Benefit (IB) claimants with a view to reducing the number of claimants. These developments have been very controversial and contested.

3. Implementation

3.1 Target Group: young persons in employment with health problems

3.1.1. Measures implemented

Evaluations of Access to Work have shown its value to service users and employers.⁴⁰ While highly valued by disabled people who receive this assistance, knowledge of the Access to Work scheme and the application process remains more limited than it might be, as it is poorly publicised.⁴¹ The Sayce review (2011)⁴² referred to Access to Work as the Government's 'best kept secret' and this influential account echoes highlighting of the problem of inadequate publicity by other authors over many years. Publicity is important for the scheme because applicants must refer themselves for it and this should be done preferably before starting work so there is sufficient time to make the necessary arrangements.

Uptake of Access to Work has increased to some extent over a number of years but numbers remain very low, especially in relation to the number of potential beneficiaries. (See Table 5 and Table 5a in Appendix 1). The Mental Health Support Service however, reports high figures of 5,000 using the service⁴³ but clearly this cannot refer to use of Access to Work, despite some ambiguity in the way the figures are presented. There are continued concerns about the under-use of this support, for example from the mental health charity, MIND⁴⁴, as those with mental health problems accounted for just 5% of new people starting Access to Work in 2014/15, and numbers have stayed at under 3% since 2011.⁴⁵

The main support to young people with mental health conditions who are in work is early intervention (see also section 4) from health services or the IAPT programme. For IAPT, targets were to treat 15% of the estimated 6.1m people with anxiety and/or depression each year by March 2015, and to achieve a recovery rate of at least 50% for those that completed treatment. The target for numbers seen was met (15.6%), but the recovery rate was just 45.4%, with a levelling out of the rate from 2011.⁴⁶

Regarding PIP, an official impact assessment of plans released in 2012, stated that the transfer to PIP would cut benefit payments by £2.24 billion annually and lead to about 500,000 fewer claimants. For the time being however, programme reductions have been put on hold, following protests by disabled people and others.

3.1.2. Implementation: roles and practices

Although Access to Work is a national scheme that is overseen and co-ordinated by the Department of Work and Pensions, it is administered locally. Job CentrePlus or Work Programme advisors have a role in making potential applicants aware of the scheme and with assisting them through the application process. AtW assessments are carried out by

contracted assessors and specialists may sometimes be engaged for some applicants, including young people with mental health conditions.

National and local organisations are part of the same body but localisation has been an important feature of recent policy. Although additional funds exist for the purpose of enhancing local partnerships, research indicates that the funds have been poorly used. The Flexible Support Fund (FSF)⁴⁷ is financing that can be used by local JobCentre Plus staff to enhance “partnerships” (what this means is to be locally determined) and to support individuals. Notably, mention is made of support to young people who are NEET (not in Employment, Education or Training) as eligible. However the Social Security Advisory Committee has expressed concern about the lack of information about FSF in the public domain. The 2014/15 budget of £136 million (excluding a further £20 million support contract) was underspent by £64 million. Investigative journalism⁴⁸ has indicated that JCP advisors have been put under some pressure not to make fund money available and a recommendation by the Work and Pensions Committee⁴⁹ that use of FSF should be evaluated has been rejected by the Government.⁵⁰ These issues suggest that pressure to reduce expenditure has won out over use of funds to support job seekers.

The UK was the only EU Member State that did not publish headline targets in the Europe 2020 framework for employment, education and poverty goals in 2015. However, a number of other goals (albeit mostly non-quantitative) have been set at a national level.

There has been no cumulative assessment of the combined impact of benefit cuts on disabled people.⁵¹

There is an intention to introduce 3 million apprenticeships in England between May 2015 and 31 March 2020.

3.1.3. Co-operation

As mentioned above regarding AtW, co-operation is needed between employers, employees, assessors and co-workers in order for the programme to be effective. It should be stated that AtW is a popular and valued programme by people who use it. However there are several issues worth noting.

Following the 2010 reforms, when employers were required to contribute to the costs of workplace equipment and adaptations to enable an employee to work, employment rates fell; in other words, employers opted not to employ rather than to pay.

Recent budget restrictions (notably through the 30 hour rule) led to considerable objections by Deaf people who rely on sign interpreters, the costs of which are relatively high. Details of areas of disagreement have been recorded by the DWP Work and Pensions Committee⁵² and clarified by Disabled People Against Cuts⁵³ This is indicative of the fact that there has not been an overall increase in the budget but an attempt to re-distribute available resources. While this may be to the benefit of young people with mental health conditions (and it is intended that they should benefit from reforms), it is not desirable in terms of harmonious relationships for another group of workers to lose support as a consequence.

Reforms have been contested politically also. For example, announcements about further cuts to PIP payments were made in Spring 2016 but were abandoned following protests and defeat in the House of Lords. However there are indications of further cuts planned (e.g. through the Welfare Reform and Work Act 2016).

3.2 Target Group: young persons with health problems who are not employed

3.2.1. Measures implemented

The Work Choice Programme was originally made available through Remploy, with a focus on assisting people who had been working in sheltered employment to secure open employment. Work Choice has aimed to give more support to on those seen as needing specialist help, including people with learning difficulties and people with mental health conditions.

The Work Choice wage incentive for young disabled people was introduced in July 2012 but the scheme ended in August 2014 following uncertain results in evaluation. This was a wage incentive for encouraging employers to recruit young disabled people aged 18 to 24 from the Work Choice programme. The total value of the wage incentive was £1,137.50 for a part-time job (between 16 and 29 hours per week) and £2,275 for 30 hours or more per week (counted as full time). It was expected that the job should last for at least 26 weeks and that the employer should not be in a position to employ the individual otherwise. The number of young people with mental health conditions who took up this scheme is not reported.

The administration of the WCA has widely been seen as a failure. There has been vocal criticism of Atos as an assessment body and also of the leadership skills and integrity of senior public officials. Critics include the National Audit Office⁵⁴ and the Public Accounts Committee of the House of Commons⁵⁵. Criticisms and failures have revolved around both quality and quantity of work done. Problems have continued with the next contractor, Maximus. Costs are reported to have risen from £115 under Atos to £190 under Maximus⁵⁶ and reports of the deaths of claimants following assessments are a continuing area of contention.

