ACCESS TO SOCIAL SECURITY BENEFITS FOR PEOPLE WHO ARE UNABLE TO WORK BECAUSE OF MENTAL ILLNESS

Thesis submitted for the degree of

Doctor of Philosophy

at the University of Leicester

by

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November 2010

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Abstract

This thesis examines the difficulties which people with mental health conditions may experience in establishing and maintaining entitlement to the social security benefits which underwrite incapacity for work. Two regimes are currently operating simultaneously, the incapacity benefits regime, introduced in 1995, and employment and support allowance (ESA), introduced in October 2008.

The thesis identifies the main barriers to incapacity for work benefits for people with mental health problems as the symptoms of mental illness, administrative procedures, national insurance contribution conditions, assessment, conditionality, appeals and complexity of the welfare system. It compares the two regimes and concludes that although problems arise with both incapacity benefits and ESA, problems with ESA are greater.

The ESA scheme and ongoing reforms appear to have worked well for people who are at the most severe end of the spectrum of mental illness, since they receive more money and are relieved of conditionality. For claimants with lesser mental health problems the situation has worsened.

The thesis makes a number of recommendations for change. It suggests that mental health teams should include welfare benefits advisers, recommends better training in mental health issues for DWP staff, and improved communication between the DWP and claimants, in particular lesser reliance on telephony.

Consideration should also be given to removal of national insurance contribution conditions for incapacity for work benefits, and replacement by a universal benefit. The thesis points out that assessment of incapacity is the most significant obstacle to entitlement and suggests a return to the informal procedure used pre-1995, as well as payment for partial capacity. It also recommends voluntary, rather than mandatory participation in work-related activity by claimants with mental health problems, and questions whether it is appropriate to use the welfare system to coerce claimants, particularly those with mental health problems, into employment.

Acknowledgements

Thanks are due to my two children, Gail Melvin and Mark Tindley, who did not turn a hair when, late in life, their mother announced that she was embarking on legal studies, and whose inheritance has been frittered away in pursuit of qualifications. They have encouraged me throughout the enterprise and provided invaluable IT consultancy services.

Special thanks are due to my supervisor, Professor David Bonner, whose enthusiasm for social security law is infectious, and who has encouraged and supported me in my journey from amateur adviser to postgraduate legal qualification. David Bonner has patiently read through countless drafts, supplied constructive comments and guided me to completion. I am grateful to the staff of the University Library who were unfailingly helpful and courteous, and who went the extra mile in assisting me to locate elusive literature. I also owe a debt of gratitude to my friend, Mike Robinson, who kindly agreed to proof-read my draft thesis, and who saved me from some silly slips.

The impetus to write this thesis arose from my work as an adviser at a Citizens Advice Bureau, and from the stories recounted by clients with mental health problems. It is to those clients and their friends, relatives and carers who persuaded them to seek advice, to whom this thesis is dedicated. The thesis is written with the hope that all those who, because they have mental health problems, are unable to work, will have a trouble-free path to establishing and maintaining entitlement to benefits.

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INTRODUCTION

This thesis examines the difficulties which people with mental health conditions may experience in accessing the social security benefits which underwrite incapacity for work. Systems of social security have evolved to meet a number of objectives. One authority suggests that these comprise three separate elements:

- relief of poverty via means-tested social assistance
- financial security and spreading of income over a lifecycle, via social insurance
- money transfer and income redistribution between different societal groups.[1]

The balance between these elements shifts in response to social, economic and political policies of the Government of the time so that welfare provision is constantly changing. However, it has long been recognised that sickness and disability can have a profound effect on a person's ability to support themselves and their family, so that some form of financial assistance for people who are unable to work has been available since 17th Century Poor Law provision.

Following the Beveridge Report,[2] social security in the UK moved towards a rights-based system by which benefits are paid to all those who meet the entitlement criteria. For many benefits, eg sickness benefit for people unable to work because of illness or disability, the criteria included national insurance contribution conditions, although 'safety-net' provision was subject to means-testing.

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1 AB Atkinson, *Poverty and Social Security* (Harvester Wheatsheaf, Hemel Hempstead 1989) 100.

2 W Beveridge, *Social Security and Allied Services* (Cmd 6404, 1942).

Studies by Rowntree in York in 1899, 1936 and 1950 established that incapacity of the chief wage-earner was a major cause of family poverty.[3] Townsend described how relative poverty and financial deprivation led to 'withdrawal from participation in the customs and activities sanctioned by culture',[4] and noted that this was a particular problem in households with disabled people.[5] This phenomenon came to be called social exclusion, and in 1997 the Labour Government established a Social Exclusion Unit to conduct research and devise ways of dealing with social exclusion at a personal and neighbourhood level. Appropriate levels of welfare benefits, that did not act as a disincentive to employment, were seen as a means of achieving social inclusion. Under the strap line 'work for those who can, security for those who cannot'[6] the Government reintroduced the concept of welfare as a contract between the State and citizens, first seen in the Poor Law, by which the right to receive benefits was accompanied by responsibilities on the claimant, such as the duty to support their family and to seek training or work where able to do so.[7]

This notion of rights and responsibilities has been further extended, so that continued receipt of benefits for incapacity for work depends on the fulfilment of conditions requiring claimants to engage in activities designed to improve their potential for obtaining employment. By imposing penalties for failure to meet the relevant conditions the social security system is also moving even further towards a

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3 BS Rowntree, *Poverty: A Study of Town Life* (Centennial edn, Policy Press, Bristol 2000).

4 P Townsend, *Poverty in the United Kingdom* (Penguin 1979) 57.

5 ibid 271.

6 Secretary of State for Social Security, *A New Contract for Welfare: Principles into Practice* (Cm 4101, 1998) pp iii, 11 para 1; Secretary of State for Social Security, *A New Contract for Welfare: Support for Disabled People* (Cm 4103, 1998) p 1 para 1.

7 Secretary of State for Social Security, *New Ambitions for Our Country: A New Contract for Welfare* (Cm 3805, 1998) ch 11.

regime which exercises 'social control'[8] over claimants. This aspect of the welfare system has been reinforced by recent statements promising to eliminate benefit dependency as a 'lifestyle choice'.[9]

Key features of current incapacity for work benefits

The thesis focuses on the incapacity for work benefits underwriting incapacity for work which are currently in payment. Two main regimes operate simultaneously. The first, in force since 1995, is the incapacity benefits regime[10] which comprises incapacity benefit, income support on the basis of incapacity and national insurance credits for incapacity. The second, the ESA regime, consists of employment and support allowance and national insurance credits-only claims.

Incapacity benefit is paid to people who are incapable of work and who met the relevant national insurance contribution conditions at the time of claim. The test of incapacity is via a functional assessment known as the personal capability assessment, which comprises tests of both physical and mental function, which are separately scored. Incapacity benefit was paid at three different rates according to the length of the claimant's period of incapacity, although all current recipients of this benefit are now on the highest, long-term, rate. Claimants who are incapable of work but could not satisfy the contribution tests were able to claim a safety-net, means-tested income support. Those who failed both the contribution and means-tests receive only national insurance credits, which may assist towards qualification for contributory benefits in the future.

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8 defined as 'encouragement or enforcement of particular patterns of behaviour' – P Spicker, *Poverty and Social Security* (Routledge, London 1993) 108.

9 George Osborne, interviewed by Nick Robinson, BBC1, 9 September 2010.

10 also known as the IB/IS regime.

Employment and support allowance was introduced on 27 October 2008 to replace the previous system of benefits paid for incapacity for work, and from that date no new claims for incapacity benefit could be made. Claimants can qualify for payment of employment and support allowance either by meeting national insurance contribution conditions or by satisfying a means-test. Those who fail both these tests receive only national insurance credits.

For the first thirteen weeks of limited capability for work, claimants are paid a basic allowance, which matches the age-related rate for jobseekers allowance. Claimants are subject to a functional test known as the limited capability for work assessment, which although similar to its predecessor test is more stringent, but which allows scores for physical and mental activities to be simply summed. Claimants who pass this assessment are held to have limited capability for work, and receive an increase of their basic rate of benefit. The majority of these claimants are required to fulfil various conditions, designed to assist them into employment, as a requirement of continued benefit receipt. A small group of the most severely disabled claimants, known as the support group, are exempt from conditionality, and receive enhanced payment, after meeting a more stringent limited capability of work-related activity assessment.

The following terminology and abbreviations are used in this thesis:

IB = incapacity benefit

incapacity benefits or IB/IS = IB, income support (IS) on the basis of incapacity, and national insurance (NI) credits for incapacity

ESA = employment and support allowance and NI credits for limited capability for work

IfW benefits = any or all of the earnings-replacement benefits listed above.

Social security law is constantly changing and the coalition Government of May 2010 has promised further radical alterations to the system. These include total abolition of incapacity benefits, tightening of the national insurance contribution conditions, and a review of the assessment test. This thesis describes the legislative provisions up to 28 October 2010, two years from inception of employment and support allowance.

What this thesis does

Effective operation of any social security system is based on the fundamental principle that benefits are paid only to those who are entitled to receive them, but equally, that citizens receive their full benefits entitlement. There has long been anecdotal evidence that people with mental health problems, who comprise more than half of current benefit claimants, have particular difficulty in establishing and maintaining their entitlement to the benefits which are available to people who are too ill to work.

The thesis tackles three research questions:

1. Do people who cannot work because of their mental health problems face particular difficulties when claiming earnings-replacement benefits which underwrite incapacity?
2. If so, what are the difficulties, and why?
3. How have claimants with mental health problems been affected by welfare reform and the introduction of employment and support allowance?

The thesis argues that people with mental health (MH) problems have particular difficulties when they claim IfW benefits. It identifies the barriers to these benefits which mentally ill people face, considers the effects of recent welfare reform, and

makes recommendations for change to remove or ameliorate some of those difficulties. As well as an analysis of the legislative framework surrounding the two regimes, the thesis discusses the impact of the law and of administrative procedures on claimants with MH problems from a medical, social and economic perspective.

Employment and support allowance (ESA) was introduced in October 2008 to replace the previous system of benefits paid for incapacity for work operating since 1995. However, the Coalition Government reiterated its intention to migrate all existing IB/IS recipients to ESA.[11] This thesis thus has particular topicality because legislation was enacted[12] to start this transfer from 1 October 2010, despite the fact that consultation on the gateway work capability assessment, which forms part of an independent review of that assessment, ended only on 10 September 2010,[13] and the resulting report will not be laid before Parliament until several months later. Assessment of IB/IS recipients began on a trial basis in Aberdeen and Burnley on 11 October 2010.[14] Although the focus of this thesis is on claimants with MH problems, some of the problems identified are common to all claimants. Thus the thesis has a wider reach, and some of the reforms suggested in Chapter Eight would be advantageous to all claimants.

Benefits for those who cannot work fall into two main groups: social insurance (contributory) benefits and social assistance (non-contributory, means-tested) benefits.

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11 Department for Work and Pensions, 'New Statistics Show Thousands Found Fit for Work as Government Vows to Push Ahead with Plans to Reassess Incapacity Benefit Claimants' DWP Media Centre 27 July 2010.

12 Employment and Support Allowance (Transitional Provisions, Housing Benefit and Council Tax Benefit) (Existing Awards) Regulations 2010 SI 2010/1905.

13 M Harrington, *The Work Capability Assessment – a Call for Evidence* (DWP 2010).

14 Department for Work and Pensions, 'Government Reforms Begin with Fitness for Work Assessments' DWP Media Centre 11 October 2010.

One approach to this topic might have been to compartmentalise these benefits and treat them separately. However, a feature of the post-war welfare system is that claimants could receive either or both of these types of benefits, depending on their individual circumstances. The complex interplay of contributory and means-tested benefits often confuses claimants, and has led to calls for a simpler system.[15] ESA was intended to be a single unified benefit paid to all claimants who have limited capability for work.

Structure of the thesis and its contribution beyond that made by existing studies

This thesis fills a number of gaps in coverage by literature already in existence. There is a wealth of material about benefits for disabled people, mostly concerning the so-called 'disability benefits' (disability living allowance and attendance allowance) and means-tested social assistance benefits such as income support and its predecessor supplementary benefit. Typical works are G Dalley, (ed) *Disability and Social Policy*[16] and — *Poverty and Disability: Breaking the Link*.[17] A more recent publication, *A Route Out of Poverty? Disabled People, Work and Welfare Reform*,[18] considers worklessness of disabled people in the context of child poverty. In 2005 the Department for Work and Pensions (DWP) issued a comprehensive report detailing existing research into the extra costs of disability.[19] By comparison, very little

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15 See eg K Stanley and D Maxwell, *Fit for Purpose – The Reform of Incapacity Benefit* (IPPR London 2004); Work and Pensions Committee, *Benefit Complexity* Seventh Report HC 463-I (2006-07) Summary; D Martin, *Benefit Simplification. How and Why it Must Be Done* (Centre for Policy Studies 2009); Secretary of State for Work and Pensions, *21st Century Welfare* (Cm 7913, 2010).

16 (Policy Studies Institute London 1991).

17 (Disability Alliance1987).

18 G Preston (ed), (CPAG 2006).

19 M Tibble, *Review of Existing Research on the Extra Costs of Disability* Working paper No 21 (DWP, London 2005).

research has been conducted into IfW benefits, and even less that concentrates on mental rather than physical illness. A report produced by the Office of National Statistics (ONS) entitled *Social and Economic Circumstances of Adults with Mental Disorders*[20] that might be expected to consider 'incapacity benefits' actually mentions them only twice, once in a table showing income sources and once in the notes accompanying the table.

One charity, Mind in Croydon, has undertaken a benefits take-up project for service users and has reported on its outcome.[21] Relevant parts of their research have contributed to this thesis. Neath Port Talbot Mind also produces a comprehensive and user-friendly annual guide to welfare benefits for its clients.[22] While lacking the rigour of a legal text it is nonetheless useful. For example, it explains the process of assessing incapacity together with the type of information and supporting evidence which will assist a decision-maker to conclude that a person is incapable of work on MH grounds.

The first chapter of the thesis explains why claimants with MH problems have become the focus for welfare reform. It specifies the most prevalent mental illnesses, their incidence and symptoms, and the ways in which these may impact on a sufferer's ability to work or seek and retain employment. The chapter summarises some of the particular problems faced by mentally ill claimants both in general and by particular groups of claimants.

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20 H Meltzer and others, (TSO, London 2002).

21 Pacitti and Dimmick, 'Poverty and Mental Health: Underclaiming of Welfare Benefits' (1996) 6 Journal of Community and Applied Social Psychology 395; M Frost-Gaskin and others, 'A Welfare Benefits Outreach Project' International Journal of Social Psychiatry 2003 Vol 49(4) 251.

22 J Stenger, *The Big Book of Benefits and Mental Health 2009/10* (Neath Port Talbot Mind 2009) and earlier editions of this book.

Chapter Two outlines the benefits currently in payment to those who are too sick or disabled to work and compares the incapacity benefit regime with its successor, the employment and support allowance regime.

The thesis identifies the interacting barriers to a successful claim for IfW benefits for people with MH problems as:

- symptoms of mental illness and their impact on functioning
- administrative procedures
- national insurance contribution conditions
- assessment
- conditionality
- appeals
- complexity of the welfare system.

The third chapter considers the administrative procedures for IfW benefits from the point of view of the claimant. It looks at the options available to people with mental illness to find out about any benefit entitlement and the difficulties they may have in claiming as a result of apathy or fear. A limited amount of research has been conducted in this field. *Standing up for Claimants*[23] concentrates on the work of welfare right advisers in local authorities, and is now somewhat outdated. *Choosing Advice on Benefits*[24] gives an overview of the advice options available to claimants but pre-dates Jobcentre Plus. Various reports by the National Audit Office have described Departmental administrative processes in general, and their impact on claimants. None of these works has specifically considered the particular needs of the mentally ill. The

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23 R Berthoud, S Benson and S Williams, *Standing up for Claimants – Welfare Rights Work in Local Authorities* (Policy Studies Institute, London 1988).

24 J Vincent and others, DSS Research Report No 35 (HMSO, London 1995).

increased use of telephony as a means of communication between claimants and the DWP is problematic for many people with MH difficulties, and has prompted research by both the Department and the Social Security Advisory Committee. Reports on this research[25] have informed this thesis.

Chapters Four and Five cover the two main hurdles to receiving entitlement to IfW benefits: the National Insurance contribution conditions and the assessment tests, respectively. Although there are contribution conditions for receipt of some IfW benefits, failing the contribution tests may not be fatal to benefit receipt because an alternative, but less secure, means-tested benefit might be available. However, because entitlement to an income-related benefit depends on falling within income and capital limits, and on a partner's employment status, this may also be ruled out, despite a claimant being undoubtedly unfit for work. The legislative stipulations are complex, and are comprehensively treated in *Social Security Legislation, Volume I: Non Means Tested Benefits*[26] and *Volume II: Income Support, Jobseeker's Allowance, State Pension Credit and the Social Fund.*[27] These texts adopt a 'black-letter law' approach, and extensive use has been made of them by this researcher, however, detailed consideration of the impact of the legislation on actual claimants falls beyond the scope of those books. A report commissioned by the DWP into gaps in national insurance records[28] has contributed to this thesis. The effects which the assessment tests and the administrative systems have on claimants with MH problems have been widely

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25 C Hay and A Slater, *The Use of Jobcentre Plus Telephony and Face-to-face First Contact Services by Customers with Specific Communication Barriers* (DWP Research Report No 446 CDS, Leeds 2007); — *Telephony in DWP and its Agencies: Call Costs and Equality of Customer Access* Occasional Paper No 3 (SSAC 2007).

26 D Bonner and others, (Sweet & Maxwell, London) updated and published annually.

27 P Wood and others, (Sweet & Maxwell, London) updated and published annually.

28 D Collins and others, *Investigation of the Gaps in Individual's National Insurance Records* (DWP Working Paper No 61 2009)

reported by charities such as Mind[29] and Citizens Advice[30] and by welfare rights forums such as Rightsnet and the National Association of Welfare Rights Advisers. This researcher has drawn heavily on these evidential reports for this thesis.

The Pathways to Work scheme for incapacity benefits required most claimants to engage in activities aimed at improving their employment prospects as a condition of retaining benefit entitlement. These conditions were extended considerably when ESA was introduced. Chapter Six considers the conditionality rules and the difficulties compliance poses for people with MH problems. Sources similar to those used for the previous chapter have contributed to this research.[31]

People who fail their medical assessment and are held to be capable of work have a right of appeal to an independent tribunal. Chapter Seven describes the dispute processes, explains the problems faced by people with MH difficulties and considers the outcome statistics for IB/ESA appeals.

Based on the results of this research, Chapter Eight makes a number of recommendations for reforming the benefits for people who are too ill to work, with particular reference to those with MH problems. Its recommendations include that mental health teams should comprise welfare benefits advisers, that consideration should be given to payment of benefit for people with partial capacity for work, and that claimants with MH problems should be relieved of conditionality. A more far-

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29 — *Responses to the Work and Pensions Committee Inquiry: Decision Making and Appeals in the Benefits System* (Mind 2009).

30 V Pearlman and S Royston, *Limited Capability: CAB Evidence on the First Year of Employment and Support Allowance Administration* (Citizens Advice, November 2009); K Dryburgh, *Unfit for Purpose: Scottish CAB Evidence on ESA* (Citizens Advice Scotland 2010).

31 L Cullen, *Out of the Picture: CAB Evidence on Mental Health and Social Exclusion* (Citizens Advice 2004); Work and Pensions Committee, *Incapacity Benefits and Pathways to Work* HC 616 (2005–06) Mind Evidence.

reaching proposal argues that there could be merit in a return to the more informal 'social model' of assessment used for the former invalidity benefit test, which was abolished in 1995.

The final chapter summarises the thesis and answers the Research Questions posed at the outset. The thesis establishes that people with MH problems experience significant difficulties, over and above those that all claimants might encounter, when claiming IB/ESA, and that although problems arise with both systems, those with ESA are greater. The process of assessment remains the biggest barrier to a successful benefit claim on MH grounds, and this problem will be solved only by a return to informal assessment or wholesale re-writing of the assessment descriptors. The ESA scheme and ongoing reforms appear to have worked well for people who are at the most severe end of the spectrum of mental illness but the situation has worsened for claimants with lesser MH problems.

Making this a thesis dealing with people

The impetus to write this thesis derived from the author's work with mentally ill clients, as a welfare rights adviser and tribunal representative. The experiences of these clients and the difficulties they faced in securing and maintaining entitlement to IfW benefits have informed this research. The management of Corby Borough Welfare Rights and Citizens Advice Bureau (CBWR&CAB) gave permission for clients to be asked to be involved with this research, and all clients of that agency whose experiences are described have given verbal, yet informed, consent to inclusion of their anecdotes in this thesis.

It would be easy for academic research of this nature to lose sight of the fact that the social security system impinges on the lives of real people who are among the most

vulnerable in society. The case studies in this thesis acknowledge that possibility, are intended to give life to the narrative, but in no way imply that the experiences recounted can be used as a statistically significant base from which conclusions may be drawn. However, documents such as Citizens Advice's Social Policy reports which are based on nationally collected evidence from Citizens Advice Bureaux indicate that these problems are not uncommon. For the individual claimant concerned, any difficulties they face are worrying and may impact negatively on their already poor mental state. All claimant quotations (printed in *Monotype Corsiva*) and the case studies are those of actual advice agency clients.

This researcher's close engagement with benefit claimants, advisers and the welfare rights community have enabled her to gain a distinctive view of the real problems faced by benefits claimants. Attendance at conferences organised by the Child Poverty Action Group, National Association of Welfare Rights Advisers and participation in a colloquium run by the Centre of Disability Law and Policy, National University of Ireland, Galway have all contributed to gaining insight into the difficulties experienced by claimants with MH problems, and have shown that the experiences of CBWR&CAB clients are not uncommon. Use has also been made of a variety of documentary sources, including that from several other welfare rights and advice agencies. Clients of these agencies are disproportionately those who have problems in securing their entitlement to benefit. For this reason it is difficult to gauge the precise extent to which such problems are typical.

CHAPTER ONE

MENTAL ILLNESS, ABILITY TO WORK AND EMPLOYABILITY

Introduction and overview

The system of social security benefits for people who are unable to work because of illness or disability is complex and the route to a successful claim requires numerous steps each of which may be problematic for claimants. In *Dealing with the Complexity of the Benefits System*, the National Audit Office reports on research by the Disability Alliance which concluded that 'claiming benefit can require a degree of physical and mental commitment that would tax perfectly fit people'.[1]

This chapter identifies the group of claimants on which this thesis concentrates, and explains why claimants with mental health (MH) problems have become the focus for welfare reform. It specifies the most prevalent mental illnesses, their incidence and symptoms, and the ways in which these may impact on a sufferer's ability to seek and retain employment, or make a benefit claim. It also outlines some of the particular problems faced by mentally ill benefits claimants, both in general and by claimants with specific illnesses. The chapter considers the statistical significance of mental illness as a factor in claims for incapacity for work (IfW) benefits and the socio-economic factors relevant to mental illness. It also explains why many people with MH problems are unable to work or, if they could work, why they are unlikely to secure employment.

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[1] Comptroller and Auditor General, NAO HC 592 (2005–06) 44.

This establishes that the attitudes and perceptions of (prospective) employers are as relevant to solving the problem of absence of people with MH difficulties from the workforce as are those of the mentally ill. This finding has important implications for the policy of successive Governments which have adopted a policy of welfare to work, underpinned by the assumption that most MH conditions are treatable. This analysis lays the foundation for subsequent chapters which consider how claimants' illnesses affect their ability to secure and maintain entitlement to incapacity for work (IfW) benefits.

What is mental illness?

The Mental Health Act 1983 provides for compulsory admission to hospital of people who pose a risk to their own health or safety or that of others.[2] Its definition of 'mental disorder' was amended by the Mental Health Act 2007[3] to 'any disorder or disability of the mind'.[4] The amendments also removed earlier references to 'mental impairment', 'severe mental impairment' and 'psychopathic disorder'.[5] The Explanatory Notes to the 2007 Act cite as examples of clinically recognised mental disorders, mental illnesses such as schizophrenia, bipolar disorder, anxiety or depression, as well as personality disorders, eating disorders, autistic spectrum disorders and learning disabilities.