3.2.2. Implementation: roles and practices

Contracts for Work Choice are organised by the DWP and contracts are issues to what are termed 'Prime Providers'. These are large organisations⁵⁷ who in turn contract for services with smaller providers on a local or regional basis. A Commissioning Strategy was developed for this purpose by the DWP, which includes the following principles: prime providers, outcome based funding, minimum service prescription (allowing local providers to make decisions with an aim of encouraging innovation and personalisation) and larger, longer contracts

(5 years with a possible 2 year extension)⁵⁸. A distinction may be made between providers with whom the DWP contracts and non-contracted organisations, namely Remploy.

The primary source of referrals is through JCP staff, although direct referrals may also be made by social services and secondary mental health services. A programme of support is conducted by support staff, with three main phases, assessment, assistance with finding employment and in-work support. Full details of the implementation of the programme are available from the DWP publications.

The Secretary of State for Work and Pensions announced in 2015 a new Government target to halve the employment gap between disabled and non-disabled people, equivalent to 'getting 1 million more disabled people into work',⁵⁹ following up a statement to this effect in the Conservative Party manifesto⁶⁰ for the May 2015 general election. The target seems to be based on research published by Scope in 2014⁶¹ and by the Trades Union Congress in 2015.⁶² It is not stated whether this target refers to Great Britain or to the whole of the United Kingdom. A consultation on this is underway but there are not as yet concrete measures. The OECD⁶³ has concluded that there has been insufficient attention to the demand side of labour as opposed to benefit sanctions.

3.2.3. Co-operation

Considerable restructuring was involved with the introduction of Work Choice. This process was protracted and not straightforward, especially as it coincided with another major and contested development – the closure of Remploy sheltered workshops. This closure was controversial in that Remploy staff objected to the factory closures and to their changing roles. Additionally, disabled people also objected to the closures on the basis that they did not consider there to be sufficient jobs available.

Welfare benefit reforms have been a particular source of conflict. There have been many well-publicised instances where disabled people have died shortly after being assessed as 'fit for work'. This has included a number of suicides by people with mental health conditions. A ruling on a Freedom of Information request to the DWP⁶⁴ indicates that between December 2011 and February 2014 the equivalent of about 90 people a month (a total of 2,300 between 2011 and 2014) died after their Employment and Support Allowance claim was ended⁶⁵.

Another tension has concerned the introduction of IAPT services into JCP, which has been opposed by both unemployed people with mental health conditions and by mental health staff.⁶⁶ A similar plan to embed employment workers in doctor's surgeries had also been opposed by disabled people.⁶⁷

The reforms have been widely contested at a number of levels. Disabled people have challenged welfare benefit cuts to measures that compensate for the costs of disability⁶⁸ for example, though a number of legal challenges, notably to the scrapping of the Independent

Living Fund⁶⁹ which has in fact ultimately been closed. A challenge to the UK government has also been issued in respect of an alleged violation of Article 28 of the CRPD⁷⁰ and which was heard in June 2016.

Other challenges have been academic, for example, there has been a debate on whether government and media characterisations of disabled people as benefit 'scroungers' and 'shirkers' have fuelled public hostility towards disabled people⁷¹ and about the basis for defining disabled people for the purposes of public policy.⁷²

Young people with mental health conditions have not had a public voice in RTW reforms and it is not clear that they have been consulted in the development of new measures.

4. Impact and lessons

4.1 Target group: young persons in employment with health problems

4.1.1. Impact on the target group

Please see Appendix 1 for the following data:

Table 6: Number of Working Days lost through Sickness, Great Britain, 1993 – 2013

Table 7: Percentage of Working Hours Lost to Sickness by Age Group, Great Britain, 1993-2013

Table 8: Disability Benefits Claim Rates, by Sex and Age Group, Great Britain, 1971-2015

The data shows that there has been a reduction over time in the amount of time taken off for sickness. Although there is a correlation with welfare reforms, this may reflect increasing health in the general population and there is also a possibility that it may reflect increasing demands for people to work when unwell (reflected in questions about the low productivity of the UK workforce) and people opting to avoid claiming where possible. MIND research based on a Freedom of Information request to the Government shows that three times as many people with mental health conditions experience benefit sanctions (cuts to payments) than are helped to find a job.⁷³

The most recent impact assessment for Access to Work is from 2013 – 2014⁷⁴. Access to Work participants with mental ill health are under-represented, making up only 4% of service users in 2013-2014⁷⁵. During 2013/14, Access to Work supported 35,540 disabled people to retain or find employment (up from 31,510 in 2012/13), spending £108m (up from £95m in 2012/13) at an average cost per person of just over £3,000.

Table 9: Access to Work: Numbers Helped Each Year, By Age Group

Age	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
16 - 17	40	30	30	40	30	30	30	50
18 - 24	1,720	1,940	2,100	2,040	1,670	1,660	2,080	2,460
25 - 34	5,260	5,940	6,770	6,610	5,890	5,980	6,750	7,030
35 - 44	8,150	9,250	10,520	9,850	8,300	8,190	8,960	9,100
45 - 54	8,160	9,800	11,760	11,330	9,690	10,050	11,370	11,650
55 - 59	2,910	3,420	4,040	3,920	3,300	3,520	3,980	4,060
60 - 64	1,110	1,400	1,630	1,610	1,460	1,520	1,710	1,790
65 +	220	290	380	380	410	540	610	540
Total	27,720	32,130	37,270	35,810	30,780	31,500	35,560	36,760

Source: DWP/Department for Work and Pensions (2015). *Access to Work: Individuals helped up to March 2015. Tables: Access to Work Official Statistics*. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/448240/tables-access-to-work-statistics-march-2015.xls.

The DWP estimates that in 2013-4 approximately 1,770 Access to Work customers were self-employed although it is noted that these figures are likely to be inaccurate. Details for young people with mental health conditions are not given.

Overall, with the current arrangements, Access to Work can provide around 3,000 places per year. DWP states⁷⁶ that: “It has a 92.8% retention rate at an average cost of almost £1,000 per job retained – just under a third of the cost of the average AtW award (£3K in 2013/14),” indicating differences in costs between service users, as might be expected. There have been some criticisms of the use of just one service provider for the Mental Health Support Service (Sayce, 2011)⁷⁷ although DWP notes by way of reply that there are options to use the non-specialist service as an alternative.

In summary, data on the use of Access to Work by young people with mental health conditions is limited. As shown, overall numbers of users of Access to Work who have mental health conditions has increased but data is not sufficiently disaggregated to provide more detail. There is a commitment to increase numbers of people using AtW⁷⁸ but data on this is not yet available.

4.1.2. Impact on organisation and co-operation

Lack of information for Access to Work has been discussed above, as has the issue of the availability of only one service provider for the Mental Health Support Service. Research on support for people with mental health conditions confirms that individually tailored support yields the best results (see section 4.2). There is clearly scope within Access to Work and the Mental Health Support Service for an individually tailored approach although detailed data on outcomes is not available. It may be surmised that young people with mental health conditions would find such support especially helpful. There is a clear acknowledgement that more needs to be done to expand the service but this may be at the expense of other groups of disabled people, with consequences for co-operation and competition, especially in relation to Deaf service users.

The OECD⁷⁹ has expressed concern at the lack of support given to people who are away from work in the early stages of a period of sickness. As they point out, very little is done to support people in this situation and to prevent people from moving on to long-term sickness and to ESA. This is particularly problematic for people with a mental health condition.

Austerity has also had wider effects in terms of its impact on services. Budgets to local authorities have been cut substantially, leaving less funding available for the provision of local services. While local authorities have been given more freedom to determine local priorities, services that are a source of support to people with mental health conditions have been cut or have closed.⁸⁰ This has made access to support for moving into employment and with wider life issues more difficult for some.

4.1.3. Evaluations and lessons learned

As noted above, Access to Work is highly valued by service users and its availability has enabled many disabled people who otherwise would not have them, to maintain employment. The figures in Table 9 above show that there have been increases in uptake when comparing

pre and post austerity; however the uptake is not as high as it might be, especially given the closure of Remploy workshops and the redundancy of 1,700 workers.⁸¹

Although disabled people and others have argued that the fund more than pays for itself by just under 1.5 times because of the taxes paid and welfare benefit payments saved,⁸² the scheme has also been affected by austerity measures in two ways. Firstly, the fund has remained under-publicised and secondly there have been attempts to cap costs, especially for Deaf users of the service, as described above.

Planned changes for the future are discussed in Section 5 and IAPT services in Section 4.2.

The main issue raised for young people with mental health conditions who are in work is the need for early intervention. However, research by Rethink Mental Illness and The Iris Network (2014)⁸³ found that early intervention services were being cut back in many parts of England. A 75% participation rate is reported and of these, 50% said their budget had been cut in the previous year. 58% reported staff reductions during the last 12 months, a reduction in the number of treatments and support that could be offered. 53% said the quality of the service they offer had decreased.

4.2 Target group: young persons with health problems who are not employed

As noted above in this report (see sections 1 and 2.2.2), there are many benefits, both means tested and non-means tested and receipt of allowances depends on assessments of eligibility by different authorities. A comprehensive list of current social protection measures is listed by Disability Rights UK⁸⁴ and social protection measures have been the subject of a recent ANED report.⁸⁵

Despite this complexity, the most relevant allowances are ESA (income replacement) and PIP (additional costs payment). Compared with some other groups, people with mental health conditions may find it more difficult to get disability – related benefits. This is because assessments often have physical components, such as testing whether an applicant can perform certain physical activities. The total amount received is likely to leave applicants with an income around the level of the UK poverty line (£9956 for a single person in 2014).

4.2.1. Impact on the target group

As noted in Section 4.1, MIND has reported that people with mental health conditions were three times more likely to be sanctioned than helped to find a job. Greater coercion to look for work and use of psychological strategies by government activation programmes have been widely documented for the unemployed population as a whole. Psychological targeting is a problematic issue for people with mental health conditions in that it can lead to greater stress and a worsening of symptoms.⁸⁶ In addition, benefits sanctions have been implicated in homelessness. Research by Sheffield Hallam University⁸⁷ found that of those sanctioned:

- 53% said sanctions made it harder for them to get or keep a job
- 42% found it harder to continue with training / courses / groups
- 50% found it harder to keep their permanent or temporary housing
- 64% said there was a negative impact on their physical health
- 61% had received a food parcel from a food bank

- 28% had resorted to begging
- 38% had stolen or shoplifted food
- 19% had taken out a loan from a loan shark or pay day lender

These findings are backed up by recent research from Oxford City Council Welfare Reform Team.⁸⁸ An evaluation of the project found that the likelihood of long-term jobless claimants finding work reduced by 2% for every £1 of income lost through housing benefit cuts. While the findings are disputed by another national study⁸⁹ (also funded by the DWP) in relation to the benefit cap, it appears that this success is more likely when constructive support to find work is also available.

Work Programme participants with a mental health condition have a 5% job outcome rate compared with 24% for those without a condition. Although results were better for Work Choice (as noted above), this was so mostly for people with more skills. Better results, at roughly a third, have been reported for supported internships⁹⁰

The Work and Pensions Select Committee has reported that as of 2015, 90,000 people had enrolled in Work Choice, and there were 1.8 million people in the Work Programme in the same period⁹¹. Of those starting Work Choice between July 2014 and December 2014, 57.3% had found a job by the end of June 2015.⁹² This compares very favourably to the outcomes for ESA claimants on the Work Programme where outcomes are much poorer. To explain this, it is worth noting some important differences between the programmes. There are more smaller providers working in Work Choice contracts and participation is voluntary, indicating greater motivation to succeed in finding work. This is especially the case if they join without having had prior involvement with JCP.⁹³

Access to psychological therapies has been welcomed by service users as an alternative to drug based therapies. There are however waiting lists and employment advisors have expressed concern that improved intergration of employment and health services will increase demand.⁹⁴

4.2.2. Impact on organisation and co-operation

Initially Work Programme and Work Choice providers were largely the same people, with Work Choice often a sub – programme of the former. This approach has been evaluated by the DWP and others and found to be largely ineffective in assisting people who need more help, such as young people with mental health conditions into work. Traditional problems of ‘parking’ and ‘creaming’ were noted, with evaluators concluding that incentive payments to service providers have been insufficient to encourage providers to assist those who need more help.⁹⁵ Better results have been found using a more dedicated approach based on the supported employment model Individual Placement and Support⁹⁶, whereby service users receive tailored help at each stage of the employment process.

As the main organisation concerned with welfare benefits and encouragement to find work, JobCentre Plus currently has two main objectives: moving people off benefit into work as quickly as possible and reducing the monetary value of fraud and error.⁹⁷ Greater coercion to look for work and use of psychological strategies by government activation programmes

have been documented in a study backed by the Wellcome Foundation and found to hinder successful employment.⁹⁸ Friedli and Stearn (2015) argue that there is an over-emphasis on the modification of job seekers' attitudes, beliefs and personalities through activation measures. This linking of unemployment to personal deficit has ethical implications.