Various terms such as 'mental illness', 'mental distress', 'psychiatric disorder' and 'mental health problems' are used to describe a range of symptoms which affect a

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2 s 2(2)(b).

3 in force from 3 November 2008.

4 s 1(2).

5 Mental Health Act 2007 s 1(3).

person's ability to undertake 'normal' daily activities. Dictionary definitions suggest that these terms are interchangeable.[6] The term 'mental disablement' which reoccurs frequently in legislation on sickness and incapacity benefits will be assumed to be the consequence of mental illness etc. For precision, the language and terminology of psychiatric diagnosis used in this thesis conform to that used in the original source.

Severe mental illness

Under the incapacity benefits regime, severe mental illness was defined as a condition

> involving the presence of mental disease, which severely and adversely affects a person's mood or behaviour, and which severely restricts his social functioning, or his awareness of his immediate environment.[7]

A person who could provide 'medical evidence'[8] that they were suffering from severe mental illness would automatically have been treated as incapable of work[9] and would not have needed to undergo medical examination. When ESA was introduced in October 2008 the concept of 'severe mental illness' disappeared, as did automatic exemption from assessment. Only a limited range of claimants are treated as having limited capability for work. Chapter Five includes further discussion and details of assessment of incapacity and of possible exemptions.

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6 *CIB/3328/1998* paras 6, 7.

7 SS(IFW) Regs reg 10(2)(e)(viii).

8 SS(IFW) Regs reg 10(2)(e).

9 SS(IFW) Regs reg 10.

Classification of Mental Illness[10]

This thesis is concerned more with the effects that mental illness has on an individual's interaction with the social security system than with accurate diagnosis of their condition. Nonetheless, it is useful to consider the more common psychiatric illnesses and their main features. This is because the various diseases have differing impacts on sufferers and affect their ability to work, seek and/or retain employment and cope with the intricacies of the benefits system, in different ways. The classification deployed here accords with that used by the Office of National Statistics (ONS) which recognises four broad categories:

- the psychoses
- the neuroses
- alcohol dependence
- drug dependence.[11]

The Disability Handbook[12] is written by DWP's Corporate Medical Group with advice from the Disability Living Allowance Advisory Board, a Non-Departmental Public Body with responsibility for giving advice to the Secretary of State for the DWP, and doctors working for the Department.[13] The *Handbook* provides decision-makers in the benefits system with authoritative information on the likely effects that the more

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10 The information in this section has been collated from several medical texts.

11 H Meltzer and others, *The Social and Economic Circumstances of Adults with Mental Disorders* (TSO, London 2002) 1. People with other conditions including dementia, personality disorders and eating disorders are usually excluded from surveys.

12 M Aylward, P Dewis and M Henderson, *The Disability Handbook* Corporate Medical Group, online version 2007 – <http://www.dwp.gov.uk/publications/specialist-guides/medical-conditions/the-disability-handbook/> accessed 13 October 2010.

13 On 14 October 2010 the Government announced its intention to abolish the DLAAB: *Public Bodies Reform – Proposals for Change,* <http://www.number10.gov.uk/wp-content/uploads/2010-10-14-Public-bodies-list-FINAL.pdf> accessed 14 October 2010.

commonly occurring medical conditions have on a person's care and/or mobility needs. The medical information which follows has been summarised from Chapter 19 of *The Disability Handbook* and from Mind factsheets.[14]

The Psychoses

The psychoses, which affect thought, mood and behaviour, are the more severe form of illness in which patients lose touch with reality and have disturbed thought processes. Schizophrenia and manic-depression are the most common psychotic illnesses.

Schizophrenia

In the UK, the annual incidence of schizophrenia is estimated at 0.1 or 0.2 per 1000, with a prevalence of 3 per 1000.[15] Symptoms of schizophrenia are described as either positive (delusion, hallucinations, disordered thinking, suspicion/paranoia) or negative (withdrawal, loss of motivation). These symptoms make it difficult for sufferers to seek help from advice agencies and to engage with officialdom.

> *I don't trust people. I get so anxious that I can't take in what they are saying.*[16]

A further difficulty is that many schizophrenics have poor insight into their illness. This may lead them to complete forms inadequately or to deny the fact that they are ill. Most sufferers will be treated with anti-psychotic drugs that are known to

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14 *Mind Factsheets* <http://www.mind.org.uk/Information/Factsheets/> accessed 4 April 2007.

15 — *Oxford Textbook of Medicine* (4th ed, OUP, Oxford 2005).

16 Client of Neath Mind, quoted in J Stenger, *The Big Book of Benefits and Mental Health 2006/07* (Neath Mind 2006) 6.

have unpleasant side-effects which include abnormal face and body movements, tremor, apathy and drowsiness. Because their psychotic symptoms improve on treatment they may be tempted to discontinue medication, resulting in a relapse. Thus their condition and their capacity for employment fluctuate.

Manic depression (Bipolar disorder)

Manic depression manifests itself by mood swings; bouts of euphoria alternating with psychotic depression, sometimes with an intervening stable period. During the manic phase people feel enormously energetic and powerful and tend to become hyperactive, going without sleep and embarking on totally unrealistic schemes or projects. They may exaggerate their own importance to the point of becoming delusional. The depressive phase resembles other forms of depression. Sufferers display lack of energy and interest in life, low self-esteem, feelings of guilt and despair and may become suicidal. In any one year the incidence of manic-depression is 10–15 per 100,000 men and up to twice this rate for women.[17]

The Neuroses

In neuroses, which are far more prevalent, sufferers' thought processes are unimpaired, and they neither lose touch with reality nor experience disturbed thought processes. Anxiety is a symptom of all neurotic illnesses, and the person may also be depressed and/or have obsessional thoughts.

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[17] Aylward, Dewis and Henderson (n 12) [19.6.2. (viii)].

Anxiety

Anxiety is a normal and appropriate reaction to stress, but should it continue once the stress has been relieved, or if it becomes disproportionate, then it is a recognisable illness. Symptoms include fearfulness, difficulty concentrating, impatience and preoccupation with one subject. Anxiety is frequently accompanied by physical symptoms such as sweating, tremor and rapid pulse.

> *I can't concentrate to do anything. I had three lots of forms but they always ended up torn to pieces in the bin.*[18]

Agoraphobia is a form of acute anxiety which people experience when they leave their home, enter public spaces or find themselves in places from which escape could be difficult. They acquire avoidance techniques and may suffer panic attacks in stressful situations.

> *I feel safe at home. Outside my front door is just too "open". If I have to go out I get panicky and can't breathe.*[19]

Although people with agoraphobia may actually be capable of work, their difficulty is that they might not be able to leave their home or to travel either to seek or engage in employment, visit Jobcentres or attend medical examinations in connection with benefits. Other phobias[20] such as fear of heights or enclosed spaces may restrict the type of work that someone can do.

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18 Client of Neath Mind, quoted in Stenger (n 16) 6.

19 Client MC of CBWR&CAB. Statement made at an incapacity benefits appeal tribunal, 22 January 2007.

20 A persistent, abnormal, and irrational fear of a specific thing or situation that compels one to avoid

Depression

Clinical depression is more than occasionally feeling sad or low. It is a strong mood involving discouragement, despair, or hopelessness that can last for weeks, months, or even longer, and which interferes with a person's ability to participate in normal activities. The illness is characterised by irritability, apathy and feelings of inadequacy. Speech, thought and movement slow down, concentration and memory suffer, and making decisions becomes difficult.

> *I haven't been able to open any letters for months. I just shove them in a bag under the bed. That doesn't mean that I forget about them but I just can't face knowing what's in them.*[21]

People with depression may have considerable difficulty motivating themselves to find out about any benefit entitlement or pursuing a claim.

The symptoms of depression may fluctuate or vary in degree. Some people report feeling depressed only in winter, a condition known as Seasonal Affective Disorder.

Obsessive-compulsive Disorder (OCD)

OCD sufferers have obsessional thoughts which intrude into their mind and dominate their activity. They engage in pointless and excessive ritual behaviour and become anxious if this is disrupted. Indecision and the time occupied by rituals make it difficult to sustain employment, claim benefits or meet conditionality requirements.

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it, despite the awareness and reassurance that it is not dangerous.

[21] Client of Neath Mind, quoted in Stenger (n 16) 6.

> *Before I post something I have to check it time and time again to make sure that I've put all the information in. Sometimes I have to reopen the envelope several times. I've stood with my hand through the slot in the postbox, quite unable to let the letter drop.*[22]

Alcohol and drug dependence

Alcoholics have a psychological craving for drink and are unable to control their alcohol consumption. Without alcohol they develop withdrawal symptoms which include shakiness, sweating and visual hallucinations. Their lifestyle tends to be arranged around their drinking. Regular use of intoxicating drugs also leads to withdrawal symptoms, although these will vary according to the drug in question. Prolonged abuse of both alcohol and drugs eventually results in physical and psychological deterioration. Employers' attitudes to both addicts and former addicts mean that they are virtually unemployable.[23]

> *The doctor said that I was fit for work. But nobody's going to offer me a job, so what's the point of signing on?*[24]

Although mental and behavioural disorders due to psychoactive substance use are recognised diseases,[25] the Mental Health Act 2007 specifically excludes dependence on alcohol and drugs as mental disorders for the purposes of the Act.[26] Nonetheless, alcohol and drug dependence are included here because they are built-in to ONS data on

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22 ibid.

23 See eg L Sutton and others, *Drug and Alcohol Use as Barriers to Employment: A Review of the Literature* (Centre for Research in Social Policy, Loughborough University 2004) [7.6.4. ff].

24 Client FB of CBWR&CAB.

25 Disease codes F10-F19, *International Classification of Diseases ICD-10*, <http://www.who.int/classifications/apps/icd/icd10online/> accessed 30 December 2007.

26 s 3.

MH[27] and because in the personal capability assessment for incapacity benefits, alcohol dependence in particular, is considered to be a condition which could affect capacity for work.[28] Furthermore, substance abuse, as a factor in IfW, is an issue which the DWP seems determined to tackle.[29]

Exclusion of learning disability

This thesis concerns those whose mental health is such that they are unable to work, and who claim IfW benefits. Under the incapacity benefits regime, individuals with a learning disability (also referred to as people with learning difficulties, mentally 'handicapped' or 'impaired')[30] were assessed for their capacity to undertake employment by the same tests as the mentally ill, with exemption only for those with severe learning difficulties.[31] The new Limited Capability for Work Assessment (LCWA) for employment and support allowance (ESA) includes descriptors which are targeted more directly at claimants with learning disabilities.[32]

Learning disabilities, which are either congenital or acquired during childhood as a result of accident or disease, are disorders of learning and cognition, the most common features of which are developmental delay, communication difficulties, slow or poor acquisition of new skills, memory deficit, difficulty with problem solving, lack

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27 See eg Meltzer and others (n 11).

28 SS(IFW) Regs sch, activity 16 (daily living). This provision was removed for ESA.

29 WRA 2009 s 11 and sch 3; DWP *2010 Drug Strategy: Consultation Paper* (DWP 2010) 13 and Questions E5-E8.

30 In the UK the Department of Health's preferred terminology is 'learning disability'. Educationalists use 'learning difficulties' to describe dyslexia, dyscalculia and similar conditions. In the US both these terms are used in an educational context, whereas 'intellectual disability' is used to describe mental impairment.

31 SS(IFW) Regs reg 10(e)(i). Defined as having: a condition which results from the arrested or incomplete physical development of the brain, or severe damage to the brain, and which involves severe impairment of intelligence and social functioning.

32 ESA Regs reg 19(2) and sch 2 part 2 para 12.

of social inhibition and poor understanding of social norms.[33] Learning disability which is not amenable to 'treatment', and mental illness, characterised by inappropriate feelings and behaviours and from which recovery is possible, are fundamentally different and present diverse issues.

People with learning disabilities can be expected to behave rationally at their own functional level, whereas a person with mental illness may oscillate between normal and irrational behaviour. Because of these differences, people with MH problems and those with learning disability could be expected to score points on different activities when assessed for IfW. For example, people with learning difficulties would score points on the LCWA activity of Learning and Comprehension in the Completion of Tasks,[34] whereas individuals with mental illness but normal intellect would not score on this activity. For the activity of Getting About,[35] 'overwhelming fear and anxiety' are pre-requisites, and these may be features of some mental illnesses but not of learning disability.

Most people with learning disabilities have a carer or support worker, who can assist them with claims for social security benefits, and they often have an appointee with legal authority to act on their behalf. People with MH difficulties, unless they are exceptionally severe, are assumed to have the capacity to claim for themselves[36] and do not have an appointee. On account of the differences noted above, learning disability does not form part of this study.

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33 J Marshall 'About Learning Disabilities' <http://www.aboutlearningdisabilities.co.uk/> accessed 5 March 2011.

34 ESA Regs sch 2 para 12.

35 ESA Regs sch 2 para 18.

36 Mental Capacity Act 2005 s 1.

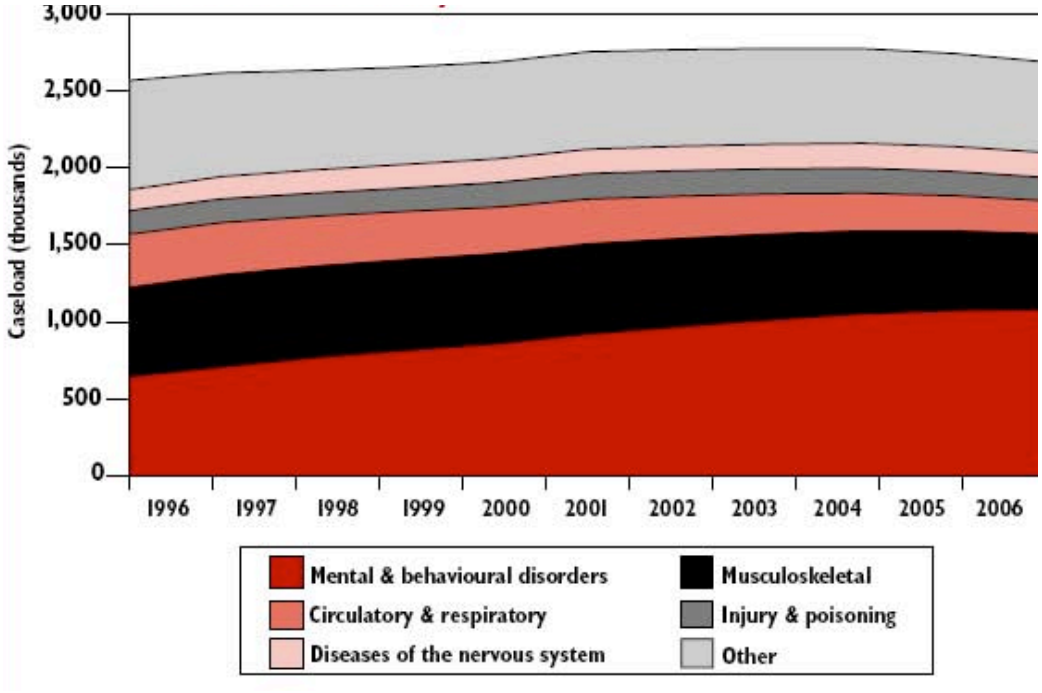
Incapacity for work benefits and mental illness

People with MH problems represent a significant, and increasing, proportion of IfW benefit claimants. The number and proportion of female claimants is also increasing. People who have claimed IfW benefits for lengthy periods are likely to remain long-term benefit recipients. This phenomenon is not unique to the UK and it occurs globally.

In its 2006 Welfare Reform Green Paper the Department for Work and Pensions (DWP) estimated that around 40 per cent of all incapacity benefits recipients claimed because of MH conditions,[37] and commented that these conditions could vary widely and be complex and challenging. More precise statistics show how both the number and proportion of incapacity benefits claimants with mental illness rose steadily. This is illustrated in Figures 1 and 2.

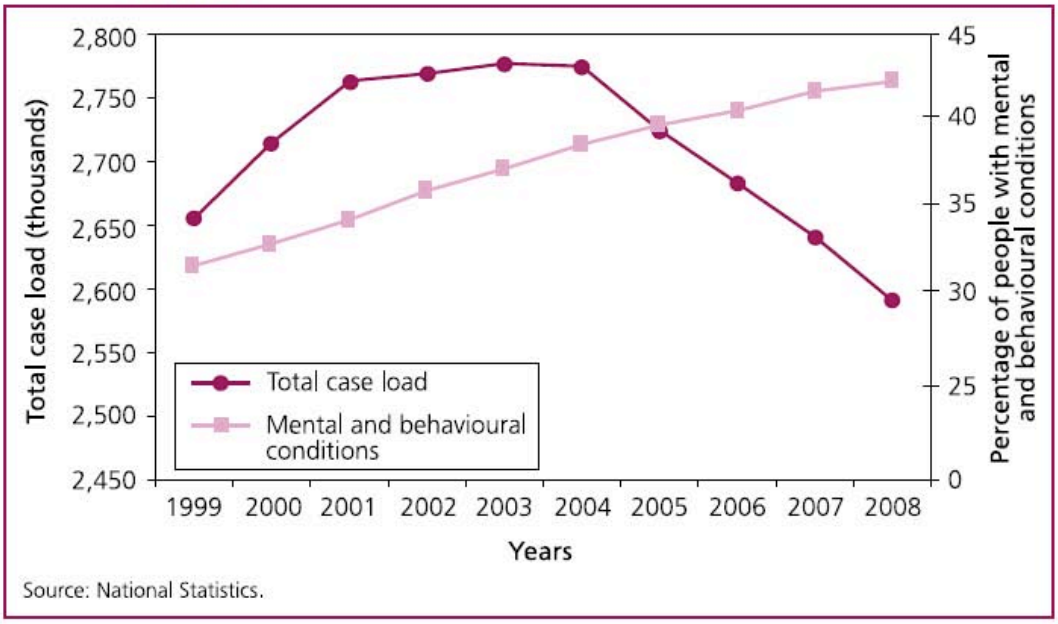
[37] Secretary of State for Work and Pensions, *A New Deal for Welfare: Empowering People to Work* (Cm 6730, 2006) [71].

Figure 1: Incapacity benefits caseload by primary health condition or disability



Source: DWP annual spring quarters.[38]

Figure 2: Incapacity benefits claimants with a mental health condition[39]

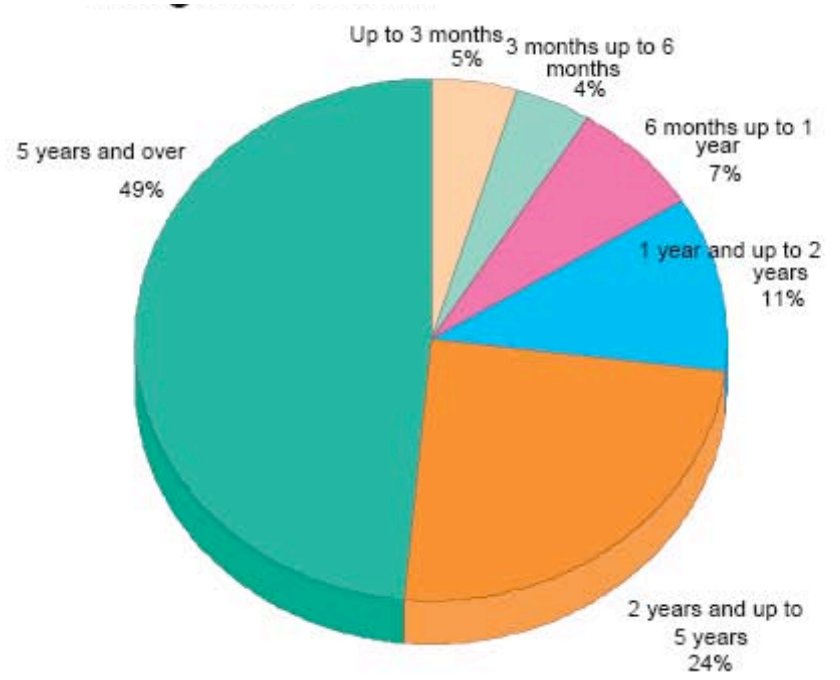


[38] reproduced from HM Treasury, *Budget 2007. Building Britain's Long-term Future: Prosperity and Fairness for Families* HC 342 2007 Chart 4.7.

[39] reproduced from R Perkins, P Farmer and P Litchfield *Realising Ambitions: Better Employment Support for people with a Mental Health Condition* (Cm 7742, 2009).

If claimants whose main diseases are physical in nature, but who also have a secondary diagnosis of mental illness are included in the figures the proportion of claimants with MH problems rises to more than 50 per cent. The 'problem' is that not only is the proportion of new claimants (inflow) with mental disorders increasing, but also that these claimants are remaining on incapacity benefits for longer,[40] as shown in Figure 3.

Figure 3: Duration of claim for claimants with mental illness[41]



Waddell and Aylward point out that there is a significant association between reported mental illness and chronic pain.[42] Statistics on the outcomes of the work capability assessment for employment and support allowance show that 12 per cent of

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40 PA Kemp and P Thornton 'Disguised Unemployment? The Growth of Incapacity Benefit Claims in Great Britain' in PA Kemp A Sundén and BB Tauritz (eds) *Sick Societies? Trends in Disability Benefits in Post-industrial Welfare States* International Social Security Association, Geneva 2006.

41 *Labour Market Statistics* <http://www.cesi.org.uk> accessed 16 July 2007 – figures relate to February 2005.

42 G Waddell and M Aylward, *The Scientific and Conceptual Basis of Incapacity Benefits* (TSO, Norwich 2005) 78.

claimants whose primary conditions were mental and behavioural disorders scored points on the lower limb impairment descriptors of the test, and one fifth of claimants with cancer score on the MH descriptors.[43] This suggests that for some patients their mental illness has a physical cause and/or physical effects.

Waddell and Aylward also noted conflicting evidence regarding the trend of increasing claims on mental ill-health grounds.

- UK epidemiological surveys show no significant change in the population prevalence of most neurotic symptoms, overall rates of neurotic disorders or rates of psychotic disorders between 1993 and 2001.
- Clinical and occupational management of MH conditions have barely changed during this period.
- Total inflow to incapacity benefits remained static, while outflow was reduced.
- Since the introduction of IB and the All Work Test in 1995, there has been a 40 per cent fall in inflow for all other conditions, but not for MH disorders.
- There is some evidence of reduced stigma, discrimination and exclusion of people with mental illness. This could increase the social acceptability of sick certification, sickness absence and benefit claims for MH disorders.[44]

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43 R Willis, *Employment and Support Allowance: Work Capability Assessment: Official Statistics* (DWP, August 2010) Table 8.

44 ibid.

Speaking shortly before publication, in 2006, of the Welfare Reform Bill Jim Murphy, Minister of State (Employment and Welfare Reform)[45] and John Hutton, Secretary of State for Work and Pensions,[46] made identical comments about the increased inflow of claimants with mental illnesses to incapacity benefits, describing MH problems caused by stress at work as 'as big a problem in this century as industrial injuries were in the last'.

Much of the increase is due to a higher number of female claimants. In 1986 only 27 per cent of people claiming incapacity benefits were women.[47] In 2005, whereas 42 per cent of incapacity benefits recipients were female, women comprised 44 per cent of those claiming because of mental or behavioural disorders.[48] The greater number of female claimants is due in part to a higher proportion of women in the workforce. In the mid-1980's men filled 2 million more jobs than women. In June 2005 the numbers in employment were similar, with each of the sexes performing about 13.3 million jobs.[49] Also, since the phasing out of the married women's reduced rate contributions from May 1977,[50] more women are now able to satisfy the NI contribution conditions for IfW benefits.[51] Berthoud estimates that 16 per cent of the growth in

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45 *The Westminster Hour,* BBC Radio 4, 2 July 2006.

46 *The Today Programme,* BBC Radio 4, 4 July 2006.

47 D Hencke, 'Stress Therapy Offer to Jobless' *The Guardian* 4 July 2006. The article also stated that 'the government is to offer therapy … to people who have to quit work because of stress and depression'.