4.2.3. Evaluations and lessons learned

There are indications that issues are known because they are well publicised in evaluation reports, but not much has been done to implement changes. For example, although negative outcomes have been reported for welfare reform (such as the transition from Incapacity Benefit to ESA), cuts to benefits have not been suspended. It may be argued that current policies are both ideological and driven by austerity; it is not so much that lessons have not been learned, but that other issues have a higher priority at present. The imperative to save money is as important a driver of UK policy as evidence of what is effective in practice.

Almost all of the initiatives taken have been supply – side rather than demand - side in focus, with an emphasis on benefit cuts as a lever for encouraging people into work. However, there is also a reluctance to ask more of employers at a time of slow growth and uncertainty in economic markets.

There have been many evaluations of IAPT but not all are connected to RTW or support in employment. All of these studies, as is the case for many other evaluations, have the same problem of not being able to isolate whether a specific outcome results from the programme, from another programme(s) or would have happened anyway, without any intervention. Limitations with information gathered in the IAPT database and difficulties with comparator samples are also reported.⁹⁹

With these important caveats, several findings may be noted. Employment Advisors (EAs) reported a lack of integration with IAPT services, although this was improved when the same service was responsible for both aspects. Evaluation of IAPT telephone services¹⁰⁰ found that 26% of potential participants took part in the programme and of these 62% completed the course. Positive changes in claimants' wellbeing, self-efficacy and mental health were recorded in tests. However there was no control group for this intervention and conclusions therefore are limited.

IAPT is a large scale programme and therefore it is limited in the extent to which it is individually tailored. Questions have been raised about its effectiveness as a CBT therapy by counsellors and mental health professionals working within psychodynamic and counselling frameworks.¹⁰¹ These perspectives also mirror wider differences in perspective in psychology and psychiatry more generally.

5. Outlook

5.1 Target group: young persons in employment with health problems

5.1.1. National political discussions since implementation

Since 2010 disability strategy has been rather low key, with few new initiatives beyond those focussed on employment that have been discussed. The current national disability strategy *Fulfilling Potential: making it happen*¹⁰² was published in 2013, with an Action Plan¹⁰³ and an 'Outcomes and indicators framework' that refers to education, employment and income. The indicators have been further described and data has been added in a Technical Annex document¹⁰⁴ that was updated in September 2014.¹⁰⁵ Strategy commitments to policy actions under each heading in the Action Plan have been made but there are not quantifiable targets.

A recent development in the UK has been a national referendum to determine whether to leave the European Union (EU) termed Brexit. The decision to leave has been widely attributed to the influence of voters in poor areas that have been neglected in social policy terms since the 1980s. Although the implications of the result have still to be determined, the period of austerity has been lengthened to 2020 and pressures on welfare payments and RTW measures seem set to continue.

The Minister for Work and Pensions who was the architect of current reforms, Iain Duncan Smith, has resigned over proposed further cuts to the PIP programme, although his objections to the cuts were not widely accepted as credible by disabled people. His replacement, although giving a commitment to no further cuts to PIP for the time being, has refused to rule them out in the future. At a time of change in national government leadership and strategy, the UK is facing a period of uncertainty.

5.1.2. Current relevant developments

Some future plans have been announced for AtW.¹⁰⁶ These are generally favourable for young people with mental health conditions in that they involve capping the total amount payable as an allowance over a period of time, to make payments available to more people. This is likely to be problematic for Deaf workers and people with physical and sensory impairments rather than people with mental health conditions. However this should not be assumed in all cases and there may be implications for workers who have several impairments and health conditions. There are also indications that this provision may be amalgamated with a personal budget, a provision that has been available in social care and health services rather than employment, to date.

A new 'Work and Health Programme' was announced in the Spending Review and Autumn Statement of November 2015¹⁰⁷. It was proposed that this would be the new source of specialised support for claimants with health conditions or disabled claimants after the existing Work Choice and Work Programme contracts end. The DWP has not yet formally set out exactly how the new programme will operate, and what services will be included.

Before the recommissioning in 2017, some have suggested (including the Employment Minister, Priti Patel) that the Work Choice programme could be integrated with the Work and

Health Programme. Although this could reduce costs by simplifying bureaucracy and management, the Work and Pensions Select Committee report on welfare-to-work has indicated that most witnesses had opposed this, including the prime providers Shaw Trust and Remploy. The reason is again that the Work Programme has not achieved good outcomes for claimants with complex, health-related needs (see earlier in this report).¹⁰⁸

Access to Work is going to be amalgamated with other welfare measures under Universal Credit¹⁰⁹, which brings together several diverse allowances into one single payment. Although the timetable for implementation has been set back on several occasions, the reforms are being rolled out to most areas. Data on the results of this are not yet available.

5.2. Target group: young persons with health problems *not employed*

5.2.1. National political discussions since implementation

As noted above, the UK is facing a period of considerable political and economic uncertainty at the time of writing this report. This makes predictions difficult.

Assuming the current government, or government with a similar outlook, remains in power for the immediate future we may anticipate continued austerity measures over a longer period.¹¹⁰ Policies in respect of disabled people and people with mental health conditions who are unemployed have been at the ‘front line’ of conflict about austerity and a clear alternative to this is not evident. Young people have been less well protected than pensioners (who have been in receipt of a ‘triple lock’ guarantee for payments) and there are not any indications that this age imbalance in policy will change imminently.

5.2.2. Current relevant developments

An expansion of the IAPT programme was announced in the 2015 Autumn Statement and Spending Review, involving an additional £600 million investment in mental health services. Through this, ‘significantly more’ people are to have access to talking therapies every year by 2020 although exact targets are not given. However it is stated in the latest NHS England plan¹¹¹ that:

‘By 2020/21, each year up to 29,000 more people living with mental health problems should be supported to find or stay in work through increasing access to psychological therapies[and].....There must be a doubling of access to Individual Placement and Support programmes to reach an extra 30,000 people living with severe mental illness (so that at least 9,000 are in employment), and the new Work and Health Programme should prioritise investment in health-led interventions that are proven to work for people with mental health problems’.(p17)

There is consistent evidence that the Individual Placement and Support (IPS) model is the most successful approach for supporting people with mental health conditions into work.¹¹² This model provides tailored support according to what is needed by the individual over the whole process of finding and keeping a job and is particularly effective for people with more serious health conditions. There is evidence that adhering to the prescribed model improves outcomes to an extent not achieved by other approaches. There has not been a detailed

analysis of this programme in this report because as yet the efforts to implement it have been quite small scale. However it represents the best example of well evidenced good practice in the UK, and one that is particularly well suited to younger job seekers in that it has the capacity to instil confidence. It is to be hoped that there is further investment in this approach in the future.

Appendix 1: Statistics and Other Relevant Data

Statistics Relevant to Section 1

Table 1: Supplementary Benefit/Income Support claimants by Client Group: 1969 - 1995

Date	Total	Client Group				
		Pensioners	Disabled People	Lone Par-ents	Unem- ployed People	Others
1969	2,687,700	1,874,800	325,600	177,200	228,300	81,800
1970	2,737,800	1,901,600	322,700	191,400	240,200	81,900
1971	2,908,900	1,918,900	304,800	212,800	387,100	85,300
1972	2,928,900	1,909,100	298,400	226,800	410,300	84,300
1973	2,675,500	1,844,000	279,200	228,400	248,600	75,200
1974	2,679,800	1,807,400	260,200	245,100	301,600	65,500
1975	2,792,600	1,679,400	241,900	275,500	541,200	54,700
1976	2,313,300	1,686,900	242,600	303,000	...	53,100
1977	2,991,500	1,738,100	229,200	309,100	671,400	43,700
1978	2,932,400	1,737,700	223,300	321,900	597,600	51,900
1979	2,854,700	1,723,000	207,500	306,200	566,300	51,600
1980	3,117,800	1,694,300	204,800	316,400	853,700	48,600
1981	3,722,600	1,737,700	221,400	368,700	1,317,900	76,800
1982	4,266,500	1,780,600	239,500	415,200	1,721,800	109,400
1983	4,349,200	1,650,900	241,000	448,500	1,826,400	182,500
1984	4,609,300	1,683,100	273,000	492,500	1,952,900	207,900
1985
1986	4,937,700	1,716,700	300,700	575,400	2,120,800	224,200
1987	4,895,500	1,727,000	351,800	629,200	1,956,800	230,800
1988	4,351,500	1,719,300	247,200	694,200	1,510,600	180,200
1989	4,160,800	1,606,500	290,100	755,900	1,215,600	292,600
1990	4,179,900	1,674,700	330,100	793,100	1,063,100	319,000
1991	4,486,700	1,574,900	374,700	871,300	1,334,600	331,200
1992	5,087,700	1,643,100	424,500	956,700	1,662,100	401,300
1993	5,642,500	1,736,200	527,300	1,012,800	1,919,700	446,500
Feb 1994	5,791,200	1,745,400	589,100	1,034,600	1,954,800	467,300
Feb 1995	5,751,100	1,783,900	722,400	1,049,000	1,774,300	421,500

Table 2: Selected Key Outcomes in the United Kingdom 2007

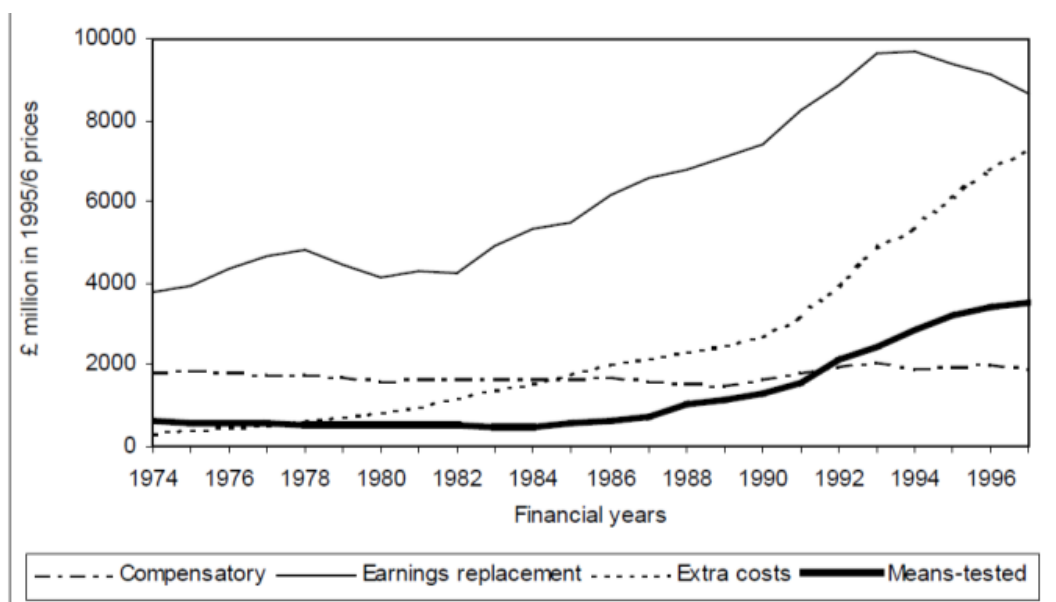
Selected Key Outcomes	(in % of GDP)
Spending on Sickness Benefits	0.6 (falling)
Spending on Disability Benefits (in % of GDP)	1.5 (falling)
Employment Rate of Disabled People %	45.3 (rising)
Unemployment Rate of Disabled People %	7.4 (constant)
Disabled People with income below 50% of median	14 (constant)
Workers on sickness absence for entire last week %	2.0 (constant)
Disability benefit recipients in % of working age population	8.1 (constant)
Disability benefit recipients with mental health problem %	40 (rising)*
Annual outflow from disability benefits in %	7.3 (constant)

*Includes behaviour disorders

Source: OECD (2007) *Sickness, Disability and Work: Breaking the Barriers (vol 2)* http://www.oecd-ilibrary.org/social-issues-migration-health/sickness-disability-and-work-breaking-the-barriers-vol-2_9789264038165-en

The main points to note in addition to these figures are a sharp increase of mental health conditions, to 40% of claimants in 2005, and the low level of pay compared with other OECD countries.