48 Incapacity Benefit/Severe Disablement Allowance Caseload: Disease code by Gender, ONS, November 2005.

49 — *Focus on Gender* ONS October 2006.

50 *Reduced Rate National Insurance Contributions* <http://www.hmrc.gov.uk/faqs/women_reduced_rate.htm> accessed 15 June 2007.

51 Contribution conditions are discussed in more detail in Chapter Four.

numbers of incapacity benefits claimants was accounted for by an increase in the number of women who both work and satisfy the contribution conditions.[52]

Waddell and Aylward also report that the trend of increasing numbers of claimants with mental illnesses started in the SE of England and spread progressively to the rest of the country. They suggest that this is a 'social rather than a biological phenomenon'.[53]

Early statistics, for ESA claims made to November 2009, show that claimants with MH conditions comprise 34 per cent of those who have been assessed as having limited capability for work.[54] These figures are not directly comparable to those for incapacity benefits because they do not yet include long-term claimants, neither do they include the impact of appeals.

As is shown in Table 1, the increasing proportion of those claiming IfW and disability benefits on the basis of mental illness is an international phenomenon.

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52 R Berthoud, *Disability Benefits. A Review of the Issues and Options for Reform* (York Publishing Services/Joseph Rowntree Foundation 1998).

53 Waddell and Aylward (n 42) 78.

54 R Willis, *Employment and Support Allowance: Work Capability Assessment: Official Statistics* (DWP, August 2010) Table 5.

Table 1: Proportion of mental illness in disability and incapacity benefits stock and inflow[55]

	Stock			Inflow		
	1990	1995	1999	1990	1995	1999
Australia (nc)	..	..	31	..	..	32
Austria	9	10	..	10	11	17
Canada	11	16	21	10	17	25
France	..	..	..	..	..	27
Germany	..	..	..	17	23	28
Netherlands	27	31	30	30	26	33
non-contributory	36	39	46	63	53	52
Norway	28	29	29	20	23	25
Sweden	24	26	..	16	20	24
Switzerland	34	36	39	..	..	34
United Kingdom	16	17	23	13	18	26
non-contributory	..	40	37	..	31	35
United States	27	31	31	21	23	22
non-contributory	53	58	59	41	42	40
OECD (10)	-	-	35	-	-	32

nc Non-contributory benefits.
.. Data not available.
– Not applicable.

Stock = existing claimants.
Inflow = new claimants.

Source: OECD database on programmes for disabled persons.

The International Social Security Association reports that not only is mental illness the leading cause of incapacity in industrialised countries, but also that it is the fastest growing condition among young workers claiming benefits.[56]

[55] — *Transforming Disability into Ability: Policies to Promote Work and Income Security for Disabled People* (OECD 2003) Table 4.12.

[56] F Bloch and P Rienk, *Who Returns to Work and Why? A Six-Country Study on Work Incapacity and Reintegration* (International Social Security Association, Geneva 2001) 34.

Incidence and impact of mental illness

The Disability Handbook states that, depending on the definitions used, at any one time about 10 per cent of the population is affected by some kind of MH problem.[57] Because many people recover from mental illness and possibly relapse, this implies that a higher proportion of the population will experience MH difficulties at some time in their life.

Lord Richard Layard, emeritus professor at the Centre for Economic Performance of the London School of Economics, and adviser to the Government on MH, puts the figure for depression and anxiety alone as high as 15 per cent, and describes mental illness as having taken over from unemployment as the greatest social problem in the UK.[58] Many people who experience mental distress go unrecognised and untreated, and may not have an exact diagnosis.

Some psychiatrists explain the increase in the number of IfW benefits claimants by suggesting that there is a growing trend in applying a diagnostic label to milder mental disorders such as depression, which is being recognised and treated more frequently than in the past.[59] Others have criticised the widespread diagnosis of depression as inappropriate medicalisation of understandable responses to adverse circumstances.[60] Certainly, a review commissioned to consider methods of reducing worklessness amongst people with MH conditions, and tasked with making proposals that could be enacted in the short to medium term without either new resources or

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57 Aylward, Dewis and Henderson (n 12) ch 19.

58 'The Case for Psychological Treatment Centres' (2006) 332 BMJ 1030.

59 E Fombonne, *Time Trends and Possible Explanatory Mechanisms* in M Rutter and DJ Smith (eds) *Psychosocial Disorders in Young People* (John Wiley for Academia Europaea 1995).

60 I Heath, 'There must be Limits to the Medicalisation of Human Distress' (1999) 318 BMJ 439.

primary legislation, suggested non-medical solutions many of which required changes in attitude by employers.[61]

The most recent published data shows that on average, employees take seven days off work annually for health reasons. MH problems are estimated to account for 40 per cent of this figure, or 2.8 days a year. In aggregate this amounts to 70 million working days lost each year, a figure which has risen steadily for 25 years. This compares to about 0.7 million days lost annually because of industrial action. Of the 70 million lost days for MH reasons, about 10 million each year are due to anxiety, depression and stress which employees ascribe directly to their work or working conditions.[62] A further £15.1 billion a year is estimated to be lost by impaired performance at work by people who report for work when they are mentally ill. This 'presenteeism' accounts for 1.5 times as much working time lost as absenteeism and costs more to employers because it is more common among higher-paid staff.[63]

Moncrieff and Pomerleau, who analysed DSS data on invalidity/incapacity benefits from 1984 to 1995, reported on the significant increase in both the number and proportion of claimants with depression and neurotic conditions.[64] Figure 4, reproduced from their report, depicts the number of days of incapacity ascribed to various mental disorders. It shows a small but gradual increase in days of work lost through mental illnesses other than the neuroses, and a steep rise in absence due to depression and the other neurotic disorders during that decade.

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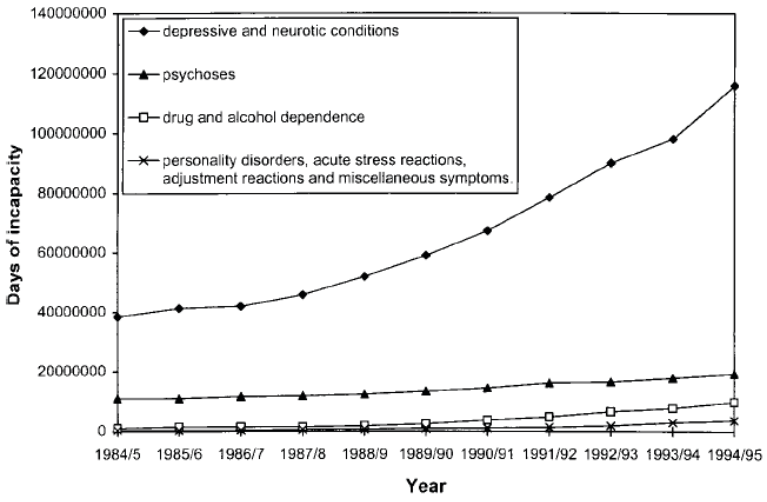
61 R Perkins, P Farmer and P Litchfield, *Realising Ambitions: Better Employment Support for people with a Mental Health Condition* (Cm 7742, 2009-10) 95-100.

62 — *Mental Health at Work: Developing the Business Case* (Sainsbury Centre for Mental Health 2007) 2.

63 ibid.

64 J Moncrieff and J Pomerleau, 'Trends in Sickness Benefits in Great Britain and the Contribution of Mental Disorders' (2000) 22 Journal of Public Health Medicine 59.

Figure 4: Days of incapacity as a result of mental disorders



Socio-economic factors in mental illness

ONS reports that mental illness is strongly linked to several aspects of social inequality. People living in England and Wales in deprived industrial areas are more likely to be treated for depression than people living in any other type of area. Between 1994 and 1998, 34 per 1,000 male patients and 77 per 1,000 female patients in deprived industrial areas had been treated for depression, compared with rates of 21 and 55 respectively in suburban areas. The gender variation is apparent in all areas, and in England and Wales overall, the rate for females was two and a half times that for males.[65]

Similar trends were noted in the Acheson Report into Health Inequalities.[66]

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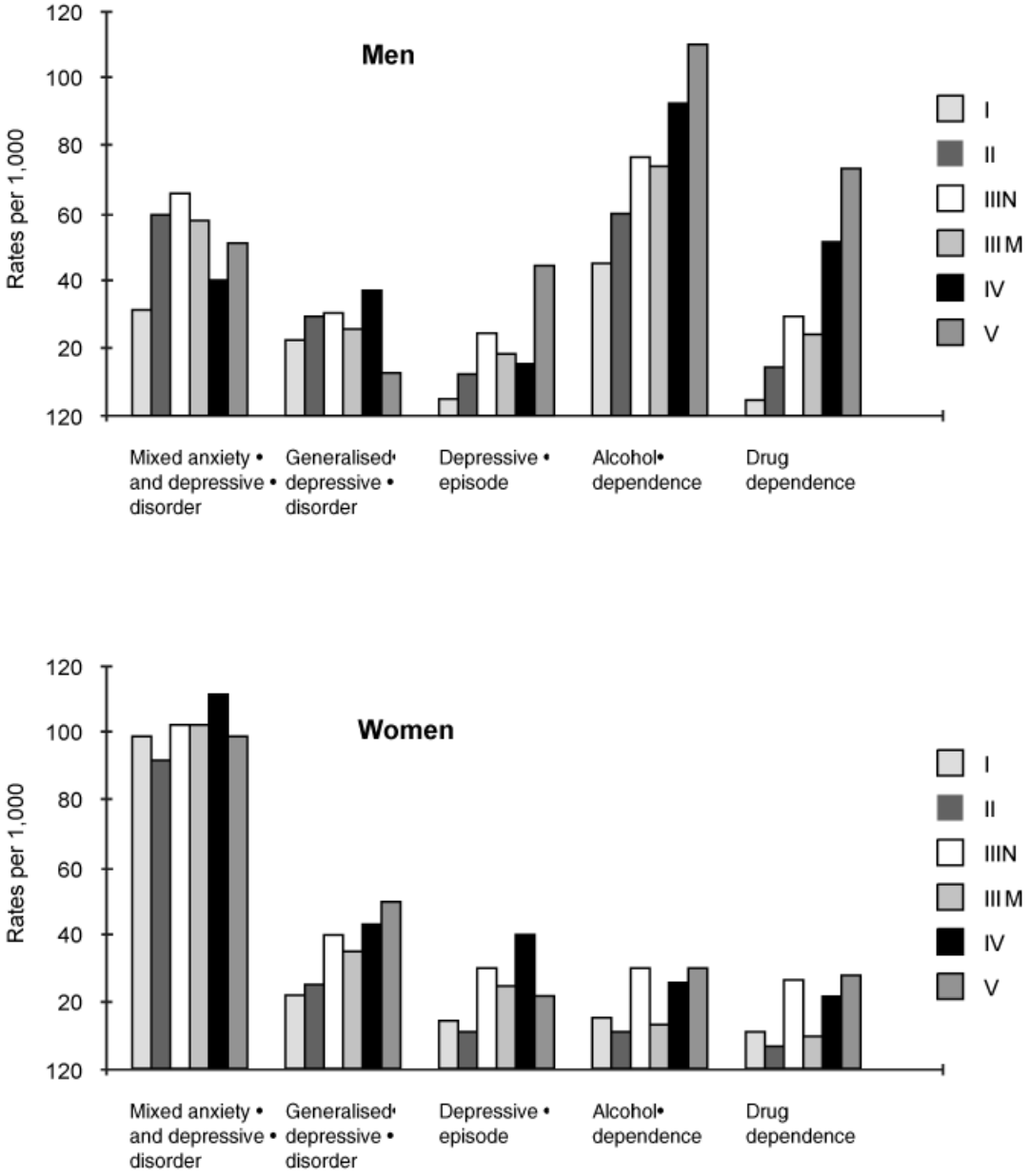
65 — 'Prevalence of Treated Depression: by Type of Area and Gender, 1994-1998' Social Trends 31 ONS.

66 D Acheson, *Independent Inquiry into Inequalities in Health: Report* (TSO, London 1998).

Figure 5: Prevalence of mental health problems, by social class, men and women, aged 16-64, Great Britain, 1993-94.



Source: Office of Population Censuses and Surveys, 1995.

Chart reproduced from the Acheson Report.

The Acheson inquiry showed that MH varies markedly with social class. Neurotic disorders were more common amongst women in classes (IV and V) than in classes (I and II), whereas men showed a doubling in alcohol and drug dependence

between classes (IV and V) and classes (I and II). A more recent review of the evidence confirmed that common mental disorders are significantly more frequent in socially disadvantaged populations.[67]

Moncrieff and Pomerleau maintain that diagnosis of the milder MH conditions, whose medical validity may be disputed, is likely to be particularly sensitive to political concerns and the economic situation. Socio-economic conditions, particularly the proportion of men in the lowest social class, correlate to the number of claimants of incapacity benefits, leading to the conclusion that incapacity benefits may represent disguised unemployment.[68] This proposition is supported by research conducted across Britain by Beatty and Fothergill who noted the steep increase in claims for sickness-related benefits in older industrial areas affected by job-losses.[69] However, it is important not to confuse correlation with causation.[70]

The Joseph Rowntree Foundation asserts that financial hardship and insecurity are sources of stress, which is in turn a contributory factor to the onset and severity of mental illness.[71] Financial strain is a powerful predictor of the onset and longer duration of episodes of common mental disorders.[72] Similar conclusions were reached

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67 T Fryers, D Meltzer and R Jenkins, 'Social Inequalities and the Common Mental Disorders' (2003) 38 Soc Psychiatry Psychiatr Epidemiol 229.

68 Moncrieff and Pomerleau (n 64).

69 C Beatty and S Fothergill, 'The Diversion from "unemployment" to "sickness" across British Regions and Districts' (2005) 39 Regional Studies 837.

70 M Blastland and A Dilnot, *The Tiger that Isn't* (Profile Books 2007), Chapter 12 'Correlation: Think Twice'.

71 N Gould, *Mental Health and Child Poverty* (Joseph Rowntree Foundation 2006) 5.

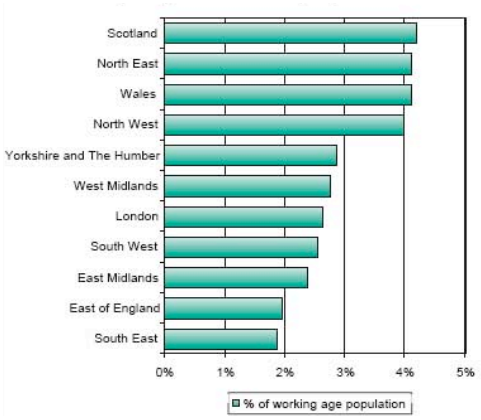
72 S Weich and G Lewis, 'Poverty, Unemployment and Common Mental Disorder: Population Based Cohort Study' (1998) 317 BMJ 115.

by Davis who summarised them in a literature review commissioned by the Office of the Deputy Prime Minister's Social Exclusion Unit.[73] A Green Paper noted that

> As many as half of the most severe pockets of deprivation in Britain are contained within the 100 Parliamentary constituencies that have the largest numbers of people claiming incapacity benefits.[74]

As Figure 6 shows, the proportion of incapacity benefits claimants on the grounds of mental illness is highest in the older industrial regions in the North and Wales, and lowest in the more prosperous South East and Eastern regions, where the increasing trend began.[75]

Figure 6: IB mental health claimants as a proportion of population[76]



More detailed statistics published by the Association of Public Health Observatories, and illustrated in Figure 7, highlight huge disparities in the proportion of IB mental health claimants in different parts of England.

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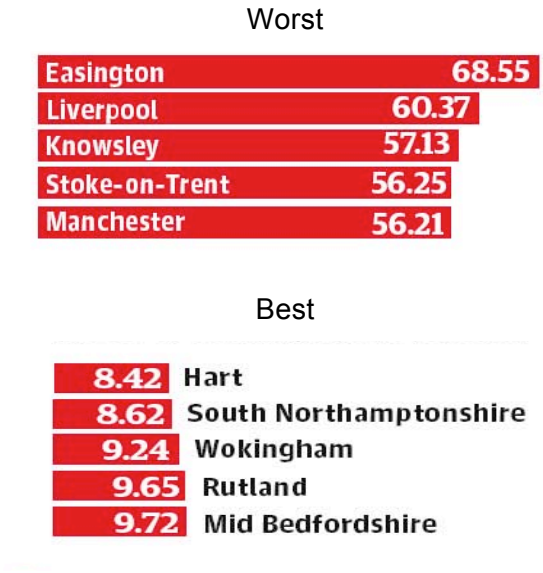
73 A Davis, *Mental Health and Personal Finances: A Literature Review* (Institute of Applied Social Studies, University of Birmingham 2003) 3.

74 DWP (Cm 6730, 2006) (n 37) [6].

75 Waddell and Aylward (n 42) 78.

76 *Labour Market Statistics January 2007* <http://www.cesi.org.uk> accessed 16 July 2007.

Figure 7: IB claimants for mental illness – rate per thousand of working age population[77]



Writing about Community Mental Health Services, an American authority states:

> Most mental health professionals share the belief that social, economic and environmental factors make a major, if not overwhelming, contribution to the development of psychopathology among the poor.[78]

The Green Paper, *A New Deal for Welfare: Empowering People to Work*,[79] proposed ways in which the Government intends to reduce the number of claimants on IfW benefits, as a means of reducing poverty. While it recognises the 'clear link between benefits dependency and hardship',[80] it ignores the possibility that the same

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77 Statistics for 2006. Source: The Guardian Tuesday 24 June 2008.

78 D Evans and WL Claiborn (eds), *Mental Health Issues and the Urban Poor* (Pergamon Press Inc 1974) 11.

79 Cm 6730, 2006.

80 ibid.

factors which produce such hardship may also be the cause of poor health and of poor MH in particular.[81]

Employment prospects for people with mental illness

As with physical illness, an individual's ability to function and to undertake employment will depend on a number of factors such as the severity of their symptoms, variability, treatment and the amount of support that they receive. Table 2 shows that compared to people with no disorder, those with a psychiatric disorder are more likely to be economically inactive (39 per cent compared to 28 per cent), and less likely to be employed (58 per cent compared to 69 per cent). However, the majority of people with psychiatric disorders are actually working.

Table 2: Employment status of adults with psychiatric disorders[82]

Employment status	Female		Male		All	
	with a disorder	no disorder	with a disorder	no disorder	with a disorder	no disorder
Employed	55	62	61	75	58	69
Unemployed	3	2	4	4	4	3
Economically inactive	41	36	35	21	39	28

All figures are percentages.

Waddell and Burton, who undertook an extensive investigation into the scientific evidence for the relationship between work, health and well-being, concluded that employment is generally the most important means of obtaining adequate resources

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81 see for example, M Howard and others, *Poverty: the Facts* (4th edn, CPAG, London 2001).

82 N Singleton and others, *Psychiatric Morbidity among Adults Living in Private Households* (ONS 2000).

which enable full participation in society, and meets psychosocial needs. However they cautioned that work may also pose a health risk, and that any beneficial effects depended on the nature and quality of the work in question.[83] Statistics demonstrating correlation between employment and better health do not prove causation and, because of the 'health selection effect' (removal of sick people from the working population),[84] should be used with care.

Why can't they work?

There are a number of factors underlying the lower rates of employment of people with MH conditions, which include the attitudes of both individual sufferers and potential employers. The current welfare to work policy appears to be concentrated on claimants, with very little being done to encourage employers to take people with MH difficulties into the workplace.

The individual's viewpoint

The reasons why mentally ill people are unable to work will vary according to the nature of their illness, but cannot be divorced from their social situation and their previous experiences of applying for or undertaking employment. Some of the factors which may lead to loss of employment are:

- difficulty in arriving on time, due to poor motivation, fatigue or insomnia
- problems using transport (agoraphobia, panic attacks)
- inability to cope with stress
- problems with memory and/or concentration

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83 G Waddell and AK Burton, *Is Work Good for Your Health and Well-being?* (DWP, TSO Norwich 2006) ix.

84 ibid 15.

- difficulties with communication and relationships
- incidents of anger or aggression
- use of alcohol or drugs.

There are further reasons why someone with a mental illness might find it difficult to seek work:

- fear of, or inability to cope with, repeated rejection by potential employers
- fear of bullying[85]
- fear of failure
- fear of social engagement
- fear of crowded situations
- concern regarding the financial consequences of leaving benefits
- uncertainty and risk aversion[86]
- worry about the availability of support.[87]

These factors may lead some people with mental illness to choose to take less challenging work that does not match their education, training and experience.[88]

An additional barrier is that any steps into employment can place both their current and future benefits at risk, and lead to loss of both incapacity and disability benefits, as illustrated in Case Study A. This is because the DWP adopts the approach

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85 Research conducted by the Mental Health Foundation showed that a third of employees with a mental illness had reported bullying at work which had caused or added to their mental health problems. — *Out at Work. A Survey of the Experiences of People with Mental Health Problems within the Workplace* 2002.

86 Stenger (n 16) 57.

87 Non-emergency mental health services are not usually accessible outside office hours, so a person in employment will effectively be denied support.

88 Jonathan Naess, Director, Stand to Reason (personal email correspondence 22 June 2007).

that a claimant who has started any kind of work or training has an improved condition and reduced care needs.[89]

Case study A[90]

Anne had suffered from mental illness since adolescence and received both incapacity benefit and disability living allowance for many years. When her own children were grown up she approached the Jobcentre with a view to becoming a nurse. Under the new Deal for Disabled people she was placed on a University course leading to a nursing qualification. Her ability to undertake a course of study was given as the reason for removing her disability living allowance.

After 15 months at University she suffered a mental breakdown and had to leave the course. She found that she was now not entitled to incapacity benefit because she could not meet the national insurance (NI) contribution tests. Her training course was not one which would have qualified for receipt of NI credits.[91]

In reality, a disabled person who starts work may have greater needs for care and support than they did prior to employment.[92]

It is also suggested that MH professionals are discouraging job applications by service users in the belief that a job rejection might be sufficient stress to trigger a relapse.[93] It has, however, been pointed out that employment preparation and support are not seen as core tasks for MH services.[94]

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89 see also eg Rightsnet Discussion Forum <http://www.rightsnet.org.uk/dc/dcboard.php?az=show_topic&forum=100&topic_id=6771&mode=full> accessed 30 April 2009; <http://www.rightsnet.org.uk/dc/dcboard.php?az=show_topic&forum=100&topic_id=6436&mode=full> accessed 24 November 2008.

90 Client KN of CBWR&CAB.

91 SS(Cr) Regs reg 7.

92 A Thomas and R Griffiths, *Disability Living Allowance and Work: Exploratory Research and Evidence Review* (DWP Research Report No 648 HMSO, Norwich 2010) 113.

93 M Rinaldi and R Hill, *Insufficient Concern* (Merton Mind 2000) 15.

94 J Evans and J Repper, 'Employment, Social Inclusion and Mental Health' (2000) 7 J Psychiatr Ment Health Nurs 15.

The employers' viewpoint

An employer's approach to the employment of a person suffering from mental illness will be based on different criteria. Employers require a workforce that is punctual, reliable and efficient,[95] but they might make assumptions about people with mental disorders which may not apply in individual cases.

Research by the Shaw Trust, a charity which assists people with disabilities to find work, has shown that one in five employers believes that employees who are off sick with mental problems for more than a few weeks will never recover.[96] One third of survey respondents also thought that these employees were less reliable than other staff.[97] People with MH difficulties are more likely to lose their jobs after becoming ill than those with physical problems.[98]

The Chartered Institute of Personnel Development has also reported that 18 per cent of organisations would reject an applicant who was currently receiving incapacity benefits because of mental ill-health. This is almost double the proportion that would exclude applicants with physical impairments.[99] This attitude, which is strongest in the private sector that has most UK jobs, persists despite the fact that disability equality legislation[100] applies to both groups of applicants.

American researchers have shown that both psychiatric symptoms and medical diagnosis were poor predictors of the ability of chronically mentally ill people to sustain

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95 see comments about absence and presenteeism at p 33, n 63.

96 — *Mental Health. The Last Workplace Taboo* (Shaw Trust 2006) 9.

97 ibid.

98 T Burchardt, *Employment Retention and the Onset of Sickness or Disability: Evidence from the Labour Force Survey Longitudinal Datasets* (DWP In-house Report 109 2003) [4.1.5].

99 — *Labour Market Outlook* (CIPD 2005–06) 15.

100 Disability Discrimination Act 1995, replaced from 1 October 2010 by the Equality Act 2010.

employment.[101] A person's prior employment history was the best demographic predictor of sustainable employment, and adjustment skills made in a workshop setting the best clinical predictor.[102]

Thus employers' discrimination against people with MH problems appears to be due more to false assumptions and stereotyping than to hard fact and statistical data.[103] The stigma of mental illness is so great that some members of the medical profession encourage people with MH problems, even if fully recovered, to lie about their medical history to prospective employers.[104]

Employment outcomes

When incapacity benefit was introduced in 1995 it was expected to produce significant savings by way of its structural changes and the new All Work Test, leading to disallowance of large numbers of claimants.[105] Research conducted shortly after introduction, showed that 325,000 claimants had been disallowed during its first three years. Of these 18 per cent were claiming primarily on the grounds of mental illness and around a third reported some kind of MH problem. Many of these disallowed claimants were found to be neither able nor ready to move into work, and most continued to report health problems. Follow-up studies, 12-18 months after leaving IB, showed that 35 per cent of disallowed benefit leavers with MH diagnoses had returned

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101 WA Anthony and MA Jansen, 'Predicting the Vocational Capacity of the Chronically Mentally Ill: Research and Policy Implications' (1984) 39 American Psychologist 537.

102 ibid.

103 G Thornicroft, *Shunned: Discrimination Against People with Mental Illness* (OUP 2006) ch 3.

104 *The Doctor who Hears Voices* Channel Four, 21 April 2008.

105 W Hague *Hansard* HC Deb vol 253 col 425W (27 January 1995). Estimated savings of £410m in 1995-96, £1185 m in 1996-97, £1720 m in 1997-98.

to benefit. This compared to return of 13 per cent of leavers with mental illness who had left IB voluntarily.[106]

Reports on the pilot projects for the New Deal for Disabled People, which were intended to set the pattern for reform of incapacity benefits, are not encouraging. Although job brokers placed many benefits claimants in employment, they were less successful in finding and maintaining work for people with MH problems.[107] A pilot project, developed to test interventions which might improve the return-to-work rate of people off work sick, produced an unexpected finding. It showed that people with MH conditions who used the pilot services had a **lower** rate of return to employment than those who did not. One possible explanation for this counter-intuitive outcome is that employers delayed a return to work, waiting for a more complete health recovery.[108]

The Centre for Economic and Social Exclusion has been tracking the number of claimants of IfW benefits along with numbers of people who describe themselves as economically inactive due to long-term sickness. Figure 8 shows that decline in the number of these claimants is generally not accompanied by a decrease in economic inactivity. This is particularly noticeable for the nine months prior to May 2010, when although the numbers of IfW claimants barely changed, there was a steep increase in the number of people recorded as economically inactive because of long-term sickness, indicating that those leaving IfW benefits are not entering employment.

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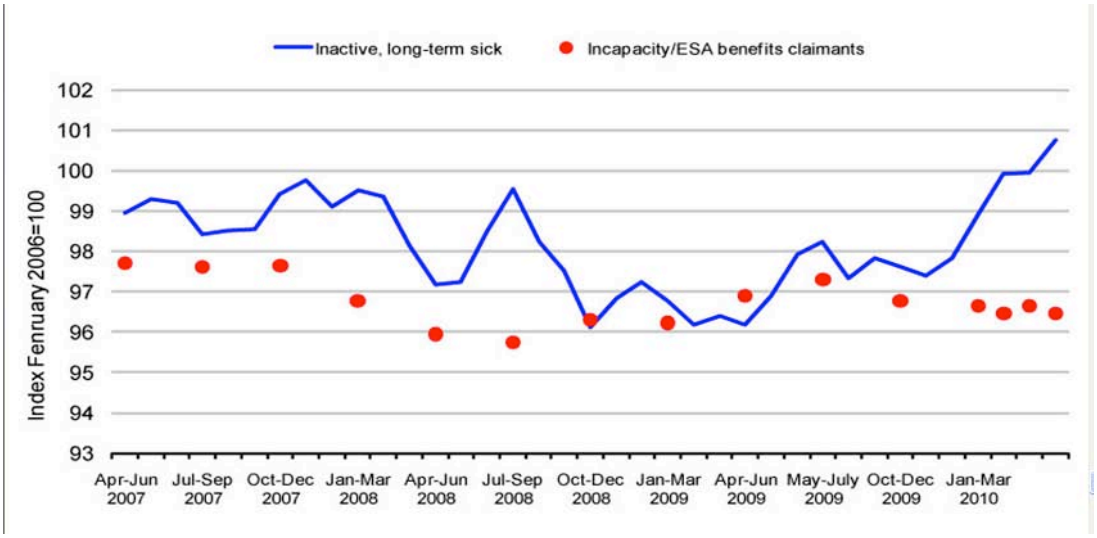
106 K Swales, 'What Happens to People Leaving Incapacity Benefit?' in DSS Social Research Branch *Research Yearbook 1997/98*.

107 B Stafford and others, *New Deal for Disabled People: First Synthesis Report* (DWP Research Report No W199 CDS, Leeds 2004) ix, [9.0], pp 119, 133.

108 R Taylor and J Lewis, *Understanding the Impact of JRRP for People with Mental Health Conditions* (DWP Working Paper No 45 HMSO, Norwich 2008) 37.

Figure 8: IfW benefit claimants and the economically inactive[109]



Can treatment of mental illness help improve capacity for work?

Mainstream psychiatrists certainly believe that psychological therapies could bring about enormous improvements in the lives of people with MH problems and help them to return to work from sickness absence.[110] The National Institute for Health and Clinical Excellence recommends that psychological treatment should be offered before a pharmacological approach is tried.[111]

In 2007 the Government commissioned a review into the health of the working-age population. The resulting report[112] recommended introduction of an occupational health service, with personally tailored support, which would reduce absence from

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[109] *Labour Market Statistics January 2010* Chart 16 reproduced from <http://www.cesi.org.uk> accessed 25 August 2010.

[110] see eg A Brimelow, 'Demand for NHS Therapy Network' <http://news.bbc.co.uk/1/hi/health/4174082.stm> (22 November 2005) accessed 15 July 2007.

[111] *The Treatment and Management of Depression in Adults* (NICE 2009).

[112] C Black, *Working for a Healthier Tomorrow* (TSO, Norwich 2008).

employment, and would facilitate early return to work from sickness. However, the options for support were not restricted to medical treatment, such as Cognitive Behavioural Therapy (CBT) and counselling, but embraced exercise and advice and support on social concerns such as finances, housing and family and childcare issues.[113]

The Government response to the Black review, *Working Our Way to Better Mental Health: a Framework for Action*,[114] promised to improve employment outcomes for people with MH problems by measures such as addressing stigma, improving training in MH and work for healthcare professionals, and placing a mental health co-ordinator in every Jobcentre Plus district.[115] Notably absent from the strategy document was a commitment to expansion of MH services and/or increased expenditure on services. As with the Perkins Report,[116] the goal is to achieve improvement within existing resources, but that services on offer should emphasise work-related aspects.

The OECD noted that patients may have to wait six to nine months to access psychotherapy while their condition becomes more entrenched, and has questioned whether the recent rapid expansion of healthcare has been appropriately prioritised. It suggests that with adequate treatment and rehabilitation many of those with MH conditions could get back to work, and that providing some meaningful activity might help their condition further. Shifting healthcare resources towards MH would help both labour-market performance and human happiness.[117]

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113 ibid 72.

114 Cm 7756 (DWP and DoH 2009).

115 ibid 10.

116 n 6.

117 — *Economic Survey of the United Kingdom: From Incapacity to Rehabilitation and Employment* (OECD, Geneva 2005) ch 6.

Similar comments were made by Lord Layard who estimated the annual cost to the taxpayer of mental illness in incapacity benefits and lost taxes at £7 billion, whereas £0.6 billion a year would provide a proper therapy service to all who need it.[118] However, another commentator questioned these figures, because although CBT has been shown to be an effective medical treatment, there was no evidence that demonstrated that CBT would get people off incapacity benefits.[119]

A key element of the welfare reform proposals, based on the theory that most mild/moderate MH problems are manageable,[120] is that claimants of ESA should be required to attend Condition Management Programmes (CMPs). The programmes, which use the principles and approach of CBT, are designed to help participants understand and manage their condition better, improve their quality of life, increase their confidence and enhance employability.[121] Although CMPs are delivered by health professionals they do not replicate NHS treatment and are tailored to meet participants' needs.[122] The pilot CMPs were based around flexible, target-free 'Memoranda of Understanding' between providers and the DWP.[123] The only constraining factors were that programmes should focus on the leading causes of incapacity (MH, musculoskeletal and cardio-respiratory problems), must not provide 'treatment', should be innovative and that data should be submitted to the DWP monthly.[124]

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118 R Layard, *The Depression Report: A New Deal for Depression and Anxiety Disorders* (Centre for Economic Performance 2006) 7.

119 B Grove, 'This Quick Fix is Worth the Risk' *The Guardian* (London 6 July 2006).

120 — Advising Patients about Work (TSO, Norwich 2007) 4; Waddell and Aylward (n 42) 140.

121 DWP, *Pathways to Work: Helping People into Employment* (Cm 5690, 2002) p .

122 *Pathways to Work* <http://www.direct.gov.uk/en/DisabledPeople/Employmentsupport/WorkSchemesAndProgrammes/DG_171745> accessed 22 March 2011.

123 DWP, *Jobcentre Plus Annual Report and Accounts 2006-2007* (DWP 2007) 84.

124 F Ford and C Plowright, *Realistic Evaluation of the Impact and Outcomes of the Condition Management Pilots* (University of Central Lancashire 2008) [3.1].

However, when the Pathways to Work programme began, there was no direct evidence on the process, effectiveness or health-related outcomes of CMPs.[125] Nonetheless, CBT was suggested for inclusion in these programmes.[126] Many areas have long waiting lists for treatment[127] so it is worrying that benefit claimants nearest the job market might be given priority over those with more serious mental illnesses. Where claimants have been able to access a CMP, including either CBT or psychodynamic counselling, they frequently complain that the service offers only group, rather than one-to-one, counselling, and criticise the brevity of counselling sessions.[128] Official research into the outcomes of Pathways to Work CMPs was not published until long after ESA inception,[129] and is somewhat equivocal. This showed that a strong focus on coping skills, together with activity and exercise, produced improvements in depressed participants, but that concentration on work-related outcomes had minimal or negative results.[130] 43 per cent of claimants with MH problems stated that participation in CMP had helped them to manage their condition 'a lot'.[131] Another researcher reported that advisers and clinicians noted that there were significant positive outcomes for claimants with MH difficulties who engaged with

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125 Waddell and Aylward (n 42) 157.

126 DWP (Cm 6730, 2006) (n 37) 40.

127 P Blenkiron, 'Cognitive Behavioural Therapy (CBT)' (Royal College of Psychiatrists 2009); 'Dealing with Depression' (Mental Health Foundation 2009).

128 R Tennant, M Kotecha and N Rahim, *Provider-led Pathways: Experiences and Views of Implementation in Phase 2 Districts* (DWP Research Report No 643 HMSO, Norwich 2010) 82.

129 M Warrener, J Graham and S Arthur, *A Qualitative Study of the Customer Views and Experiences of the Condition Management Programme in Jobcentre Plus Pathways to Work* (DWP Research Report No 582 HMSO, Norwich 2009) and K Nice and J Davidson, *Provider-led Pathways: Experiences and Views of Condition Management Programmes* (DWP Research Report No 644 HMSO, Norwich 2010).

130 Warrener, Graham and Arthur (n 129) 5; Nice and Davidson (n 129) 5; Ford and Plowright (n 124) [13.2].

131 O Hayllar and M Wood, *Provider-led Pathways to Work: The Experiences of New and Repeat Customers in Phase One Areas* (DWP Research Report No 723 CDS, Leeds 2011) Table 6.9.

CMPs, such as improved confidence, getting more out of life, challenging negative thoughts and enjoying the attention of a medical professional, but that these gains did not extend to employment.[132]

Summary

Mental illness is a leading cause of absence from employment and of claims for IfW benefits. The barriers to work are complex and include the sufferer's perceptions of their situation and prospective employers' false assumptions resulting in stigma.

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[132] A Grant, *The Condition Management Programme: Early Findings from Qualitative Research in Wales* Social Policy Association Annual Conference, University of Lincoln 5-7 June 2010, abstract p 1.

CHAPTER TWO

WHAT IS INCAPACITY FOR WORK?: AN OUTLINE OF THE INCAPACITY BENEFITS AND EMPLOYMENT AND SUPPORT ALLOWANCE REGIMES

Introduction and overview

People who are unable to work because they are ill or disabled may be entitled to receive certain earnings-replacement benefits known generically as incapacity for work (IfW) benefits. This chapter lays the foundation for an in-depth analysis of the obstacles faced by claimants in establishing and maintaining entitlement to IfW benefits, which occurs in Chapters Four to Seven of this thesis.

The difficulties faced by claimants of IfW benefits are best appreciated in the context of the meaning of the term 'incapacity' and the nature of such benefits. The chapter, therefore, begins with a short explanation of the concept of incapacity in social security law, and introduces the notion of 'partial capacity' which is found in other jurisdictions. A full understanding of present-day provision for people who are too ill to work requires consideration of the schemes which preceded it. Hence the following sections outline the evolution of IfW schemes and contain a brief discussion of the invalidity benefit regime, which used an informal assessment process to determine incapacity.

The chapter gives an account of the schemes on which the thesis focuses - the incapacity benefits and the employment and support allowance (ESA) regimes. It explains the formal test of functional capacity which accompanied the introduction of the incapacity

benefits regime in 1995, and which was carried forward, but with significant changes, to ESA. This chapter explains the rationale for recent reform of the social security system and compares the two regimes, with particular emphasis on the impact of changes for claimants with MH problems. It demonstrates that the eligibility conditions, notably the contribution conditions and the assessment tests, became more stringent with each new regime.

The concept of incapacity in Social Security Law

Disability and incapacity

A feature of UK[1] social security law is that the terms 'disability' and 'disablement' are not synonymous with 'incapacity'. Not all jurisdictions make this distinction, and in Central and Eastern Europe disability is thought of mainly or exclusively in terms of loss of partial or total capacity for work.[2] For example in Poland, disability is defined as 'a physical, psychological or mental state which permanently or temporarily hinders, limits or prevents the fulfilment of social roles, especially an ability for employment'.[3] In contrast, the UK benefits system distinguishes between incapacity for work and disablement, which may, or may not lead to IfW. This was reiterated in *R(S) 2/74*, in which Commissioner Shewan said:

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1 Although Great Britain and Northern Ireland have separate legislation, social security provisions are coterminous.

2 P Spicker, 'Distinguishing Disability and Incapacity' International Social Security Review [2003] vol 56 31-43.

3 Act on Vocational and Social Rehabilitation and Employment of Persons with Disabilities 1997.

> There are many kinds of "work" which a man may be capable of doing even if he suffers from some form of disablement. Disablement must be distinguished from incapacity.[4]

The UK's first contributory scheme of workers' insurance, a century ago, provided for 'periodical payments whilst rendered incapable of work by some specific disease or by bodily or mental disablement'.[5] The phrase 'by specific disease or by bodily or mental disablement' was, nonetheless, carried forward to subsequent incapacity for work legislation.

Incapacity benefits, April 1995 to date

One standard textbook on Social Security Law notes that, despite its title, the Social Security (Incapacity for Work) Act 1994 contains no comprehensive definition of incapacity for work.[6] Instead it uses the concept of a 'day of incapacity for work' which forms part of a 'period of incapacity for work'.[7] Defined in primary legislation, a day of IfW is one on which the person is incapable of work because of a 'specific disease or bodily or mental disablement'.[8] Neither is there a statutory definition of 'disablement'. The consultation document which preceded IB stated that

> … disablement is conventionally defined as the limiting, loss or absence of capacity of an individual to meet personal, social or occupational demands, or to meet statutory or regulatory requirements.[9]

This interpretation of 'disablement' clearly brings into its remit mental as well as physical origins. Although 'disablement' is variable in its extent, a person is either capable

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4 para 7.

5 National Insurance Act 1911 s 8(1)(c).

6 NJ Wikeley and AI Ogus (ed), *The Law of Social Security* (5th edn Butterworths, London 2002) 538.

7 s 1(1) incorporated into SSCBA 1992 s 30A.

8 Social Security (Incapacity for Work) Act 1994 s 5 incorporated into SSCBA 1992 ss 171B(2) and 171C(2).

9 Benefits Agency, *A Consultation on the Medical Assessment for Incapacity Benefit* (DSS 1993) 8.

of work or not, and no leeway is allowed for someone whose ability to work is limited in some way.

The lack of a precise definition of incapacity is surprising, and was described in the consultation document as 'a weakness of the present system'.[10] In particular, the document comments that *R(S) 11/51 (T)* which held that a person was incapable of work

> if, having regard to his age, education and experience, state of health and other personal factors there is no work or type of work which he could reasonably be expected to do.[11]

had 'broadened and blurred the definition of incapacity for work far beyond the original policy intention'.[12] It also states that 'a clear and simple definition of incapacity which focuses only on the effects of the medical condition' was needed in order to establish whether the effects on capacity for work were the result of a diagnosed condition.[13] During the Second Reading debate on the Social Security (Incapacity for Work) Bill one MP described the omission of a specific definition of incapacity as 'outrageous'.[14]

However, the significant measure within that Act was to insert into SSCBA 1992 powers for the Secretary of State to make regulations regarding an **assessment system** for questions of incapacity (for work) known, initially, as the All Work Test, but later renamed the Personal Capability Assessment.

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10 ibid ch 3.

11 para 5.

12 ibid [3.1].

13 ibid [4.1].

14 Keith Bradley, *Hansard* HC Deb vol 236 col 166 (8 March 1994).

Limited capability for work for ESA – since October 2008

The key proviso for ESA entitlement is that the claimant has limited capability for work (LCW), which means that their capability for work is limited by their physical or mental condition such that it is not reasonable to require them to work.[15] Neither the Welfare Reform Act 2007 (WRA) nor the Regulations made under that Act supply a further explanation of LCW, other than to provide for LCW to be determined via a statutory assessment process.[16]

The notion of partial capacity

Under the UK benefits system, IfW is an 'all or nothing' term and, despite the use of the term 'limited capability for work' for ESA, does not conceive of a partial or limited capacity for employment by way of shorter hours, reduced productivity or a 'light' job.

Incapacity is difficult to define because it is represented by a spectrum, at one end of which are placed those who are totally incapable of anything, as would be someone in a coma. At the opposite end would be placed people capable of amazing feats of agility or endurance. Most people would therefore fall mid-range, with some limitation as to the nature of any work they could perform. The difficult task is to determine at what stage it becomes unreasonable to expect people to seek and enter employment. Some authorities have pointed out that application of the phrase 'incapable of work' does not necessarily

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15 WRA 2007 s 1(4)(a).

16 WRA 2007 s 8; ESA Regs Part 5 and sch 2.

mean that a person is not capable of performing any work, rather that it recognises that it is unreasonable to require them to do so.[17]

Unlike the scheme for Industrial Injuries, IfW assessments make no attempt to quantify the extent to which a person's capacity is limited. Claimants failing to score the requisite number of points in the assessment are not incapable of work/do not have limited capability for work; those attaining the requisite points are considered to be 'incapable'/have 'limited capability for work'.

Even before the change to ESA, the OECD reported that although the UK did not formally specify incapacity as a percentage, it was understood to correspond to a minimum required level of incapacity of 70–100 per cent. As the Table below shows, this makes the PCA one of the toughest gateways to incapacity benefits in OECD member states.[18] Assessment outcomes following the introduction of the LCWA for ESA indicate that the gateway is now even more stringent. This is discussed further in Chapter Five.

Table 1: Minimum level of incapacity to qualify for full benefit across OECD[19]

0–40%	Australia, Germany, Netherlands, Switzerland
41–70%	Austria, Poland, Mexico, Belgium, Portugal, Turkey
70–100%	USA, UK, Canada

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17 Work and Pensions Committee, *Employment for All: Interim Report* HC 401-I (2002-03) [16].

18 — *Transforming Disability into Ability: Policies to Promote Work and Income Security for Disabled People* (OECD, Paris 2003) 84; *Pathways to Work* DWP presentation <http://www.dwp.gov.uk/pub_scheme/2005/mar/pdfs/pathways_presentation.pdf> accessed 15 October 2008.

19 — *Transforming Disability into Ability: Policies to Promote Work and Income Security for Disabled People* (OECD, Paris 2003) 84.

Interestingly, the OECD evidence appears to show that there is no correlation between the stringency of the gateway and the number of benefits claimants. In the US, where the gateway process takes a year and is considered to be the tightest in the world, the number of claimants of IfW benefits has risen consistently while the employment rate of disabled people has fallen.[20]

Certain other jurisdictions provide for partial or limited capacity[21] although schemes vary as to whether the emphasis is on the extent of injury or incapacity or, on loss of economic potential or earning capacity.[22] In Norway, for example, a partial benefit is granted to those who have lost less than 100 per cent of their work capacity.[23] In Poland, partial benefit is paid to people who can work, but are not able to sustain their former occupation.[24] In Switzerland, partial entitlement requires earning capacity to be reduced by between 40 and 70 per cent.[25] In practice, very few recipients of partial benefits do in fact work, so that the system operates as a means of awarding lower sums to less severely disabled people.[26] Furthermore, even a system of partial benefits requires cut-off points and a system of assessment.

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20 K Stanley, LA Lohde with S White, *Sanctions and Sweeteners: Extending Conditions in the Benefits System* (IPPR, London 2004).

21 — *Transforming Disability into Ability: Policies to Promote Work and Income Security for Disabled People* (OECD, Paris 2003) 65.

22 *Definitions of Disability in Europe: a Comparative Analysis* <http://www.bbk.ac.uk/politics/our-research/projects/past-projects/documents/final-report> accessed 9 March 2011.

23 — *Sickness, Disability and Work: Breaking the Barriers. Vol 1: Norway, Poland and Switzerland* (OECD, Paris 2006) 84.

24 ibid.

25 ibid.

26 D Pozzo and others, *Assessing Disability in Europe Similarities and Differences* (Council of Europe 2002).

The absence of partial IfW benefits in the UK is of particular relevance to those who claim on the basis of mental illness. This is because their condition may fluctuate from day to day or they may have periods of days, weeks or months during which they are well, interspersed with period of illness.

The evolution of incapacity for work benefits

The current social security scheme for those who cannot work has evolved from the early Poor Law provision for the relief of poverty. As the welfare system has developed, changes have been made, and each time the impetus for change has been either that the scheme was proving more costly than anticipated or that it appeared to be poorly targeted at people who were 'genuinely' unable to work because of long-term illness or disability. Schemes have also needed to respond to changing trends in the nature of illness from which claimants suffered, particularly the growth in the proportion of claimants with mental illnesses. A brief survey of the development of welfare provision for those too sick or disabled to work may assist understanding of the current position.

The second decade of the 20th Century saw the introduction of a contributory, non-means tested scheme for certain workers,[27] variants of which continue today. The Beveridge Report,[28] published in 1942, outlined proposals for a 'cradle to grave' welfare state, and the period following Second World War II saw major reorganisation of welfare provision and introduction of new benefits which made financial help available to a greater number of claimants. Beveridge's proposals for sickness benefits based on social

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27 National Insurance Act 1911.

28 W Beveridge, *Social Security and Allied Services* (Cmd 6404, 1942).

insurance for those in employment were planned for the social context of the time, ie full male employment, 'dependent' wife and children, and a short period of retirement.

The proposals, for a scheme of flat-rate benefits in return for flat-rate contributions were implemented by the National Insurance Act 1946, which also introduced a National Health Service (NHS), including hospital mental health services, to replace the medical benefits available under the previous scheme.