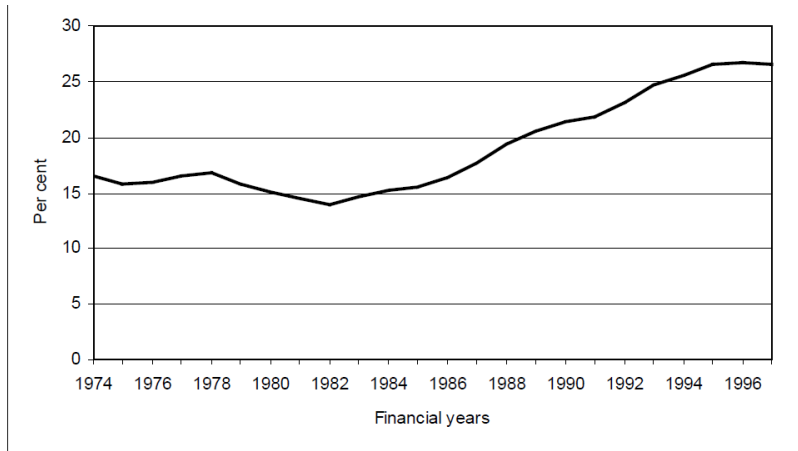
Table 3: Total Expenditure on Benefits for Disabled People 1974 – 1977, by Type of Benefit



Source: Burchardt, T. (1999) *The Evolution of Disability Benefits in the UK: Re-weighting the basket*, London: Centre for Analysis of Social Exclusion

As shown in Table 3, expenditure more than trebled from £600 million in 1974 to £3,500 in 1997 (in 1995/6 prices).

Table 4: Expenditure on Benefits for Disabled People as a Percentage of Social Security, 1974 - 1997



Note: Supplementary benefit and Income Support paid to sick and disabled people are included but Housing Benefit and local tax benefits are not.

Sources: Department for Social Security (1998) Social Security Department Report: the Government's expenditure plans 1998 – 99 CM: 3913, London: The Stationary Office; Department for Social Security (1998) Social Security Statistics 1998, London: The Stationary Office

Table 5: Access To Work: Numbers of New Starts on Access to Work Programme Each Financial Year, by Primary Medical Condition

Primary Medical Condition	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	Total new starts since April 2007
Missing/Unknown	10	30	10	0	10	20	10	10	90
Arms or hands	1,020	1,390	1,540	1,250	870	830	910	790	8,590
Legs or feet	740	1,010	1,230	960	680	960	1,050	800	7,420
Back or neck	3,370	4,210	4,960	3,430	2,220	2,010	2,430	2,570	25,190
Stomach, liver, kidney or digestion	20	30	60	50	40	30	30	40	310
Heart, blood, blood pressure or circulation	70	90	130	90	60	80	100	70	670
Chest or breathing	40	50	70	50	40	60	80	60	430
Skin conditions and severe disfigurement	10	0	10	10	10	10	0	10	40
Deaf and hard of hearing	1,130	1,320	1,500	1,180	930	1,140	1,150	1,030	9,380
Difficulty in seeing	1,080	1,120	1,130	1,000	760	860	920	850	7,720
Difficulty in speaking	50	60	60	50	30	40	50	40	370
Learning disability	390	370	360	370	280	310	460	520	3,060
Progressive illness	580	650	800	620	500	480	490	390	4,490
Dyslexia	930	1,370	1,960	1,830	1,580	1,610	1,900	1,910	13,080
Epilepsy	280	290	330	270	260	330	330	240	2,340
Diabetes	50	70	120	110	80	60	70	50	600
Mental health condition	90	110	240	240	340	440	800	610	2,860
Cerebral Palsy	120	120	120	100	80	70	90	100	800
Spina Bifida	50	30	40	30	20	20	10	20	220
Other	1,150	1,310	1,590	1,410	1,010	1,140	1,390	1,520	10,520
Total	11,150	13,620	16,240	13,070	9,770	10,490	12,240	11,620	98,180

Table 5a Disabled People Helped by Access to Work 2013 to 2015

	2013 – 14 Q4	2014 – 15 Q4
Number of disabled people	6,521,800	6,611,100
Number of disabled people working (LFS)	2,904,700	3,045,800
Number of people helped by Access to Work	35,560	36,760
Percentages of disabled people helped by Access to Work	Of all disabled people 0.55%	Of all disabled people 0.56%
	Of disabled people who are working 1.22%	Of disabled people who are working 1.20%

Sources: Department for work and Pensions (2015) *Labour Force Survey analysis of disabled people by region and main health problem* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/406369/labour-force-survey-disabled-people.pdf

Department for Work and Pensions (2015) Official Statistics: Access to Work: individuals helped up to March 2015 <https://www.gov.uk/government/statistics/access-to-work-individuals-helped-up-to-march-2015>

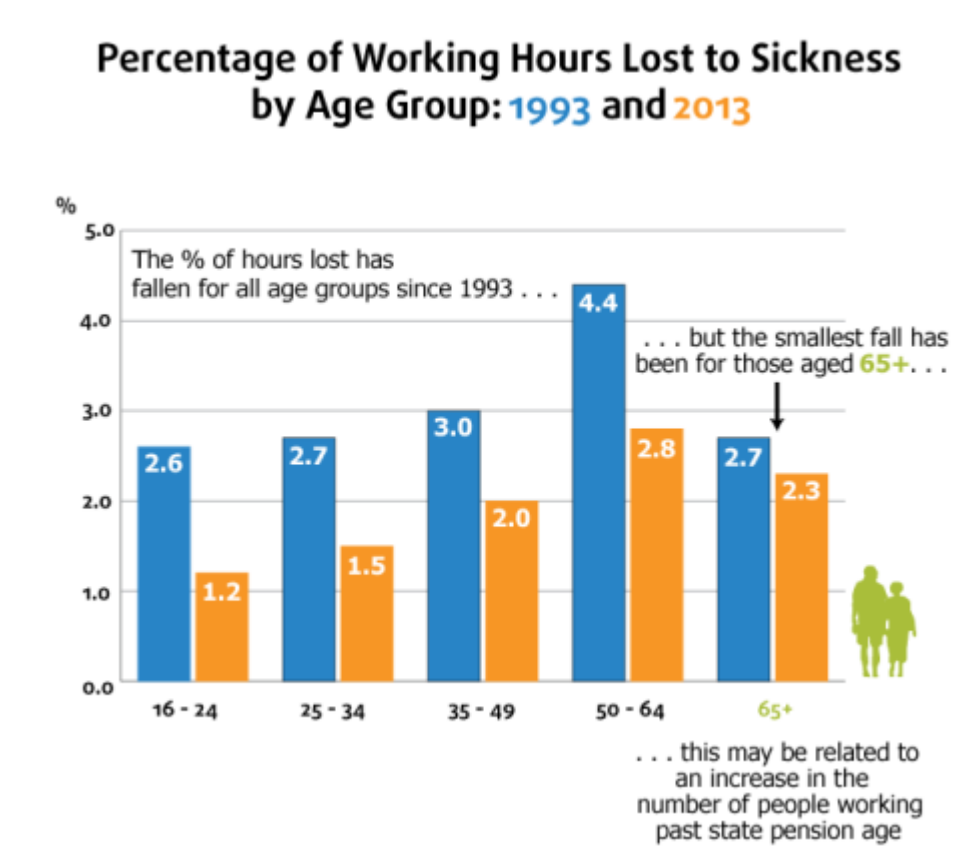
Note: Figures for disability are not comparable between 2008 and 2015 as a whole because of changes in how it is measured throughout this period. The LFS last changed how it defined disability in Q2 2013 following the Equality Act 2010. Therefore just the most recent years have been shown.