Insurance contributions were required from all employees and from employers. Sickness benefit could be paid to those meeting the contribution conditions, for 'a day of incapacity for work' on which they were 'incapable of work by reason of some specific disease or bodily or mental disablement'.[29] Additional allowances for dependents of sick claimants were introduced for the first time, and the self-employed were brought within the scheme's remit.

The long-term sick who were unable to meet the NI contribution conditions had to rely on means-tested national assistance which replaced the poor law provisions but retained some discretionary elements.[30] National assistance was abolished in 1966, to be replaced by supplementary benefit. Supplementary benefit was a sea-change in the delivery of means-tested allowances in that, for the first time, claimants who met the statutory provisions received benefit as of right.[31]

The sickness benefit scheme proved to have a number of flaws.

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29 National Insurance Act 1946 s 11(2)(a)(ii).

30 National Assistance Act 1948.

31 Ministry of Social Security Act 1966 s 4(1).

- Sickness benefit was a single benefit covering sickness without time limit.
- The scheme applied only to sickness and not to disability.
- There was no formal assessment process; sickness certification by GPs was all that was required.

1971–1995: Sickness Benefit, Invalidity Benefit and Social Assistance Benefits

Invalidity benefit (IVB) was introduced in 1971[32] in response to the growing number of long-term claimants of sickness benefits towards the end of the 1960's, but the 'test' for incapacity was unchanged. Sickness benefit was retained for the first six months of incapacity, then replaced by an invalidity pension paid at a slightly higher rate.[33] This pension, described in the legislation as for the 'chronic sick',[34] could be supplemented by an age-dependent invalidity allowance which increased, the younger the claimant on their first day of incapacity.[35] An earnings-related component, also known as an 'additional pension' was added to IVB in 1975.[36] Unusually, IVB could be paid for five years beyond pensionable age, and because it was neither means-tested nor taxable, many recipients continued to receive IVB in preference to a state retirement pension.

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32 National Insurance Act 1971 s 3(1).

33 National Insurance Act 1971 s 3(1)(a).

34 National Insurance Act 1971 preamble.

35 National Insurance Act 1971 s 3(5) and sch 2, Part I, para 3. There were three rates of payment: incapacity commencing <40, 40–49, and 50–for men and 50–54 for women.

36 Social Security Pensions Act 1975 ss 6, 14.

Receipt of IVB was subject to contribution conditions, but since actual payment of contributions was required for only any one tax year,[37] few workers failed this test. Sick people unable to meet the contribution conditions had to fall back on means-tested benefits. On 11 April 1988 income support (IS) replaced supplementary benefit as the 'safety net' benefit.[38] IS could also include 'disability premiums' which were additional amounts that could be paid, inter alia, to those who had been incapable of work for 364 days.[39] The disability premium was recognition that the long-term sick faced additional expenditure that the short-term sick would be able to meet when they returned to employment, and would not be incurred at all by those who were well. Waddell and Aylward describe the premium as 'a pragmatic measure to address poverty among disabled people and to overcome benefit traps' with the worthy aim of directing additional help to some of the poorest and most disadvantaged of society. However they describe the means of achieving this goal as 'quite illogical' and 'based on a combination of political expediency, lobbying and concessions at committee stages'.[40]

As with earlier schemes, IVB was introduced without a formal assessment process, although adjudication officers could make referrals for medical examination by Departmental doctors if thought appropriate. The lack of such assessment, together with

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37 Social Security Act 1975 s 13 and Sch 3.

38 Social Security Act 1986 Part II; IS Regs.

39 IS Regs Sch 2 paras 11,12.

40 G Waddell. and M Aylward, *The Scientific and Conceptual Basis of Incapacity Benefits* (TSO, Norwich 2005) 61.

burgeoning case law which introduced non-medical factors for deciding incapacity[41] and increasing claimant numbers led to its replacement by incapacity benefit.

Non-contributory non-means-tested benefits

In 1975 the Government responded to pressure from disability organisations by introducing non-contributory invalidity pension[42] for disabled people, including the mentally ill, who were unable to work but had insufficient NI contributions to qualify for IVB. Although it carried the same incapacity test[43] it was paid at 60 per cent of the IVB rate. The lower rate of payment was justified by the view that contributors to social security should be treated more favourably than non-contributors,[44] and was based on what became known as the 'insurance myth' ie that NI contributions paid for future benefits.

Initially, married and cohabiting women were excluded from receiving non-contributory invalidity pension on the ground that, even if they were incapable of work, they were likely to be at home anyway. This was widely held to be discriminatory, and in 1977 the pension was extended to married/cohabiting women who, as well as being incapable of work because of physical or mental disablement, were 'incapable of performing normal household duties'.[45] This extension was nonetheless still discriminatory in that it comprised an additional test applied only to women.

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41 See further, page 68.

42 SSA 1975 s 36; Social Security (Non-Contributory Invalidity Pension) Regulations 1975 SI 1975/1058.

43 SSA 1975 s 36; Social Security (Non-Contributory Invalidity Pension) Regulations 1975 SI 1975/1058 reg 4(1); SSA 1975 s 17(1)(a).

44 AI Ogus (ed) *The Law of Social Security* (Butterworths 4th ed 1995) 157.

45 Social Security Act 1975 s 36(2) as amended.

Severe disablement allowance

In November 1984 (housewives) non-contributory invalidity pension was abolished[46] and replaced by the non-contributory, non-taxable, severe disablement allowance (SDA).[47] The 'household duties' test disappeared, so that SDA was paid, at 60 per cent of the IVB rate, both to ex-employees with poor NI contribution records (mostly men) and those who stayed at home (mainly women).

SDA was targeted specifically at those whose disabilities had begun in childhood and who had been unable to accumulate an NI contribution record. The majority of SDA recipients were people with learning difficulties. Claimants whose incapacity commenced after the age of 20 were required to meet a test of 80 per cent disablement,[48] assessed as under the industrial injuries scheme. Certain groups such as recipients of disability living allowance at the highest rate and the blind were automatically deemed to have reached the 80 per cent threshold.[49] Although people with mental illness were not barred from receiving SDA, the 80 per cent disability threshold effectively excluded all but those with the most severe psychiatric illnesses who would almost certainly be hospitalised.

The Social Security Advisory Committee was critical of the idea of a severe disablement test which was based on a loss of faculty ,'inappropriately' borrowed from the

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46 The discriminatory nature of (H)NCIP would have been incompatible with the equal treatment provisions of Council Directive 79/7/EEC which came into force on 22 December 1984.

47 Health and Social Security Act 1984 s 11(1); SDA Regs.

48 Social Security Act 1975 s 36(5) as amended.

49 SDA Regs reg 10.

industrial injuries scheme, when a loss of function approach would have been more appropriate.[50]

SDA was abolished for new claimants in April 2001. The reason given in the House of Lords for this move was that many young people receiving SDA had an inadequate income. Because of the low payment rate, 70 per cent of recipients also claimed an income support top-up, and because SDA was taken into account pound for pound it did not provide any additional help. Under incapacity benefit their weekly income increased by up to £26.40 a week.[51]

Following SDA abolition, people who were incapable of work but did not meet either the NI contribution tests or the 'disabled in youth' criterion,[52] were ineligible for IB. Providing they continued to be incapable of work and submitted regular medical certificates they could claim IS, the means-tested 'safety net' benefit.

The charts, below, illustrate the steady increase in incapacity-related claimants between 1978 and 1995, which was a major factor leading, in 1995, to the introduction of incapacity benefit.[53]

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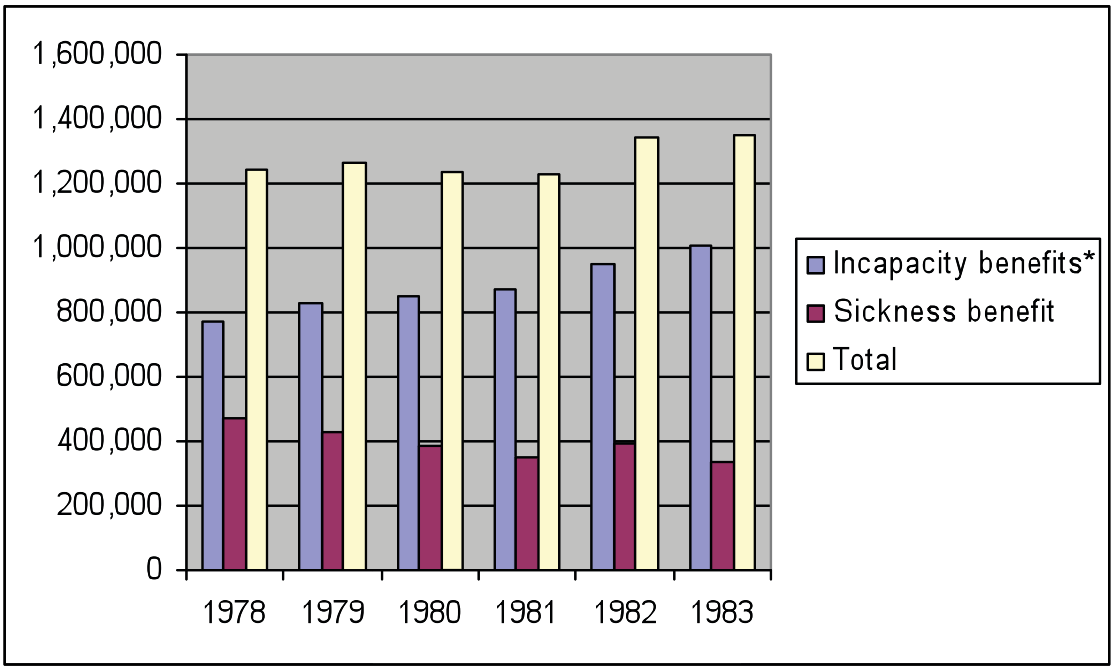
50 Social Security Advisory Committee, *Third Report August 1983-July 1984* (SSAC 1984) Appendix 3.

51 Baroness Hollis, *Hansard* HL Deb vol 604 col 325 (13 July 1999).

52 IfW before the age of 20 (or 25 in the case of students); SSCBA 1992 s 30A(1)(b) and (2A).

53 SSCBA 1992 ss 20(1), 30A-30E, 171A- 171G; SS(IB) Regs.

Figure 1: Incapacity-related benefits claimants in Great Britain on the last day of the Department's statistical year (1978–83)

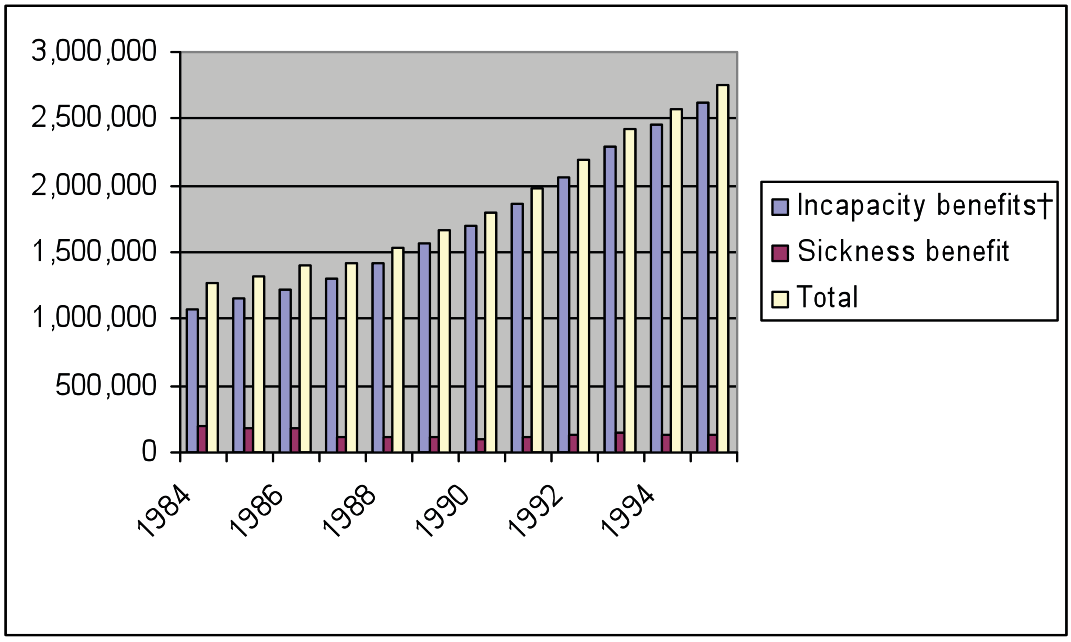


* Incapacity benefits were invalidity benefit, (housewives) non-contributory invalidity pension, and sickness benefits credits-only cases, until 1983.

Notes: 1. Figures are rounded to the nearest hundred.
2. Figures include some people over pension age.

Source: Information Directorate, 1 per cent sample.

Figure 2: Incapacity-related benefits claimants in Great Britain on the last day of the Department's statistical year (1984–95)



† Incapacity benefits were invalidity benefit, SDA and sickness benefits credits-only cases, up to April 1995.

Notes and source: as for Figure 1.

The pre-1995 test of incapacity

The test of incapacity for all sickness and invalidity benefits was the same ie that the claimant was incapable of work by reason of some specific disease or bodily or mental disablement, ('work', meaning work which the person could reasonably be expected to do).[54] Although there was no hard and fast rule, for the first six months of sickness benefit, the 'work' in question was taken to be work which the person would reasonably be

[54] Social Security Act 1975, s 17(1)(a)(ii).

expected to do in their usual occupation.[55] Thereafter, capacity for work for IVB purposes was decided relative to any 'remunerative work … for which an employer would be willing to pay, or work as a self-employed person in some gainful occupation'.[56] Although, after six months, the range of work to be looked at was expanded, the test of incapacity remained whether having regard to the claimant's age, education and experience, state of health and other personal factors there was work within that broader range they could reasonably be expected to do.

It fell to the claimant's GP to decide whether their patient was incapable of work, or not, and if so, to provide a sick certificate. There was no statutory framework which dictated the criteria for establishing IfW neither was there any formal assessment process. Adjudication officers could, however, if thought appropriate, make referrals for medical examination by Departmental doctors.

Informal assessment is based on what has become known as the 'social model' of disability, which professes that participation in work or other activity is limited, not by a person's impairment, but by the way that society is organised for the unimpaired.[57] The model forms the basis for the current quest for 'social inclusion' and policies of non-discrimination, but assessment based on this model is difficult to place in a legislative setting.

Critics suggest that informal processes in which the claimant's GP undertakes the assessment are unreliable because the GP may be put under pressure by their patient, but

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55 AI Ogus and NJ Wikeley (eds), *The Law of Social Security* (4th edn Butterworths, London 1995) 177.

56 R(S) 11/51(T) para 5.

57 G Waddell and M Aylward (n 41) 27.

does not wish to damage the doctor-patient relationship by declining to issue a certificate.[58] However, research has established that doctors made decisions on sickness certification regardless of the patient's explicit wishes and, when MH conditions were in question, certificates were not issued in order to maintain a relationship with their patient.[59] The advantages of informal assessment are that it is simple and inexpensive to undertake, and that adopting a holistic approach produces a 'commonsense' outcome. One expert in welfare provision for disabled people has stated:

> It is not only desirable but essential to consider the interaction between an individual's impairments and a range of other factors – because that is the way disability actually affects individuals. A purely medical analysis will not provide an accurate measure of claimants' position.[60]

For example, a person who experiences panic attacks when travelling on public transport, might have this factor taken into account as a barrier to employment. The disadvantage of informal assessment is that it can lead to inconsistent results for people with similar impairments.

The interpretation made in *R(S) 11/51 (T)*, prior to the introduction of IB, that a person was incapable of work:

> if, having regard to his age, education and experience, state of health and other personal factors there is no work or type of work which he could reasonably be expected to do[61]

is notable because it brings into consideration factors other than the strictly functional. Matters other than personal factors could not, however, be considered. In *R(S) 2/82 (T)* a

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58 Benefits Agency, *Consultation* 1993 (n 10) [3.9].

59 A Campbell, A and J Ogden, 'Why Do Doctors Issue Sick Notes? An Experimental Questionnaire Study in Primary Care' (2006) Family Practice 2006 23 125–130.

60 R Berthoud, 'The "Medical" Assessment of Incapacity: a Case Study of Research and Policy' (1995) 2 JSSL 75.

61 para 5.

Tribunal of Commissioners held that the local level of unemployment was not a relevant consideration for IVB, and the correct question was whether the claimant was capable of work, and not whether he could obtain work.[62] Nonetheless, the non-medical approach to incapacity, and the perception that case law had expanded the number of successful claimants to include some who were not genuinely unable to work, were factors that led to the introduction of a structured functional capacity test under incapacity benefits.[63]

Incapacity benefit and/or income support

Incapacity benefit (IB)[64] was introduced in April 1995 for people with some specific disease or bodily or mental disablement[65] who were assessed as being incapable of work.

With the exception of those who were incapacitated in youth,[66] to whom special rules applied, IB was entirely a contributory benefit. It comprised:

- a short-term lower rate for the first 28 weeks of incapacity
- a short-time higher rate after 28 weeks of incapacity
- a long-term benefit after 52 weeks of incapacity, paid at an enhanced rate.[67]

For most employees, Statutory Sick Pay (SSP) was paid for a maximum of 28 weeks, instead of IB at the short-term lower rate. Even when SSP is being paid by the employer, there is no requirement for a person's incapacity to be caused by their work. To be

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62 para 11.

63 See for example, Peter Lilley, *Hansard* HC Deb vol 236 col 35 (24 January 1994).

64 SSCBA 1992 ss 20(1), 30A-30E, 171A- 171G; SS(IB) Regs.

65 SS(IfW) Regs reg 24.

66 IfW before the age of 20 (or 25 in the case of students); SSCBA 1992 s 30A(1)(b) and (2A).

67 SSCBA 1992 s 30A.

incapable of work for the purposes of SSP, a person must be incapable of doing work that they could reasonably be expected to do under the terms of their contract, because they have a specific disease or bodily or mental disablement.[68] When the SSP period was exhausted the person will have needed to claim IB and meet all its eligibility criteria to receive benefit. Since the inception of ESA, people at the end of their SSP entitlement are required to claim ESA.

The change from IVB to IB was accompanied by a number of alterations to the system. Not all the changes occurred from the outset, however most of them affected claimants adversely. These included making IB taxable, having lower rates for the first year of incapacity, removing an earnings-related component, restricting the circumstances in which an adult dependent addition could be paid, removing entitlement to IB after pension age and reducing benefit for recipients of occupational pensions, thus introducing a partial means-test. Other changes which were made had a disproportionate affect on claimants with MH problems. Those with a patchy employment record were disadvantaged by tightening of the NI contribution tests so that receipt of IB required employment at some time in the previous three to four years (depending on the time of year the claim was made). People with MH problems whose illness began in middle age[69] were affected by elimination of an age allowance for claimants whose incapacity began after the age of 45. Those with MH problems also found it more difficult to comply with requirements for IB recipients to engage in programmes to improve their employment prospects.

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68 SSCBA 1992 s 151(4).

69 Incapacity due to physical illness tends to occur later than for mental illness.

The most significant change was the imposition of a formal test of functional capacity, known as the All Work Test. The name was later changed to the Personal Capability Assessment (PCA) but the test was substantially the same. The PCA was applied from the beginning of their claim to those without a recent connection with work, and after 28 weeks of incapacity to almost all other claimants.[70] This new feature was a major change which was expected to have a significant impact in reducing claimant numbers.

The impact of many of these changes on claimants, particularly those with MH problems, is explored later in this thesis.

Transitional protection was provided for recipients of the earlier benefits[71] so that at the time of transfer they suffered no cash loss.

Those who were ill or disabled but had insufficient NI contributions may have been able to claim severe disablement allowance (SDA)[72] and/or means-tested income support (IS).[73] IS provides for 'disability premiums' which are additional amounts that can be paid, inter alia, to those who have been incapable of work for 364 days.[74] The disability premium was recognition that the long-term sick faced additional expenditure that the short-term sick would be able to meet when they returned to employment, and would not be incurred at all by those who were well. Waddell and Aylward describe the premium as 'a

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70 SSCBA 1992 s 171C; SS(IFW) Regs Part III.

71 Social Security (Incapacity for Work) Act 1994 s 4; Social Security (Incapacity Benefit) (Transitional) Regulations 1995 SI 1995/310.

72 Until SDA abolition for new claimants in April 2001. SDA was non-contributory and paid at lower rate than IB to severely disabled claimants, mostly those with learning difficulties.

73 SSCBA 1992 s 124; IS Regs.

74 IS Regs reg 17(1)(d) and sch 2 paras 11 12.

pragmatic measure to address poverty among disabled people and to overcome benefit traps' with the worthy aim of directing additional help to some of the poorest and most disadvantaged of society. However they describe the means of achieving this goal as 'quite illogical' and 'based on a combination of political expediency, lobbying and concessions at committee stages'.[75]

Disability premiums based on IfW can also be included in other means-tested benefits eg housing benefit, council tax benefit and a partner's income-based jobseekers allowance. Because IS represents a minimum 'guaranteed income', it can also top-up payments of other benefits.

The entitlement conditions for IS are complex and the situation is complicated by the fact that couples' resources are aggregated.[76] Detailed consideration of the rules is beyond the scope of this thesis, but in summary claimants can be ineligible for IS when:

- income exceeds their applicable amount[77]
- capital exceeds £16,000[78]
- their partner is engaged in remunerative work.[79]

The effect of these criteria is that it is possible for a person who is patently not able to work not to receive any payment, either because their own or their partner's circumstances

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75 Waddell and Aylward (n 41) 61.

76 SSCBA 1992 s 136(1); IS Regs reg 23(1).

77 SSCBA 1992 s 124(1)(b); WRA 2007 sch 1 para 6(1)(a).

78 SSCBA s 134(1); IS Regs reg 45; ESA Regs reg 110.

79 SSCBA 1992 s 124(c); WRA 2007 s 6(1))(f)

make them ineligible. The fairness of excluding from payment a person who is too ill to work on the ground that their partner **is** in full-time employment is arguable.

NI credits, which assist claimants to accumulate pension entitlement, were paid alongside all the incapacity benefits,[80] but many described as 'incapable of work' received only credits. In 2006 more than a third of those deemed incapable of work were receiving either NI credits only or credits paid with IS.[81]

Background to welfare reform

The measures contained in the Welfare Reform Act 2007 were intended to enable the Government to realise its aspiration of an 80 per cent employment rate for people of working age and an inclusive society with opportunity for all.[82] The Green Paper, *A New Deal for Welfare: Empowering People to Work*,[83] made several proposals aimed at achieving that employment target, including reducing the number of incapacity benefits claimants by million.[84]

Although fiscal and economic considerations formed the basis of the Government's reform agenda, they were accompanied by ideas about dignity.

> Our economy will benefit from higher employment rates among lone parents, older people and people with a health condition or disability. Taxpayers will gain too as the bills for

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80 Social Security (Credits) Regulations 1975 reg 8B.

81 By May 2009, less than 44 per cent of ESA recipients met the NI contribution test (ONS statistics).

82 DWP, *The Department for Work and Pensions Five Year Strategy – Opportunity and Security throughout Life* (DWP 2005).

83 Cm 6730, 2006.

84 Green Paper, Executive Summary para 9.

benefit dependency come down. But the gains for those individuals helped into work will be the greatest: respect, dignity, security, and achievement.[85]

Other reasons cited for the necessity of reform were:

1. **Changes in claimant characteristics.** In 2006 one third of new claimants cited MH conditions as the primary cause of their incapacity compared to one-fifth ten-years previously. More than a third of claimants did not come from employment but from other benefits such as JSA and IS.[86]

2. **Poor management of the benefit gateway.** Claimants received benefits before satisfying a medical test.[87]

3. **Perverse benefit incentives.** Paying claimants more the longer they claimed.[88]

4. **Almost no expectations of claimants.** Little support offered, and claimants' perception that volunteering or training attempts risked losing benefit entitlement.[89]

The welfare-to-work programme was intended to provide a co-ordinated approach to addressing the barriers that people face when they have an illness or disability, rather than simply compensating them for any disadvantage.[90] The measures combined a balanced

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85 Green Paper, Executive Summary para 51.

86 ibid para 12.

87 ibid para 14.

88 ibid.

89 ibid.

90 Green Paper p 27.

package of rights and responsibilities, which aimed to target a number of the health-related, personal and external barriers to returning to work.[91]

Despite research, conducted by the Institute of Fiscal Studies, which showed that the Pathways to Work project produced no statistically significant impact on claimants for whom mental illness was the primary reason for claiming,[92] and the worsening employment situation, the Government continued to pursue its reform proposals.

Immediately prior to the introduction of ESA in October 2008, 2.6 million people were claiming incapacity benefits.[93] Removing 1 million from the claimant count thus appears to be exceptionally ruthless.

Welfare Reform Act 2007

The 2006 Welfare Reform Bill (hereafter the Bill), with the stated aim of helping more people move off benefits into work, was preceded by the Green Paper[94] and consultation by the Work and Pensions Select Committee. The Joseph Rowntree Foundation predicted that the proposals would impact differentially on people with MH problems.[95] It was also concerned that the often cited doubling of the number of incapacity benefits claimants from 1995–2004 was seen by policy makers as a 'soft target' for reducing public spending, rather than a reflection of greater recognition of common

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91 ibid.

92 S Adams and others, *Early Quantitative Evidence on the Impact of the Pathways to Work Pilots* (DWP Research Report No354 CDS Leeds, 2006) 53; reported in HC Debs Vol Col.650 24 July 2006.

93 DWP Quarterly Statistical Summary.

94 n 93.

95 N Gould, 'Mental Health and Child Poverty' Joseph Rowntree Foundation 2006 p 17.

mental disorders, and changes in working practices and conditions of employment which are creating higher rates of common mental disorders.[96]

Introducing the Bill's Second Reading debate in the Commons, the Secretary of State for Work and Pensions, John Hutton, stated that existing welfare provision which

> treated functional limitations as automatically disqualifying people from the world of work … (was) based on a flawed analysis of the nature of disability.[97]

He reassured sceptics that the new assessment of capacity would be better at identifying people with MH conditions, and that it would be fairer and more accurate than previously.[98] Commenting that 'It is especially difficult to craft the assessment … for those who are mentally ill' he promised that the new system would be well able to assess incapacity of those with fluctuating illnesses.[99]

As well as introducing ESA, the Act provided for contracting out of welfare-to-work services, including responsibility for carrying out work-focused interviews, new work-focused health-related assessments, action plans, and a requirement to take part in work-related activity. However, much of the detail as to how ESA would operate was left to Regulations[100] which comprise 169 regulations and nine schedules.

Further reform

Even before ESA came into force a raft of official publications signalled changes in social security. In 2006, the DWP commissioned David Freud to investigate how to

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96 ibid.

97 *Hansard* HC Deb vol 449 col 616 (24 July 2006).

98 *Hansard* HC Deb vol 449 col 619 (24 July 2006).

99 *Hansard* HC Deb vol 449 col 620 (24 July 2006).

100 Employment and Support Allowance Regulations 2008 SI 2008/794.

'tackle the "can't work, won't work culture" – and help those caught in a cycle of benefit dependency'. His report,[101] published in March 2007, recommended that all benefit recipients, including those on incapacity benefits, should receive intensive, individualised support into employment, which would be supplied by private and voluntary sector providers on outcome-based contracts.[102] It also suggested that the Government's ambition of work for those who can and support for those who cannot, would be achieved by moving towards a single system of working age benefits, ideally a single benefit.[103]

July 2007 saw the publication of *In Work, Better Off: Next Steps to Full Employment*[104] which set out proposals 'to deliver a step change in the support we offer to those who are most disadvantaged in the labour market'. The Paper laid out five guiding principles:

- a balance of rights and responsibilities
- a personalised and responsive approach
- retention and progression, not just job entry
- partnership working
- devolution and local empowerment.[105]

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101 D Freud, *Reducing Dependency, Increasing Opportunity: Options for the Future of Welfare to Work* (CDS Leeds).

102 ibid 6.

103 ibid 9.

104 Department for Work and Pensions (Cm 7130).

105 ibid [20].

While promising condition management programmes led by health providers, targeted particularly at claimants with mental health, drug and alcohol problems, it confirmed mandatory participation in Pathways to Work schemes for ESA claimants.[106]

The 2008 Budget Report, S*tability and Opportunity: Building a Strong, Sustainable Future*,[107] reiterated the 'five principles of welfare reform',[108] stated that:

> A successful labour market is dependent on a benefit system that supports these aims. The Government will be bringing forward radical reforms to the benefit system …[109]

and announced that all incapacity benefits claimants would eventually be required to take the Work Capability Assessment.

A background research and discussion paper,[110] issued in July 2008, reviewed evidence from conditionality regimes in the UK during the previous decade, compared this with evidence from other jurisdictions and drew lessons for future policy from behavioural economics and social psychology. Concluding that conditionality had played an important role in increasing employment and reducing the numbers on out-of-work benefits it reiterated the Government's intention to develop conditionality policies further and match more support with higher expectations from claimants.

Also in July 2008, Professor Paul Gregg was commissioned to 'examine the effectiveness of conditionality within the welfare state to apply rules fairly across the

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106 ibid [30].

107 HM Treasury, March 2008 HC 388.

108 see page 77.

109 p 59.

110 DWP, *More Support, Higher Expectations: the Role of Conditionality in Improving Employment Outcomes* (DWP 2008).

system'. His report,[111] published in December 2008, recommended a single personalised conditionality and support system, in which almost everyone claiming benefits and not in work should be looking for or engaging in activity to help them move towards employment. Gregg's 'vision' included a sanctions regime which would be 'better able to deal with repeat offenders', however it did recommend that those with the most severe MH conditions should not have conditions applied.

The Department's response to the Gregg Review agreed with all its key recommendations[112] and promised pilot projects to test them. It is clear that WRA 2007 and ESA are only the beginning of the Government's plans for the welfare state. Benefit claimants will be subject to increased conditionality, accompanied by threats of sanctions for non-compliance and, for the reasons discussed in Chapter Four, this is likely to affect those with MH problems disproportionately. To redress the balance of rights and responsibilities, claimants are promised increased support, although this will be delivered by private and voluntary agencies rather than by public services. How well the Government succeeds in reducing the number of people claiming benefit because they are too ill to work remains to be seen, but in a worsening economic climate the challenge is enormous.

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111 P Gregg, *Realising Potential: A Vision for Personalised Conditionality and Support* (DWP 2008).

112 Appendix B para 2.

Employment and Support Allowance

From 27 October 2008, all the incapacity benefits (IB, SDA and IS on the basis of incapacity) were replaced for new claimants by employment and support allowance.[113] Gradually, claimants receiving the older benefits will also be moved onto ESA and all recipients of incapacity benefits are expected to be transferred to ESA between 2010 and the end of 2013.[114] Assessment of IB/IS recipients under the rules for ESA began on a trial basis in Aberdeen and Burnley on 11 October 2010.[115]

IfW benefits have always been classified as earnings-replacement benefits[116] and are included amongst those benefits which are covered by the 'overlapping benefits' rules, which prevent payment of duplicate earnings-replacement benefits.[117] However the DWP described ESA as a means of supporting people with an illness or disability to move into work rather than to stay on benefits.[118] A key feature of ESA which distinguishes it from previous sickness and incapacity benefits is that claimants are required to fulfil various conditions and activities towards improving their employment opportunities.[119] However, the ESA scheme recognises that there is a group of claimants, known as the support group,

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113 WRA 2007 Part I schs 1 and 2; ESA Regs.

114 ESA (Up-rating Modification) (Transitional) Regs SI 2008/3270 Explanatory Memorandum para 2.2.

115 Department for Work and Pensions, 'Government Reforms Begin with Fitness for Work Assessments' DWP Media Centre 11 October 2010.

116 see eg T Burchardt, *The Evolution of Disability Benefits in the UK: Re-weighting the Basket* (Centre for Analysis of Social Exclusion 1999) 4.

117 SSCBA 1992 parts II, III; Social Security (Overlapping Benefits) Regulations 1979 SI 1979/597 reg 4.

118 Work and Pensions Committee, *Employment and Support Allowance* HC 892i (2007-08) DWP memorandum 2 July 2008 [2].

119 WRA 2007 ss 11 – 15; ESA Regs Part 8.

whose condition is sufficiently severe for them not to be required to engage with the labour market.[120]

Since the basic premise of ESA is to support claimants into employment, its structure and entitlement conditions are different to those of IB. The introduction of increased conditionality and a more stringent gateway assessment are designed to reduce claimant numbers, and has had a major impact on claimants with MH problems, particularly those suffering from mild to moderate anxiety and depression.

Structure of ESA

ESA is similar to Jobseekers Allowance (JSA) in that it comprises both a non-means-tested allowance with a NI contribution test[121] (contributory ESA) and a means-tested allowance[122] with income[123] and capital[124] limits (income-related ESA). The contribution conditions for IB, detailed in Chapter Four, have been retained for ESA, and the means test is substantially the same as that for IS.

Employees who have received SSP transfer onto ESA once they have exhausted their 28-week entitlement to SSP.[125] People not in receipt of SSP may claim ESA from the

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120 WRA 2007 s 24(4).

121 WRA 2007 s 1(2)(a).

122 WRA 2007s 1(2)(b).

123 WRA 2007 sch 1 para 6(1)(a).

124 WRA 2007 sch 1 para 6(1)(b).

125 SSCBA 1992 ss 153(2)(b), 155.

fourth day of their illness.[126] All new claimants of ESA enter a 13-week assessment phase[127] during which they are paid a basic allowance aligned to the age-appropriate JSA figure. This means that claimants aged under 25 are paid less than older claimants.[128] This measure particularly affects patients with schizophrenia and bipolar disorder which generally manifest themselves during the late teens and early twenties.[129]

Article 14 of the European Convention on Human Rights, which is incorporated into UK law,[130] prohibits discrimination on a number of specified grounds and on 'other status'. A person's age could come within the 'other status' remit. However, differential treatment is only classed as discriminatory when it has no objective or reasonable justification, and Contracting States have a margin of appreciation in assessing whether, and to what extent, differences in otherwise similar situations could justify different treatment.[131] The Joint Committee on Human Rights considered the differential treatment of under-25s during the assessment phase for ESA and concluded that the provision was unlikely to be incompatible with Article 14 of the Convention. Differentiation could be justified because younger claimants have lower earning potential than those over 25 and have lower living

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126 SSCBA 1992 sch 2 para 2. There are complicated rules which may link periods of limited capability for work to previous such periods.

127 WRA 2007 s 24(2) and (3); ESA Regs reg 4.

128 £51.85 per week, compared to £65.45 for those over 25 (2010/11 rates).

129 Sane factsheet: *Schizophrenia* p 2. <http://www.sane.org.uk/uploads/schizophrenia.pdf> accessed 10 March 2011>;

NHS Choices, *Bipolar Disorder* <http://www.nhs.uk/conditions/bipolar-disorder/pages/introduction.aspx> accessed 10 March 2011.

130 Human Rights Act 1998.

131 *Burden v United Kingdom* App no 13378/05 (ECtHR, 29 April 2008) [60].

costs.[132] A similar argument, used by the Government to justify a lower rate of JSA for the under-25s was upheld by the High Court in *Reynolds*.[133]

During the assessment period, claimants are allocated either to a 'support group' (SG)[134] of the most severely ill/disabled, or are required to undergo a medical examination known as a Work Capability Assessment (WCA)[135] which has been modelled on the PCA for incapacity benefits but with significant changes.

Claimants who 'pass' the WCA are described as having 'limited capability for work' (LCW)[136] and proceed to the 'main phase' of benefit on the fourteenth week. A small proportion of the most severely disabled claimants who, after another assessment, are found to have 'limited capability for work-related activity' are allocated to the SG and are relieved of conditionality.[137] All claimants not placed in the SG are required to participate in 'work related activity' as a condition of receiving an additional work-related activity component[138] which tops up the flat-rate basic allowance paid during the main phase. Those in the SG receive a, higher, support component.[139] Detailed consideration of the SG will be found in Chapter Five at page 219ff.

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132 Joint Committee on Human Rights, *Drawing Special Attention to: ... Welfare Reform Bill ...*Second Report HL34/HC 263 (22 January 2007) [3.33, 3.34].

133 *R (on the application of Reynolds) v Secretary of State for Work and Pensions* [2002] EWHC 426 (Admin) (7 March 2002).

134 WRA 2007 s 24(4).

135 WRA 2007 s 8; ESA Regs reg 19.

136 WRA 2007 s 8.

137 WRA 2007 s 24(4); ESA Regs reg 34.

138 WRA 2007 s 13.

139 WRA 2007 s 2(2) and 4(4).

ESA timeline

Administrative procedures as well as statutory time limits impose a 'timeline' for ESA claims, as shown in the table. (Statutory references are supplied in footnotes.)

Table 2: ESA timeline[140]

Day	Action
1	Claimant telephones 0800 number to make initial claim. *Many claimants with MH problems have difficulty with telephonic communication.* Asked if they wish to claim under 'special rules'.[141] Call is recorded therefore 'no need for claimant signature'.
2-3	Claimant receives printout of claim for checking. *Claimants with MH problems may find this difficult, delay or not bother.* Claimant begins to gather information required eg medical and means-test information. *Claimants with MH problems may find this difficult or delay.* GPs of claimants under special rules may be contacted.
5	Jobcentre Plus receives Medical Services report for special rules claims. Decision made on special rules claims.
8-9	Claimant (normal rules) sends evidence to Benefit Delivery Centre (BDC). *Claimants with MH problems may delay this.* Medical certificate received at BDC and consideration given for early entry to 'work capability assessment' (WCA) for those treated as having 'limited capability for work'.

[140] compiled from Citizens Advice eLearning tutorial.

[141] claimant is terminally ill. ESA Regs reg 7(1)(a).

Day	Action
11	Claim processed; basic rate paid on due date. Local Authority is advised of claimant's entitlement. If appropriate for early entry to WCA, because of the evidence in the medical certificate, ESA50 questionnaire sent by Medical Services to those treated as having limited capability for work.
33	If claimant has not provided the required evidence requested on day 2/3, claim may be considered defective and claimant held not to have limited capability for work.[142] *Claimants with MH problems may have difficulty meeting time limits.*
35	Review of returned ESA50 questionnaires.
36	Decision sent to some claimants who can be allocated to support group by satisfying one descriptor of limited capability for work-related activity assessment based on the information given in their ESA50 and medical evidence.[143]
37	Claimants not allocated to SG receive an appointment for a medical examination.
43	Claimant attends WCA.[144]
45	Claimant gets benefit payment decision and outcome letter from LCWA and a copy of the work-focused health-related assessment (WFHRA) report.
47	Claimant receives work-focused interview (WFI) appointment.
55	Claimant receives telephone call reminder for WFI. *Useful for claimants with MH problems.*
57	Claimant attends and participates in WFI. *Attendance and participation may be problematic for those with MH problems.*

[142] ESA Regs reg 22(1).

[143] ESA Regs, reg 34(1) and sch 3.

[144] ESA Regs reg 23.

Day	Action
92	Claimant enters main phase of ESA[145] and is paid basic ESA plus either a support component or work-related activity component.[146]
92+	Conditionality applies to the WRA group, including: WFIs and further WFHRA if required.[147]

How does ESA differ from IB?

There are a number of significant differences between ESA and IB which are summarised in the table below. Differences in the methods of assessment of incapacity are discussed in Chapter Five.

Table 3: Differences between ESA and IB

ESA	IB
Intended to support claimants into employment.	An earnings-replacement benefit.
Income-related and contributory components.	Contributory component only.
Contribution conditions currently the same as for IB, but plans to require sufficient NI contributions to have been paid in previous two tax years prior to claim. *Conditions may disadvantage claimants with mental health problems who have a patchy employment record.*	Contribution conditions based on NI contributions in previous three tax years prior to claim.

145 ESA Regs reg 4(1).

146 ESA Regs reg 67(3) and sch 4 paras 11, 12.

147 ESA Regs 47-61.

ESA	IB
Claimants who do not satisfy contribution conditions can receive means-tested component.	Claimants who do not satisfy contribution conditions required to claim IS.
Basic allowance for first 13 weeks of claim, excluding period on SSP.	Short-term lower rate for first 28 weeks of sickness, which includes period on SSP; short-term higher rate after 28 weeks of sickness.
Main phase after 13 weeks of claim.	Long-term rate after 52 weeks of sickness.
No age-related additions. *Disadvantages some claimants with early-onset mental illness.*	Age-related additions to long-term rate.
Claimants under 25 receive lower basic allowance. *Disadvantages claimants whose illness begins in youth eg most schizophrenics and those with bipolar disorder.*	All claimants have same short-term rates.
No dependant additions on contributory ESA.	Dependant additions to long term rate.
Support Group of most severely disabled claimants who have limited capability for work-related activity. Entry to SG decided by an assessment with high threshold criteria. *A small number of claimants with severe mental illness will reach the threshold.*	
SG claimants receive enhanced payment. *May advantage the most seriously mentally ill claimants*.	PCA-exempt claimants receive same rate as other claimants.
Claimants in main phase and not in SG required to participate in work-related activity and work-focused interviews (WFIs). *Includes claimants with MH problems.*	Claimants required to participate in WFIs.
Provision only for deferral of WFIs if inappropriate or would not assist the claimant. Waiver only if about to enter employment. *Claimants with MH problems may be required to attend WFIs*.	Provision for both deferral and waiver of WFIs if inappropriate or would not assist the claimant.

ESA	IB
Increased conditionality and heavier sanctions. *Claimants with mental illness could find it difficult to comply with conditions and face sanction*.	Sanctions for failure to participate in WFIs but rarely invoked.
Claimants not in SG required to attend a work-focused health related assessment. *Includes claimants with MH problems.*	

Summary

Each regime after IVB was less generous in its treatment of claimants than the previous scheme. An important, but not the only, change was the replacement of informal assessment by a test of functional capacity.

Tables 2 and 3, above, show that claimants with MH problems may face a number of problems in establishing and maintaining their entitlement to both incapacity benefits and to ESA. Some of these are issues common to both regimes eg meeting the NI contribution conditions, negotiating administrative procedures and meeting time limits. Other factors are unique to ESA eg the lower benefit rate for under-25s and the test for admission to the SG. There are also difficulties which are evident for incapacity benefits, but which have been exacerbated under ESA. These include making a claim for benefit, particularly by telephone, attending medicals and engaging with WFIs.

This chapter has identified several of the key barriers to IfW entitlement, which particularly affect claimants with MH problems. The barriers form the subject of subsequent chapters: the problems posed by the claim processes, NI contribution conditions, assessment, conditionality and challenging adverse decisions.

CHAPTER THREE

CLAIMING INCAPACITY FOR WORK BENEFITS

Introduction and overview

Access to any social security benefit is achieved only by going through a formal claim process, requiring the prospective claimant to appreciate that they have a need, understand that benefit is available, and initiate contact with the appropriate department. This may involve telephoning, filling-in forms and/or answering numerous personal questions. Then they will have to provide documents to support their claim.

There is a wealth of evidence that many people do not claim benefits, including IB/IS and ESA, to which they would be entitled,[1] and research has shown that this is particularly the case for people with mental health (MH) difficulties.[2] This chapter discusses the process of claiming IfW benefits and considers the reasons for failing to make a claim.

As far as is possible, the thesis relates the particular difficulties faced by claimants to their specific illnesses, as mentioned in Chapter One. The chapter shows that people with MH problems may lack awareness of their illness and of how this impacts on their ability to work. They have problems accessing appropriate benefit advice, registering a claim for benefit and in participating in the Work-focused Interviews which now form part of the claiming process.

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1 see eg T Sefton, *Maximising the Benefits: An Analysis of British Gas' Benefit Health Check Programmes* (London School of Economics 2007); DWP, *Income Related Benefits Estimates of Take-up 2007/08* (DWP 2009).

2 see eg M Frost-Gaskin and others, 'A Welfare Benefits Outreach Project' (2003) 49 International Journal of Social Psychiatry 251.

Some of the difficulties, such as problems making a claim over the telephone, and challenging behaviour, stem from the nature of their mental illness. Further problems are caused by poor training of Jobcentre staff and their inability to engage with claimants with MH problems, and by the inflexible nature of the administrative processes which cannot accommodate the special needs of some mentally ill claimants. The chapter also demonstrates that anti-fraud campaigns may impact on people with MH problems causing them intense anxiety and reluctance to claim.

Research has identified three, clearly distinguished, phases in the path to benefit. These are: **finding** entitlement, **claiming** entitlement and **receiving** entitlement.[3] After consideration of the evidence for benefit under-claiming this chapter looks at each of these phases in turn.

As outlined in the Introduction,[4] illustrative claimant Comments and Case Studies are used throughout this thesis. These have been garnered, mainly, from welfare rights advisers who have close contact with mentally ill clients, and who have been made aware of the problems they encounter when claiming IfW benefits. The examples are intended to bring a potentially dry topic to life and to reinforce the reality that this is an issue which concerns actual, vulnerable people.

Evidence of under-claiming by people with mental health problems

A study undertaken amongst service users at a day hospital in Purley showed that 51 per cent of regular attendees with MH problems were not receiving their full

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3 R Pacitti and J Dimmick, 'Poverty and Mental Health: Underclaiming of Welfare Benefits' (1996) 6 Journal of Community & Applied Social Psychology 395.

4 pages 12, 13.

entitlement to welfare benefits.[5] This study was followed by a larger scale take-up project in Croydon[6] which found that 66 per cent of users of MH outpatient services were under-claiming.[7] No guarantee of receipt of correct entitlement was provided by being in contact with MH services for a longer time, having a social worker or having previously been given benefits advice. More alarmingly, there is evidence that clients were being given wrong or inadequate advice by social workers and other professionals who were not benefits specialists, largely as a result of their inability to keep abreast of legislative changes. Lack of insight on the part of their mentally ill clients, which is a common feature in psychosis,[8] also requires advisers to modify what they describe as 'the standard advice model'[9] so that they are more perceptive and probing in their questioning than is usual, a task for which particular expertise is needed.

Potential claimants may be handicapped by their MH difficulties in seeking advice, however, it is abundantly evident that high quality advice is important, particularly when the claimant has difficulty in making even simple decisions. In the Croydon project, those found to be under-claiming, who accepted offers of help, gained a mean annual income of £3079 each, most of which was accounted for by incapacity benefits (IB, IS and SDA).[10]

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5 Pacitti and Dimmick (n 3) 395.

6 Frost-Gaskin and others (n 2) 251.

7 These studies investigated entitlement to **all** incapacity and disability benefits.

8 See Chapter One page 18ff.

9 CABx have a Standard Advice Model which comprises four main stages: Exploration, Options, Action and Conclusion.

10 Other under-claimed benefits included disability living allowance, housing and council tax benefits and community care grants.

Why people don't claim

Bryson has identified two broad groups of reasons why people failed to claim benefits for which they may be eligible:

- lack of relevant knowledge
- attitudinal factors about the claiming process.[11]

Research undertaken by Mind in Croydon established the following reasons given by people with MH difficulties for failing to claim.

- False beliefs that they did not qualify
- incorrect assumptions that they might be worse off financially if they claimed
- concern that pursuing entitlement to IfW benefits would lead to a review of other benefits they were already receiving
- worry about delays in payment which follow changes in entitlement
- lack of confidence as to a successful outcome
- lack of knowledge as to how to initiate/pursue a claim
- being too unwell to deal with their benefits
- inability to cope with procedures seen as too complex
- concern at having to provide personal information or of intrusive questioning
- dislike of form-filling
- fear of unsympathetic and bureaucratic staff
- fear at having to attend an appeal tribunal
- perceived stigma attached to claiming benefits.[12]

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[11] A Bryson, *Information and Advice about Benefits* (Policy Studies Institute 1994).

Some of the fears expressed by service users were entirely rational and resulted from previous experiences with benefit claims.