Table 6: Number of Working Days lost through Sickness, Great Britain, 1993 - 2013



Source, Labour Force Survey: Office of National Statistics <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/labourproductivity/articles/sicknessabsenceinthelabourmarket/2014-02-25#main-points>

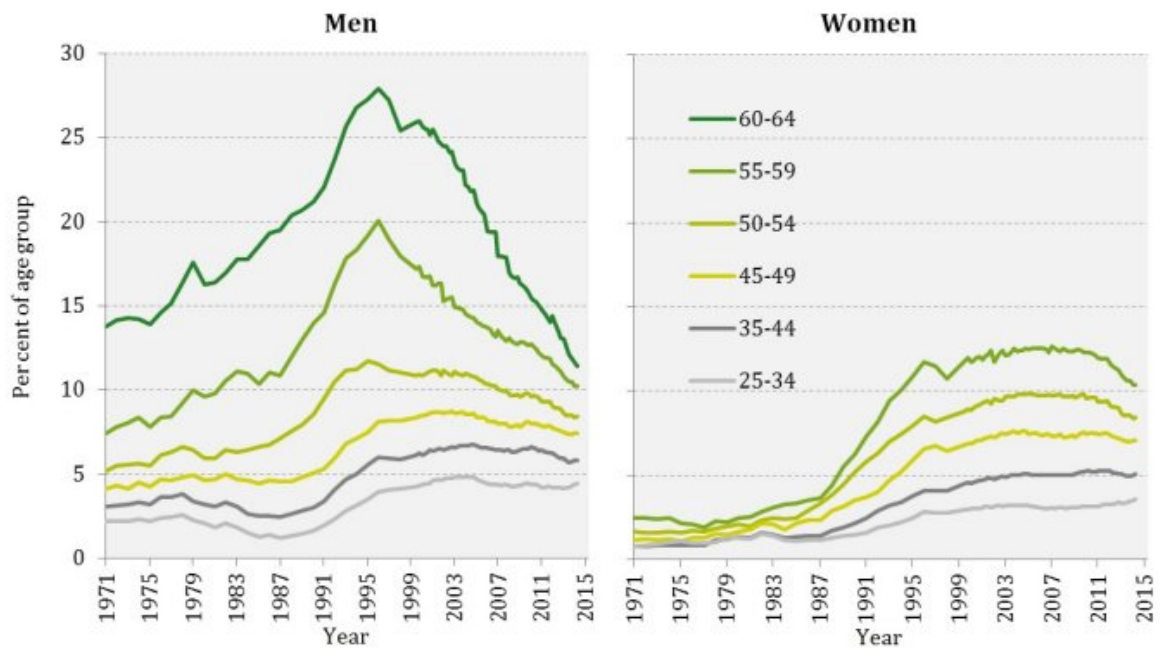
Table 7: Percentage of Working Hours Lost to Sickness by Age Group, Great Britain, 1993 - 2013



Source, Labour Force Survey: Office of National Statistics <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/labourproductivity/articles/sicknessabsenceinthelabourmarket/2014-02-25#main-points>

Table 8: Disability Benefits Claim Rates, by Sex and Age Group, Great Britain, 1971-2015

Figure: Disability benefit claim rates, by sex and age-group



Notes and sources: Claimants of Invalidity Benefit, Incapacity Benefit, and Employment and Support Allowance in Great Britain. See Figure 2 of <http://pubs.aeaweb.org/doi/pdfplus/10.1257/jep.29.2.173>

Source, Labour Force Survey: Office of National Statistics <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/labourproductivity/articles/sicknessabsenceinthelabourmarket/2014-02-25#main-points>

Appendix 2: ICD codes and mental health conditions

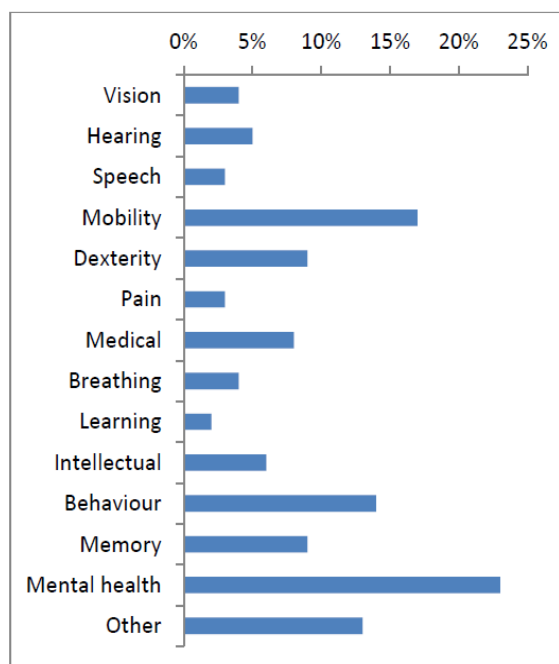
The UK government has produced an analysis of ESA claimants in relation to a number of ICD codes in response to a Freedom of Information request.¹¹³ This file, from 2013, is attached as an additional appendix to this report.

National statistical indicators for disability equality produced by the Department for Disability Issues, which is part of the Department for work and Pensions, have in previous years included mental health conditions as a variable¹¹⁴. However mental health is no longer listed as part of these.