The perception of stigmatisation is most common among the elderly[13] and those who have been previously healthy, able and economically active, who see themselves as unproductive or in some cases not respectable members of society.[14]

Finding entitlement

Reporting on research into benefit uptake, the Local Government Association, states that in order to initiate the claiming process, people need to pass through a series of linked stages. These are:

1. *a perception of need* – "I am as badly off as Joe next door".
2. *a requirement for some basic knowledge about the existence of particular benefits* – "benefit is for people in my situation".
3. *perception of eligibility for the particular benefit* – "I think I might qualify for this".
4. *a view that the benefit will be useful* – "but even if it's only 50p a week, that's £25 a year. I could buy some kids shoes with that".
5. *positive beliefs and feelings about the process of claiming and the institutions that administer benefits* – "they were helpful, polite and quick when Gurinder claimed".

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12 Pacitti and Dimmick (n 3) 395; Frost-Gaskin and others (n 2) 251.

13 People over the female retirement age, are ineligible for ESA. Evidence abounds for under-claiming of Pension Credit; see eg DWP, *Entitled but Not Claiming? Pensioners, the Minimum Income Guarantee and Pension Credit* (DWP Research Report No 197 CDS, Leeds 2003), and attitudes to welfare benefits have been passed on to later generations.

14 G Jones and A Fenyoe, *Review of Incapacity Benefit: Qualitative Research Findings* Evidence to the GLA (Synovate Ltd 2006) [3.1.1.]

6. *perception by the claimant that their situation will be stable* – "I am going to be off work for at least a month".[15]

Claimants may also need to overcome fears that in applying for benefit they may be gaining access to something to which they are not entitled. This 'failure of the "entitlement relationship"' is described in *Standing Up for Claimants*[16] as resulting from public perceptions that welfare recipients are scrounging and claiming benefits they don't really need.

> Not surprisingly, claimants themselves begin to feel uneasy about their own position in such a climate of opinion, and doubt the moral force of their entitlement even when it is backed by law.[17]

These comments apply to claimants in general, but those with mental illness, in which paranoia is a feature, may be disproportionately affected. Anti-fraud campaigns and their attendant publicity have also had the effect of making some mentally ill people fearful of making a claim.[18] The issue of how claimants with MH problems are affected by anti-fraud campaigns is considered in greater detail later in this chapter.

Awareness

The first necessary step is that the person concerned must recognise that they are ill and unable to work. People with MH problems such as schizophrenia[19] may have false perceptions about their situation and the administrative procedures to which they

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15 — *It's a Right ..... Not a Lottery. Benefits Take-up Initiative - a Good Practice Guide for Local Authorities* (Local Government Association 1998).

16 R Berthoud, S Benson and S Williams, *Standing up for Claimants – Welfare Rights Work in Local Authorities* (Policy Studies Institute 1988) 1.

17 ibid.

18 See for example Conference Report, National Disability Welfare Conference, Sheffield 15 October 2005 and Rightsnet Discussion Forum. The author of this thesis also has personal experience of people with mental health difficulties stating that they were afraid to claim benefits in case they were accused of fraud.

19 page 18.

would have to submit, and may therefore fail to even begin the claiming process. Psychotic patients frequently deny that they are ill at all and consequently they may initiate their claim long after they would have been entitled to benefit.

Case Study A describes the situation faced by a welfare rights adviser who was approached by a concerned friend of a person with MH problems. The potential claimant had failed to acknowledge their illness and had delayed in making a claim to benefit.

Case Study A[20]

Alan was brought into the Advice Centre by his flatmate. His flatmate reported that Alan was still in bed when he went off to work in the morning and was refusing to eat the meals he prepared because he said they were poisoned. However, Alan would stay up until about 4 am although he didn't seem to be doing anything. Alan had recently borrowed a lot of money from him and he was worried that he didn't seem to have any source of income. The flatmate felt sure he ought to be getting some sort of benefit.

Questioning by an adviser revealed that, three months ago, Alan had been dismissed from work after he threw a paperweight at his computer screen. Alan had been convinced that he was being watched from behind the screen. Since then Alan had been living on what savings he had, but these had now been exhausted.

Surmising that Alan could be mentally ill, the adviser suggested that Alan should see his GP. He also telephoned the Jobcentre Plus Contact Centre[21] and initiated a claim for IB. The adviser specifically requested a clerical claim form so that he and Alan could complete it together. A request for backdating of benefit was also made.

The potential claimant will need to obtain a medical certificate confirming their incapacity for work.[22] Certification requires them to admit, not only to themselves, but also to a doctor, that they are mentally ill. Doctors face difficulties dealing with some patients who, fearing stigma, find this step difficult, a particular problem for young

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20 Client RS of CBWR&CAB.

21 Jobcentre Plus is an Executive Agency of the Department for Work and Pensions.

22 SS(ME) Regs reg 2.

people who are reticent to talk about their problems with an older person.[23] There is also some evidence that GPs do not always correctly diagnose mental illness, especially in the case of adolescents and young people.[24] Other young people may hesitate to consult their GP because of concern that information may get back to their family.[25] The next Case Study, provided by an adviser at a CAB which runs a mental health project for young people, illustrates these situations.

Case Study B[26]

Barry had admitted suicidal ideation to a Youth Worker but had not felt able to discuss this with his GP. His Youth Worker volunteered to accompany him to the doctor's surgery, but during the consultation Barry only mentioned asthma to the GP. Only when prompted by the Youth Worker did Barry reveal his mental health problems.

Information and advice

Potential claimants are usually recommended to seek advice on claiming appropriate benefits. However mental illness such as depression[27] may prevent sufferers from motivating themselves to do so.

People may choose to seek out information leaflets published by the DWP or to approach an adviser in person or by telephone. Possible sources of advice include:[28]

- Jobcentre Plus Offices
- Citizens Advice Bureaux

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23 Evidence from Stockton CAB Young Persons Mental Health Project.

24 ibid.

25 ibid.

26 Client of Stockton CAB Young Persons Mental Health Project.

27 page 21.

28 It is necessary to distinguish between information/advice and representation. Whereas all the sources listed may provide information/advice, not all are able to act on a claimant's behalf and/or provide representation.

- Local Authority welfare rights services
- Law centres/independent advice agencies
- social workers
- mental health team members
- friends, family and other claimants.

The nature and quality of advice will vary according the source. That given by a Jobcentre might be considered not to be impartial, whereas that provided by friends or family may be well-meaning but not authoritative.

In choosing from where to seek advice a mentally ill person might look for:

- somewhere nearby
- someone already known to them who is sympathetic to their condition
- somewhere they won't have to wait
- an organisation with welfare rights expertise
- experts in mental health.

In 1982 the National Consumer Council produced a report about advice agencies[29] which identified four factors that influence a person's choice of agency:

- referral: they have been referred to the agency from another source
- familiarity: they are already familiar with the agency through long use
- "checking out": they want to check on the situation before taking a further step
- appropriateness: the agency is seen as the appropriate place to get advice.

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[29] G Borrie, *Advice Agencies: What They Do and Who Uses Them* (National Consumer Council, London 1982).

Case Study C demonstrates the different advice provided by different organisations and the consequences to a potential claimant of not seeking independent expert advice.

Case Study C[30]

Colin has suffered from Post-traumatic Stress Disorder for many years. He experiences flashbacks to traumatic incidents, is severely depressed and is unable to work. He had been receiving IB for seven years. Following a medical examination, he scored 9 points on the mental health descriptors of the PCA (only one point short of what he needed to "pass" the PCA).

Colin called in to his local Jobcentre for benefit advice where he was told that he would have to claim income support pending the outcome of an appeal against the decision that he was capable of work. In these circumstances, a deduction of 20 per cent of the IS single person's personal allowance is made.[31]

Colin was not informed that he had another option. He could have claimed Jobseekers Allowance instead. To do this Colin would have needed to be available for and actively seeking work,[32] although he could have placed restrictions on his availability on grounds of his mental health.[33] However, he would have been unlikely to have been placed under any pressure by the Jobcentre until after an unsuccessful appeal hearing.

An experienced welfare rights adviser would have provided Colin with a range of options and their advantages and disadvantages, so that he could have made an informed choice. By claiming IS rather than JSA he suffered a loss of income of £11.13 a week (2006/07 rates).[34]

Although the Jobcentre would be liable were false or misleading information to be provided, there is no obligation on staff to point out options or indicate other benefits to which the claimant may be entitled.

However, claimants want more than just information about their entitlement to benefit. They may require 'better-off' calculations to establish the best route for their individual circumstances, as was illustrated in Case Study C.[35] They also need advice about how to obtain application forms, help to fill in forms, information about what other documents or data they may need to supply, and to be told what to do with the

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30 Client AMcC of CBWR&CAB.

31 IS Regs reg 22A.

32 Jobseekers Act 1995 ss 1(2), 6 and 7; JSA Regs chaps II, III.

33 JSA Regs reg 13(3).

34 IS Regs reg 17(1) and sch 2 para 1.

35 There is a complex interplay with means-tested benefits and tax credits and there are rules regarding 'overlap' of earnings replacement benefits.

completed form. They will almost certainly want to know how much money they are going to receive and how other benefits may be affected. Claimants may also be concerned about what to do should their circumstances change.

In a survey of welfare advice given in GP surgeries,[36] recipients reported a range of benefits resulting directly from that advice. These included:

- extra money: incapacity benefits, disability benefits
- housing and council tax benefits
- free prescriptions, dental check-ups and eye tests
- debt counselling and debt rescheduling
- respite care, meals-on-wheels
- social benefits: improvements in relationships with family and friends.

All survey participants stated that as a result of the advice received their mental health had either stabilised or improved. These results confirm earlier research which demonstrated that increased income consequential on welfare benefits advice improved mental health and vitality, and resulted in reductions in GP consultations and in prescribed medication.[37]

DWP leaflets

Claimants who are diffident about approaching advisers in person may prefer to obtain official Departmental leaflets. A report by the National Audit Office (NAO),

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[36] S Moffat and others, 'The Impact of Welfare Advice in Primary Care: a Qualitative Study' (2004) 14 Critical Public Health 295.

[37] S Abbott and L Hobby, *An Evaluation of the Health and Advice Project: Its Impact on the Health of Those Using the Service*, Report No 99/63 (Health and Community Care Research Unit, University of Liverpool 1999).

published in 2006,[38] criticised the reliability and accuracy of DWP leaflets and the difficulty of obtaining up-to-date copies of leaflets. The report also commented on the difficulty many people had in understanding the content of leaflets. It is essential that information supplied to people who may be mentally ill, and therefore have problems with concentration or interpretation of material, is clear and unambiguous.

After the critical NAO report the DWP undertook a major review of its leaflets and reduced the number of pre-printed leaflets from 208 at a cost of £10.3 million in April 2005 to 53 at a cost of £1.7 million in December 2008, and put in place a new contract for printing and distribution.[39] In recent years the Department has made an effort to provide a service which is more responsive to the needs of its customers and has changed the way in which it provides information. There has been significant growth in telephone enquiries and in provision of online information about benefits on the internet. Many leaflets are now available in an Easy-Read version, which although intended for people with learning difficulties are also suitable for those with MH problems who have poor concentration and interpretive skills. However, telephone based services are not always suitable for mentally ill claimants.[40]

The Jobcentre

Visiting a 'social security' office is a different experience to that of 20 years ago. The modern Jobcentre is bright and furnished with comfortable seating. Gone are the screens which used to separate claimants from staff. Nonetheless, they can still be

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38 Comptroller and Auditor General, *Using Leaflets to Communicate with the Public about Services and Entitlements* NAO HC 797 (2005–06).

39 Comptroller and Auditor General *Department for Work and Pensions: Communicating with Customers* NAO HC 421 (2008–09) 5.

40 This issue is discussed in further detail later in this chapter.

frightening places for people with mental illness, and staff may be poorly equipped or insufficiently trained to deal with them appropriately.

Jobcentres can be crowded, and confusing to those who are unfamiliar with the layout. A screened-off area has been replaced by desks in an open plan office, and visitors frequently complain of a lack of privacy.[41] This can be a particular problem where people are discussing matters they consider very sensitive and personal, such as mental health problems.[42] A Research Report quoted a DSS customer.

> *You are trying to talk to someone and there's half a dozen people behind you listening to what you're trying to say.* [43]

In their review of incapacity benefits in London, researchers Synovate Ltd report on comments made by Jobcentre staff who felt that better provision could be made for sick and disabled customers. Staff stated that open plan offices did not work for claimants who might be discussing their health issues with a stranger for the first time. Staff also commented on the lack of toilet facilities available to clients.[44]

Some personnel at Jobcentres have been described as 'rude', 'emotionless' or judgemental. Comments such as these were made about staff with whom claimants had not built personal relationships, such as staff on the front desk, those they had met on one occasion or had seen in the past. These criticisms were sometimes made alongside

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41 A Corden, K Nice and R Sainsbury, *Incapacity Benefit Reforms Pilot: Findings from a Longitudinal Panel of Clients* (DWP Research Report No 259 CDS, Leeds 2005) 80.

42 — *Submission to the Work and Pensions Committee* Rethink September 2005 [21].

43 Customer ED, quoted in J Vincent and others, *Choosing Advice on Benefits* (DSS Research Report No 35 HMSO, London 1995) 45.

44 Jones and Fenyoe (n 14) [3.2.9.]

favourable comments about other staff, particularly their current incapacity benefit Personal Adviser (IBPA).[45]

Rethink also reports on a general lack of understanding of mental illness by Jobcentre staff, evidenced by the use of unhelpful, inappropriate language in both written and verbal communication with mentally ill people. This 'translates into a failure among DWP staff to be sufficiently flexible in arrangements' to meet the specific needs of the mentally ill.[46] Specifically cited are:

- refusal to visit claimants at home, because anxiety is not perceived as a major barrier to attendance at a Jobcentre
- scheduling of appointments at inconvenient times, given the frequency of disturbed sleep patterns amongst mental health sufferers
- giving of insufficient advance notice of appointments, which makes it difficult for people with anxiety problems to adjust to the idea of attending the Jobcentre.

Personal Advisers in Jobcentres, themselves, have said that they lack knowledge and experience in mental illness and feel out of their depth with these customers. There have been circumstances where advisers were concerned that either by their action or inaction they could be having a negative impact on a person's mental health.[47] One IBPA described:

> … on three occasions now, we've actually had clients who were verging on suicide. And that was a major concern for us. Fortunately in, I think two of the cases, we actually had colleagues from the NHS who were actually sitting in and who were able to just take the client away and speak to them. Because, for me, it's like…if this chap's

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45 Corden, Nice and Sainsbury (n 41) 41.

46 — *Submission to the Work and Pensions Committee* Rethink September 2005 [69].

47 S Dickens, A Mowlam and K Woodfield, *Incapacity Benefit Reforms - the Personal Adviser Role & Practices* (National Centre for Social Research 2004) 16.

found lying in the [name of river] in the morning, you know, could I have done something?[48]

A CAB client described her experience of a visit to the local Jobcentre.

Case Study D[49]

Diane suffers from severe anxiety, depression and panic attacks. She has been receiving income support on the basis of incapacity for several years. Diane recently moved home from Norfolk to Northamptonshire and called in to a Northants. Jobcentre to inform them of her change of address. As she entered the building she was met by a uniformed security guard[50] who asked her business. Diane felt intimidated and left immediately.

Rethink has recommended that, to avoid people with mental illness encountering a hostile or threatening atmosphere when attending a Jobcentre, all Jobcentre Plus staff should receive mental health awareness training.[51]

Enquirers at a Jobcentre may have to wait for long periods before being seen and then may have only a brief interview. A Mind service user described their reaction to having to wait.

I get terribly worked up if I've got to queue or wait for something.[52]

One contributor to the DWP Welfare Reform blog wrote:

I also have problems with my mental health and feel there is a lack of empathy all round including people who deal with benefit claims. How are we expected to go back to an

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48 ibid.

49 Client LT of CBWR&CAB.

50 Security personnel at Jobcentres are not employees of the Jobcentre but work for private security companies contracted by the DWP.

51 — *Submission to the Work and Pensions Committee* Rethink September 2005, Recommendation 14.

52 Client of Neath Mind, quoted in J Stenger, *The Big Book of Benefits and Mental Health 2006/07* (Neath Port Talbot Mind 2006) 6.

> employer with a problem when your confidence gets constantly knocked by the people who are actually supposed to be helping you in the first place ie jobcentre staff and there call centre staff. they are implicitly rude and condescending and don't want you on the phone or at there desk and will tell you anything to get rid of you. the answer to the problem of getting people with mental health issues back to work is simple. Retrain government jobcentre staff to be more approachable and all round nicer people then maybe we will find the confidence to ask for help and look for jobs!!![53]

Similar remarks were made in evidence given to the Greater London Assembly enquiry into Incapacity Benefit in London.

> Stigma and discrimination are important problems in how people with a mental health problem are approached (or avoided) by Jobcentre staff. This can mean that despite a government drive to help people move from IB to work, those with a mental health problem are seen as difficult and complicated, and not offered the help they need to return to work. However, a consequence of the experiences described above is that Jobcentre Plus is also subject to stigma. People with mental health problems expect poor treatment and avoid communication - which can cause them problems. This can become a self fulfilling prophecy, with increased distance from the labour market, and worse mental health. The systems currently in place and being developed often contribute to this. Letters are phrased in such a way as to make vulnerable people frightened – which can again lead to avoidance and problems for that person. Many people with mental health problems will now not open letters in a Jobcentre plus envelope for fear of the contents. The development of call centres to begin the claim process is designed to make the service more efficient, but is seen as a barrier by many with a mental health problem. They find the systems unfriendly, overly bureaucratic, and unable to deal with their particular problems.[54]

Once possible entitlement to benefit has been identified, the potential claimant must then take positive steps towards initiating a claim. Some benefit uptake campaigns have concentrated only on finding entitlement and have then left the claiming of benefit to the client. As a result not all of those eligible for benefit will actually make a claim. Mentally ill people, in particular, will require guidance and encouragement to help them through the next phase.

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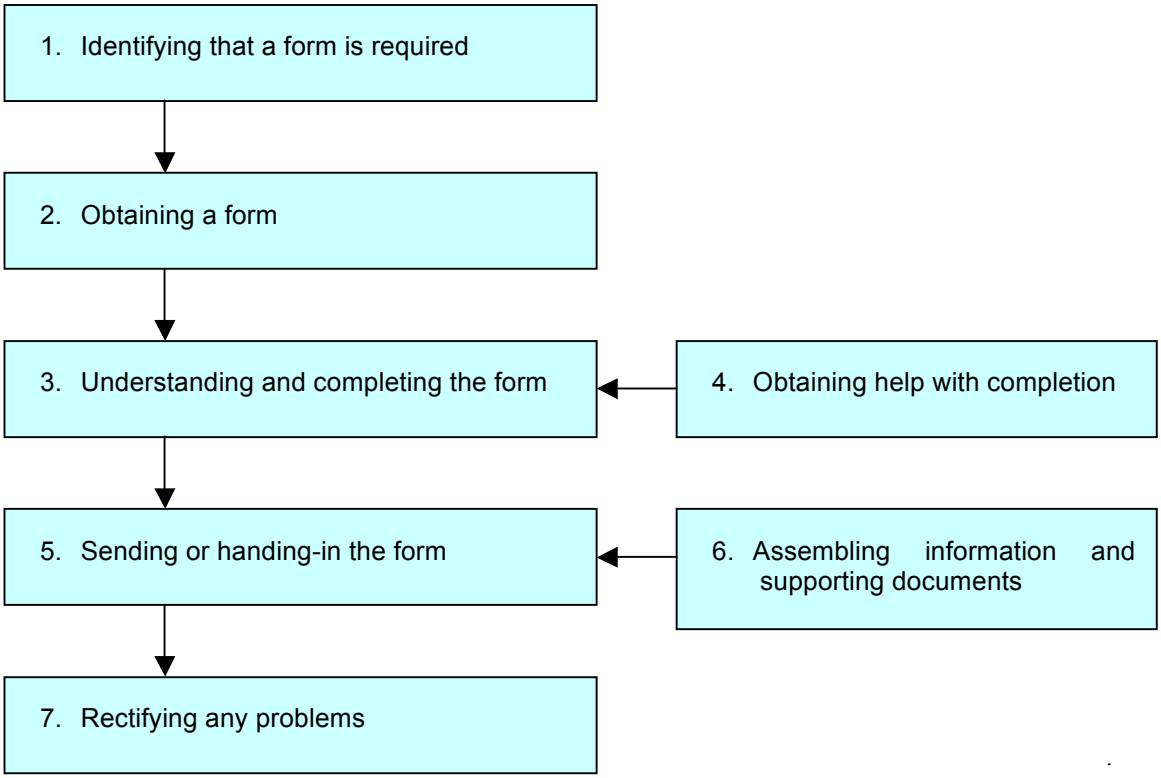
[53] <http://www.dwp.gov.uk/welfarereform/blog/index.php/2006/10/19/mental-health-action/>, posted 8 November 2006 at 11:01 pm by "lisa smith".

[54] Evidence to the GLA Review of Incapacity Benefit in London, Brendan McLoughlin, Care Service Improvement Partnership, 2006.

Claiming entitlement

The route towards securing any of the IfW benefits is by making a 'claim' ie an application for benefit.[55] The National Audit Office has identified seven main stages in the process of form-filling.[56]

Figure 1: Stages in form-filling



Each of these steps is fraught with problems for people with MH difficulties. Chapter One has previously considered the nature of mental illnesses and the way in which they may impact on a claimant's ability to successfully negotiate the social

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55 Social Security Administration Act 1992 s 1; SS(C&P) Regs reg 4.

56 Comptroller and Auditor, General *Difficult Forms: How Government Agencies Interact with Citizens* NAO HC 1145 (2002-03).

security system. For example a person suffering from psychotic illness[57] may not appreciate the need for a claim form. Getting hold of a claim form presents problems for people who lack motivation (depressives and those who are drug/alcohol dependent), and also for those who are anxious about using the telephone. Understanding the form can be a problem even for those who are not mentally ill, but those suffering from anxiety or who are paranoid may be reluctant to seek help. Assembling the required information and documents presents a challenge to those who lack motivation (depression) or whose lives are chaotic (some psychotics, those who are drug/alcohol dependent).

Problems with claiming processes

Once a person becomes aware of possible entitlement to benefit they must then do something positive towards making an actual claim. As discussed in Chapter One, when a potential claimant is suffering from an illness whose features may include apathy (as in depression), fear (anxiety) or paranoia (schizophrenia) then this apparently straightforward step can be problematic.

For many years the procedure for making a claim for incapacity benefits was the same as for other benefits. Intending claimants could either call into their local Social Security Office in person and request a claim form, or telephone and arrange to have a form sent to their home address. In 1988 an investigation by the National Audit Office identified difficulties in obtaining the necessary forms as one of the significant factors

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[57] page 18.

inhibiting claims for social security benefits.[58] This is a particular problem for the mentally ill for whom it could be a considerable effort to make enquiries, and who will give up when faced with problems.

Having obtained their claim form, it was filled in and returned to the Social Security Office, either in person or by post. This procedure provided an opportunity for claimants to seek help and advice with their claim from an advice agency or other source of assistance.

In April 2005 the DWP introduced a Customer Management System (CMS) which required claimants of certain benefits, including incapacity benefit, to register their claim by telephoning a Contact Centre and answering some diagnostic questions from an operator's script. This was followed by a return telephone call lasting about 45 minutes in which the claimant provided all the information required for their claim. A summary of that information was then sent to the claimant who amended it as necessary, signed it and posted it to a central processing department.

Problems with telephone claims

The CMS was gradually rolled-out nationwide so that all incapacity benefits claims were intended to be made by telephone. From its inception, the CMS was on the receiving end of an avalanche of complaints from welfare rights organisations.[59] Criticism focussed on the refusal to issue clerical claims forms, which had the effect of denying the assistance of welfare rights advisers, or to accept any completed forms at

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58 Comptroller and Auditor General, *Department of Health and Social Security: Quality of Service to the Public at Local Offices* NAO HC 451 (1997–1998).

59 See eg Rightsnet discussion forum at <http://www.rightsnet.org.uk/dc/dcboard.php?az=show_mesg&forum=103&topic_id=1308&mesg_id=1308&listing_type=search> accessed 10 April 2008.