Berthoud's analysis¹¹⁵ of employment rates from the Life Opportunities Survey (data was collected from 2009 – 2011) shows the following rates, which illustrate the greater level of disadvantage experienced by people with mental health conditions:

Table : Logistic Regression Equation estimating the Employment Penalty Experienced by Disabled People with Different Types of Impairment

	Frequency	Coeff	Penalty
Vision	1.5%	-0.244	4%
Hearing	1.1%	-0.304	5%
Speech	0.7%	-0.263	3%
Mobility	5.0%	-1.023	17%
Dexterity	3.8%	-0.588	9%
Pain	13.5%	-0.195	3%
Medical conditions	9.3%	-0.445	8%
Breathing	1.6%	-0.282	4%
Learning	1.7%	-0.139	2%
Intellectual	0.3%	-0.413	6%
Behaviour	0.9%	-1.123	14%
Memory	2.3%	-0.642	9%
Mental health condition	4.5%	-1.347	23%
Other	0.9%	-0.910	13%



Source: Berthoud, R. (2014) *Diverse Disability: Evidence on employment outcomes from the Life Opportunities Survey*, Institute for Social and Economic Research.

Finally, the Psychiatric Morbidity Study^{116, 117} provides information on mental health conditions for people aged 16 upwards in England, Scotland and Wales. The most recent data is from 2007 and results from a 2014 survey will be available in late 2016.

Endnotes

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<http://www.centreforwelfarereform.org/library/type/pdfs/a-fair-society1.html>

² Joseph Rowntree Foundation (2016) *Destitution in the UK* York: Joseph Rowntree Foundation
<https://www.jrf.org.uk/report/destitution-uk>

³ Committee of the International Covenant on Economic, Social and Cultural Rights 58 Session (06 Jun 2016 - 24 Jun 2016) Concluding observations on the sixth periodic report of the United Kingdom of Great Britain and Northern Ireland

http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2fGBR%2fCO%2f6&Lang=en

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⁶ See for example: Standing, G. (2011) *The Precariat: The New Dangerous Class* London: Bloomsbury Academic

⁷ In 1968 the Office of Population Censuses and Surveys (OPCS) identified 3 million disabled adults living in private households. It also provided evidence of widespread poverty, and of the sorts of additional expenditure incurred as a result of living with disability. In 1971, Attendance Allowance was introduced for those who required significant amounts of personal assistance, followed in 1975 by Mobility Allowance for those who needed help with moving around. However, subsequent surveys in the 1980s showed the persistence of poverty, and in 1992, extra costs benefits were reformed, with Disability Living Allowance replacing Mobility Allowance and Attendance Allowance for people under 65.

⁸ The examples given are of welfare benefits that have now been superseded by benefits with other names. Typically, while the function of new benefits remained the same, eligibility requirements were made more stringent and provisions less generous on each occasion.

⁹ Disability Discrimination Act 1995 <http://www.legislation.gov.uk/ukpga/1995/50/contents>

¹⁰ Equality Act 2010 <http://www.legislation.gov.uk/ukpga/2010/15/contents>

¹¹ For Guidance on the Equality Act 2010, see:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/85010/disability-definition.pdf

¹² Public Sector Equality Duty <https://www.gov.uk/government/publications/public-sector-equality-duty> The public sector equality duty (PSED) was established by the Equality Act 2010 and applies to all characteristics protected by that Act. It requires all public authorities in England, Scotland and Wales to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations. In advancing equality of opportunity, authorities must consider minimising disadvantages shared by persons with particular protected characteristics and consider taking steps to meet their particular needs.

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<http://www.legislation.gov.uk/nisi/2006/312/contents/made>
- ¹⁴ United Nations Convention on the rights of Persons with Disabilities
<https://www.un.org/disabilities/convention/conventionfull.shtml>
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https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181060/health-at-work.pdf
- ¹⁹ TUC Occupational Sick Pay <https://worksmart.org.uk/health-advice/employer-support/sick-pay/what-occupational-sick-pay>
- ²⁰ Access to Work <https://www.gov.uk/access-to-work/overview>
- ²¹ Access to Work Provider Guidance: Mental Health Support Service
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/515570/access-to-work-mental-health-support-service-provider-guidance.pdf
- ²² For further details of Access to Work Eligibility see: Disability Rights UK
<http://www.disabilityrightsuk.org/access-work>
- ²³ Employment Support Information, Northern Ireland
<https://www.nidirect.gov.uk/articles/employment-support-information>
- ²⁴ Personal Independence Payments <https://www.gov.uk/pip/overview>
- ²⁵ Disability Living Allowance <https://www.gov.uk/dla-disability-living-allowance-benefit/overview> Note that the information here describes transitional arrangements (for example, adults may no longer make a new claim for DLA but the programme is still open to children (at the time of writing), who will be migrated onto PIPs at a future date).
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- ²⁷ Improving Access to Psychological Therapies (IAPT) <http://www.iapt.nhs.uk/about-iapt/>
- ²⁸ NHS England: Children and Young People <https://www.england.nhs.uk/mentalhealth/cyp/>
- ²⁹ Education Maintenance Allowance <https://www.gov.uk/education-maintenance-allowance-ema>
- ³⁰ European Convention on Human Rights (ECHR)
http://www.echr.coe.int/Documents/Convention_ENG.pdf
- ³¹ Human Rights Act 1998 <http://www.legislation.gov.uk/ukpga/1998/42/contents>

³² The Work Programme

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/49884/the-work-programme.pdf

³³ The Work Choice Programme <https://www.gov.uk/work-choice>

³⁴ Job Seekers Allowance <http://www.disabilityrightsuk.org/employment-and-support-allowance-overview>

³⁵ Employment and Support Allowance <https://www.gov.uk/employment-support-allowance> This is the main income replacement benefit for disabled people and people with mental health conditions and it is of particular importance for people who are unemployed. However it is also available to people who are employed but on low incomes and it therefore included in this section.

³⁶ Job Seeker's Allowance <https://www.gov.uk/jobseekers-allowance/overview>

³⁷ Young Minds, Clegg Announced Plan for Job Centre Mental Health Treatment Scheme http://www.youngminds.org.uk/news/blog/2599_clegg_announces_plan_for_job_centre_mental_health_treatment_scheme

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Access to Work grants are available to support anyone over the age of 16 if their employment is in England, Scotland or Wales, and they are not receiving out of work benefits. There is a separate system of employment support in Northern Ireland. Access to Work is funded by the Department for Work and Pensions via JobCentre Plus.

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⁴⁶ NHS and Social Care Information Centre <http://www.hscic.gov.uk/iaptreports>

⁴⁷ McGuinness, T. And Kennedy, S. (2016) House of Commons Briefing Paper: JobCentre Plus Flexible Support Fund

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<http://www.publications.parliament.uk/pa/cm201314/cmselect/cmpubacc/777/77703.htm>

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<https://www.nao.org.uk/wp-content/uploads/2016/01/Contracted-out-health-and-disability-assessments.pdf>

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