Social Security offices. The Departmental insistence on tele-claiming was despite the explicit terms of the Claims and Payments Regulations which state that claims for all benefits except IS and JSA are to be made in writing on a form approved by the Secretary of State,[60] that such forms are to be supplied free of charge on request,[61] and may be delivered or sent to an appropriate office.[62] It was not until May 2006 that Jobcentre managers were instructed that although 'Customers should always be encouraged to make new and repeat claims via the Contact Centres, clerical claims forms must not be refused'.[63]

Many claimants and advisers reported the lack of alternatives to telephone claims, difficulties in obtaining IB claim forms and refusal of Jobcentres to accept clerical forms.[64] In response to a Parliamentary question requesting an estimate of the likely change in the number of postal claims for IB, IS and JSA as a result of Jobcentre closures, the Secretary of State produced a statement from the Chief Executive of Jobcentre Plus, Lesley Strathie:

> We do not have a postal claim scheme for these three benefits. For the vast majority of claimants, the initial claim to these benefits will be made by a telephone call to a Contact Centre. For those vulnerable customers who are unable to make contact by telephone, the claim will be taken at a face-to-face interview.[65]

A further source of complaint was the script used by Contact Centre staff, who have limited training about the social security system in general. Callers could have been informed, sometimes incorrectly, that they were not eligible for IfW benefits, but not be advised about any alternative benefits to which they might have been entitled.

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60 SS(C&P) Regs reg 4(1).

61 SS(C&P) Regs reg 4(5).

62 SS(C&P) Regs reg 4(6)(b). 'Appropriate office' is defined in reg 2(1) as an office of the DWP.

63 Managers' Update, Jobcentre Plus, May 2006.

64 Citizens Advice submission to the GLA Review of Incapacity Benefit in London, August 2006 p 3.

65 *Hansard* HC vol 472 col 2426W (4 Mar 2008).

Telephone contact is of use only when the claimant can take in what is said, respond appropriately and remember everything they are told, something which is recognised in the Personal Capability Assessment for IB/IS.[66] Large numbers of people with MH problems have difficulty using the telephone because of anxiety, fear that telephone calls are being 'monitored' somehow, or problems with unease about 'officialdom'.[67] A report by the National Audit Office into the DWP's contact centres confirmed that '… in the case of customers with mental illness or learning difficulties, telephone calls can be stressful or confusing.'[68]

> *I just go to pieces on the telephone. I have to get my sister to phone for me.*[69]

In 2007 the Social Security Advisory Committee reported on the barriers to access to DWP personnel that are faced by those with MH problems, and stated that solutions to the provision of reliable alternatives to telephone access had yet to be established.[70] Even people without mental illness might find a 45-minute telephone conversation, in which they must provide detailed personal information, harrowing.

> *I've only been out of the psychiatric hospital for three days. And they were asking me what sort of job I thought I could do.*[71]

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66 SS(IFW) Regs sch Descriptor 15(a): Cannot answer the telephone and reliably take a message.

67 Stenger (n 52) 5.

68 Comptroller and Auditor General, *Delivering Effective Services through Contact Centres* NAO HC 941 (2005–06).

69 Client of Neath Mind, quoted in Stenger (n 52) 6.

70 — *Telephony in DWP and its Agencies: Call Costs and Equality of Customer Access* (Occasional Paper No 3 SSAC 2007).

71 Reported by Judy Stenger, NAWRA conference, 7 March 2007, Peterborough.

Regrettably, following the introduction of ESA, problems with tele-claims were even worse. A year after ESA inception, Citizens Advice produced a report on the administration of this new benefit.[72] Claimants and advisers reported long waits on hold for telephone calls to be answered with typical delays of 20-30 minutes[73], with a further 30-40 minutes (for an experienced adviser, longer for an unaided claimant) to complete a telephone claim.[74]

Since these calls are to a 0845 number with a message system, charging starts immediately and callers are placed in a queue. One claimant had a telephone bill totalling £15 for the calls necessary to resolve the problem on her case.[75] As a result of a campaign by Citizens Advice on the cost of telephone calls from mobile phones, in January 2010, the DWP reached agreement with companies covering more than 90 per cent of the UK mobile market[76] to end charges to their customers for mobile calls to around seventy of its 0800 numbers, including numbers used to make initial benefit claims.[77] However, one adviser reported that a client using a mobile phone to claim ESA on a 0800 number, had incurred a bill of £45 to Vodafone because the length of the call exceed their permitted minutes.[78]

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72 V Pearlman and S Royston, *Limited Capability: CAB Evidence on the First Year of Employment and Support Allowance Administration* (Citizens Advice 2009).

73 ibid 9.

74 Minutes of NAWRA Conference Edinburgh 4 September 2009 p 3.

75 Work and Pensions Select Committee, *Decision Making and Appeals in the Benefits System* HC 313 (2009-10) NAWRA memorandum DM16 [5].

76 O2, Orange, Tesco Mobile, T-Mobile, Virgin Mobile and Vodafone.

77 'Free Mobile Calls for Benefit Claimants Starting from 18 January' DWP press release 15 January 2010.

78 ariadne2, Rightsnet Discussion Forum <http://www.rightsnet.org.uk/dc/dcboard.php?az=show_topic&forum=108&topic_id=4395&mesg_id=4395&page=> accessed 27 March 2010.

Difficulties were again reported with the inflexible nature of the call centre operators' script and its inability to cope with likely scenarios, for example claims from people on Statutory Sick Pay (SSP) about to transfer to ESA.[79]

The Government has made clear that it sees telephony and IT as key to its Welfare Reform agenda,[80] and has already made a huge investment in telephony with a promised 25,000 contact centre seats[81] and a 'vision' for electronic service delivery and online benefit applications.[82] One contributor to a TUC Conference described the proposals as 'the development of the business model which had removed the ability to provide a personalised approach'.[83] Some claimants with MH problems may prefer to interact with their computer rather than a live person; others will be reluctant to engage with, or become frustrated by, new technology. Claimants need to be provided with a range of methods of contacting DWP, so that they can choose the most suitable for their circumstances.

It is still not yet well-known that claim forms for ESA (ESA1) can be downloaded for written completion or filled in on-screen then printed.[84] ESA1s can also be submitted to the DWP via a secure server.[85]

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79 NAWRA Conference, Chesterfield 27 November 2009.

80 J Hutton, *Report by the Secretary of State for Work and Pensions under section 82 of the Welfare Reform and Pensions Act 1999* HC 39 (21 November 2006).

81 — *ICONS - Integrated Communications Network Services* (Cabinet Office 2007).

82 — *Electronic Government Services for the 21st Century* (Cabinet Office 2000).

83 P Barton, *An Alternative Vision for the Welfare State* TUC Poverty Conference, Congress House 19 October 2009.

84 at <http://www.dwp.gov.uk/advisers/claimforms/esa1.pdf> accessed 16 February 2010.

85 at <http://www.dwp.gov.uk/eservice/#> accessed 16 February 2010.

Problems with clerical claims

The problems faced by customers with mental ill-health were highlighted in a National Audit Office Report which remarked on the length of claim forms and the difficulties of gathering together evidence.[86] The SC1 claim pack for IB consisted of 10 pages of notes and a 38-page form to complete; this is a daunting task for anyone, let alone a person with MH difficulties who may have difficulty understanding or interpreting instructions, or lack concentration, motivation and will-power. If the claim had been made by telephone a similar-length document was sent to the claimant who was required to check it for accuracy and sign it, before returning it the processing centre.

A common complaint was of a 'one-size-fits-all' treatment, with an impersonal and generic claim form that conveyed a negative approach from the 'powers that be'.[87] This was seen as a first sign that claimants were required to 'prove' that they were special enough to merit entitlement to support, rather than as a key to access it.[88]

The claimant carried the onus of satisfying the test of incapacity for work[89] and in addition to completing the form, a number of documents may have needed to be supplied. One of these was a medical certificate (Med 3) which conformed to the prescribed form.[90] A Med 3 certificate could only be obtained following 'an examination', and thus required the claimant/patient to make an appointment to see their doctor. Those with anxiety and depression may find taking this step difficult, and even

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86 Comptroller and Auditor General, *Dealing with the Complexity of the Benefits System* NAO HC 592 (2005–06) 10.

87 Jones and Fenyoe (n 14) [3.1.2.]

88 ibid.

89 *R(S) 13/52*.

90 Social Security (Medical Evidence) Regulations 1976 SI 1976/615 s 2 and sch 1.

if they make it to the surgery could be reluctant to enter into discussion about their problems.

With effect from 6 April 2010 Med 3 forms were replaced by Statements of Fitness for Work,[91] known colloquially as 'fit notes'. The doctor completing the certificate can record either that their patient is not fit for work, or that they may be fit for work subject to advice regarding a phased return to work, altered hours, amended duties and/or workplace adaptations which may be appropriate. One slight improvement, for patients and doctors alike, is that telephone assessments are permitted, however there were some reservations on the part of the BMA who felt that the occupational health sector, rather than GPs, was best placed to make judgements of this kind.[92] The new Statement goes some way to recognising the spectrum of incapacity and some of the occupational barriers to employment. It does not, however, address the social and environmental factors such as poor self-esteem, lack of confidence and educational disadvantage which affect many claimants with MH problems.

Other documents such as a birth certificate, marriage certificate, SSP1 and details of any pension may also be needed to support a claim for benefits. Someone with MH problems may have difficulty remembering where these documents are located and in collating them. (Not altogether irrational) fears of losing valuable documents and of bureaucratic processes may discourage claimants from sending them by post.

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91 Social Security (Medical Evidence) and Statutory Sick Pay (Medical Evidence) (Amendment) Regulations 2010 SI 2010/137.

92 — 'New Fit Note Means Onus is Now on Employers to Act, Says BMA' BMA Press Release 1 April 2010.

Most IfW benefit claimants perceived the claim process as 'over-bureaucratic, complex and lengthy'.[93] Research conducted into the pilot programmes for reform of incapacity benefit confirmed this view and showed that claimants were generally critical of the process. Administrative inefficiency and error, the pace of proceedings and the size and 'confusing' nature of application forms were all cited as problems. It was also felt that there was not enough help and advice available in making a claim.[94] Problems such as these have a disproportionate impact on claimants suffering from mental illness who find it difficult to cope when things go awry.

When ESA was introduced, the workload for Jobcentre staff increased dramatically, due partly to the 'integrated' nature of ESA, as a benefit which is both contribution-based and income-related, and they struggled to cope. Although some of that increase in work was also due to a worsening economic situation, much of the problem resulted from the fact that staff were ill-prepared for the nature and volume of the work entailed by the new benefit. At a conference of welfare rights advisers held almost a year after the introduction of ESA, delegates from all over the country reported instances of official error and maladministration, inadequate advice being given to claimants particularly in relation to possible alternative benefits on which they could be better off, and poor training of call centre operators.[95] A leading mental health charity has stated that this poor decision-making, inadequate information sharing and deficient training exacerbate claimants' mental distress.[96]

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93 Jones and Fenyoe (n 14) [3.1.2.]

94 Corden Nice and Sainsbury (n 41) 16.

95 Minutes of NAWRA Conference Edinburgh 4 September 2009 p 2.

96 Work and Pensions Select Committee HC 313 (2009-10) (n 75) Mind memorandum DM24 Ev 109.

In his foreword to the 2008/2009 Annual Report of the Social Security Advisory Committee, SSAC Chair, Sir Richard Tilt, commented:

> ... we have become increasingly concerned about the capacity of Jobcentre Plus and its partners to continue to deliver quality services, tailored to the needs of individual customers that can achieve these goals[97] in a weakened labour market, in which the most disadvantaged work seekers face relatively more daunting barriers than previously.[98]

In November 2009 Citizens Advice produced a report[99] which it described in the following terms.

> The purpose of this paper is to provide a commentary on the experiences of CAB clients and advisers of the administrative problems they face in claiming ESA. It aims to provide timely feedback to Jobcentre Plus and the DWP, with a view to improving both policy and practice.

Citizens Advice expressed concern over their statistics which showed that between May and October 2009 the percentage of bureaux enquiries dealing with poor administration of ESA was 50 per cent higher than the equivalent for IB. Administrative difficulties were also reflected in a sharp increase in CAB qualitative evidence on ESA problems.[100]

The document described what it called 'pinch points' during claimants' journeys to ESA entitlement ie stages of the process during which systemic problems become apparent.

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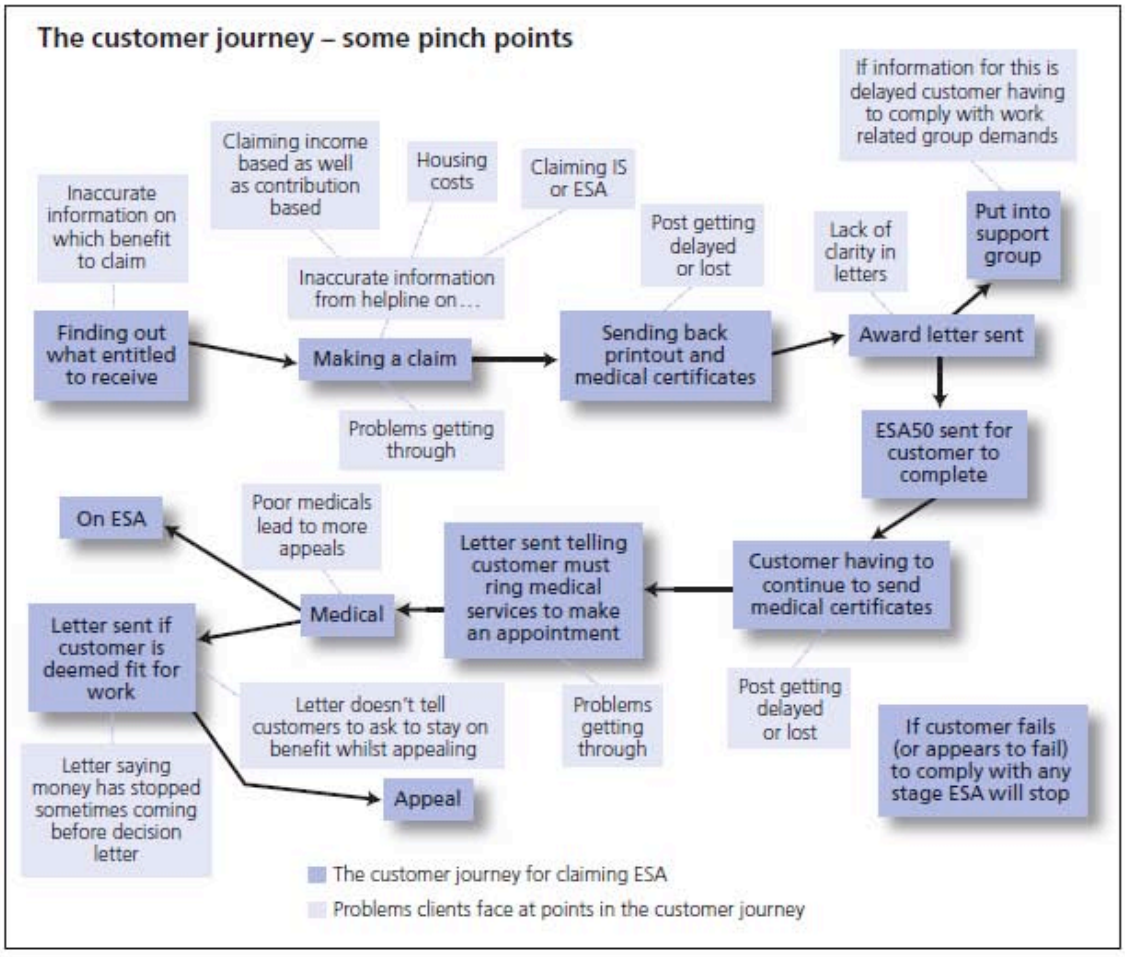
97 maintaining the pace and direction of welfare reform, and supporting all those who can do so to take and keep employment.

98 Social Security Advisory Committee *22nd Report August 2008–July 2009* (SSAC 2009) v.

99 Pearlman and Royston (n 72).

100 ibid 3.

Figure 2: Stages of an ESA claim at which systemic problems may occur[101]



Whereas administrative failures are not unique to claimants with MH problems they may have particular difficulty in coping with them, for example they may be easily confused by poor information and lack of clarity in written communication.

Case Study E illustrates the consequences of the confusion caused to a vulnerable person by a badly worded DWP letter.

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[101] ibid 4.

Case Study E[102]

A CAB worker based in a County Court was approached for help by a slightly confused man facing possession of his property for non-payment of rent. Detailed investigation of his circumstances showed that he was under-claiming benefits by about £75 a week.

The client's wife was severely physically disabled and received IB and higher rate DLA care and mobility components. He was her sole carer. When he contacted the Jobcentre he was told to claim ESA. The letter which he produced to his CAB adviser stated

> You are not entitled to employment and support allowance. This is because the law says that you are not entitled to employment and support allowance.

A telephone call to the Jobcentre elicited the information that his claim had been denied because he had failed to provide the documentary evidence for which he had been asked. The client's confusion and inability to cope with paperwork and manage his finances were all symptoms of a MH problem.

The adviser discussed a number of options with the client. He could reclaim ESA, provide the necessary documents, attend a Work-focused interview and a medical, with the possibility of being found capable of work. Alternatively, he could claim carers allowance for looking after his wife, and either of them could make a claim for income support.

Advisers also reported a lack of 'ownership' of cases, with one adviser having spoken to 22 different people before resolving a particular problem.[103] People with MH problems need to establish a relationship of trust with one person, and may become upset if they have to repeat information previously supplied, or make repeated calls to a call centre.

There were also reports of forms being lost[104] and of long delays in processing claims, resulting in delayed payment.[105] As illustrated in Case Study F, delays were often caused by medical certificates being mislaid somewhere in the system, possibly

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102 client AH of CBWR&CAB.

103 Work and Pensions Select Committee, HC 313 (2009-10) (n 75) NAWRA memorandum DM16 [6].

104 Minutes of NAWRA conference Edinburgh 4 September 2009 p 2.

105 See for example Rightsnet Discussion Forum <http://www.rightsnet.org.uk/dc/dcboard.php?az=show_topic&forum=111&topic_id=4187&mesg_id=4187&page=3> accessed 1 November 2009.

because the claimant sent their certificate separately from other documents and did not appreciate the need for it to be clearly identified with a NINO and an address.

Case Study F[106]

A CAB client in Dorset was assisted by his adviser and his community psychiatric nurse (CPN) to make a claim for ESA. The DWP at Chippenham requested medical certificates to support his ESA application and these were sent by the CPN. The medical certificates appeared to have become lost in the system.

The delay in putting ESA into payment caused the client to run out of money and resulted in considerable hardship. His telephone was cut off, making it difficult for both the bureau and the DWP to contact him, and he fell in to rent arrears.

The client's illness was exacerbated, to the extent that he was readmitted to a mental health care unit as an in-patient.

When the CAB arranged for further certificates to be sent, the client was eventually awarded ESA from March 2009.

Currently, however, there is no effective mail tracking system, so that once correspondence has gone astray it is very difficult for claimants to establish that it was actually sent or to find out where it is.[107]

While delays are irritating to all claimants, they present major difficulties to those with MH problems who are already struggling with their claim, and their condition may be made worse. CABx across the country have reported cases of clients with MH problems allowing ESA claims to lapse because of the frustration involved in trying to contact a call centre and their inability to cope with the stress.[108]

The case study below illustrates, not only the complexity of the current social security system, but also the poor service given by Jobcentre staff to one claimant.

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106 ibid.

107 Pearlman and Royston (n 72) 7.

108 ibid 9.

Case Study G[109]

A man sought advice about his ESA claim from a CAB in Greater Manchester. The CAB discovered that he had been turned down for contribution based ESA because he had insufficient NI contributions but would have been eligible for income based ESA if the claim had been taken when he telephoned the call centre to make his original claim. By the time he came to the bureau, it was calculated that he had lost about £1,000 of benefit.

Claimants with MH problems, who have a patchy employment record, are disproportionately represented amongst those who do not meet the contribution tests for contribution based ESA. The situation is complicated by the poor quality of ESA award letters received by claimants. A report by the Work and Pensions select committee on decision-making and appeals, stated, with specific reference to ESA notification letters:

> We are disappointed to hear that computer-generated notification letters continue to make it difficult for some claimants to understand how a decision on their benefit claim has been reached. Both this Committee and the National Audit Office have raised the issue of incomprehensible written communications from DWP in the past and yet this continues to be a problem. We ask the Department to outline what work it is undertaking to improve its notification letters and to ensure that decisions are properly explained and easily understood by claimants. We believe that better explanation of the rationale behind decisions could reduce the number of appeals and requests for reconsideration that are brought forward, delivering savings elsewhere in the system.[110]

Following an Equality Impact Assessment, in September 2010 the DWP conceded that some of its communications were confusing, and reported that more than 4 million calls annually were generated by their poor letters. It announced proposals to 'transform' Departmental letters.[111]

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[109] Pearlman and Royston (n 72) 6.

[110] Work and Pensions Committee, *Decision Making and Appeals in the Benefits System* HC 313 (2009-10) [109].

[111] Department for Work and Pensions, *Transforming Departmental Letters* (DWP 2010).

Any advice and information supplied to potential claimants must also be accurate and comprehensive. Some advisers described claimants as being 'lured' onto ESA when there are other, unexplored, options.[112]

Claiming means-tested benefits

Incapacity benefits claimants who could not meet the NI contribution conditions might have been eligible for income support (IS), which is a means-tested benefit (MTB). To qualify for IS, claimants and their partners are assessed jointly, and must meet conditions relating to their combined income and capital.[113] The partner must not be working for 24 hours, or more, per week.[114]

The eligibility conditions for receipt of MTBs are extremely complex and are poorly understood by potential claimants, so that claiming MTBs may be fraught with problems. As discussed earlier,[115] claimants with MH problems may be particularly disadvantaged when claiming these benefits. However, such problems are not unique to IfW claims and they can occur with any of the MTBs.[116] There is also an interplay between tax credits[117] and MTBs which further complicates the situation. For these reasons, and also because of lack of space, detailed discussion of the entitlement conditions for MTBs is precluded.

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112 ibid.

113 SSCBA 1992 ss 124(1)(b) and 134(1); IS Regs Part V.

114 SSCBA 1992 s 124(1)(c); IS Regs reg 5(1) and (1A).

115 p 106ff.

116 MTBs comprise IS, IRESA, income-based JSA, pension credit, housing benefit and council tax benefit.

117 Tax credits paid by HMRC are also means-tested, but are not classed as 'benefits'.

The research by Pacitti and Dimmock illustrates vast under-claiming of MTBs, which can top-up other benefit income, by claimants with MH problems.[118]

The following table, illustrates IB and IS rates paid in 2008/09 (the year ESA was introduced).

Table 1: Incapacity benefit and income support rates, 2008/09

	Single person (>25)	**Couple (both >18)**
Incapacity benefit (short term higher rate)	£75.40	-
Incapacity benefit (long term)	£84.50	-
Income support, personal allowance	£60.50	£94.95
Disability premium	£25.85	£36.85
Income support after a year of incapacity	£86.35	£131.80

Thus, a single person on short term IB was above the IS level, whereas on long term IB, and with no other income, they received less than the relevant income support rate. Entitlement to additional amounts, known as premiums, for example to carers, and offset of other income, created further complexity.

A frequent cause of confusion for incapacity benefits claimants was that even when someone knew for certain that they were not entitled to IB eg because they had a gap in their NI record, they had to complete the SC1 claim form in addition to the forms required to claim incapacity credits and income support on the basis of incapacity. The

[118] Pacitti and Dimmick (n 3) 395. See p 93ff.

introduction of ESA as a single benefit removed the need to complete two claim forms when claiming only the means-tested benefit but created new administrative problems.

When a person makes their initial claim for ESA they need to specify from the outset whether they are claiming contribution based or income-related benefit (IRESA). This could be difficult if they either do not know of, or do not understand, the difference between them. Welfare rights advisers have also noted that ESA award letters sometimes fail to supply important information such as whether the claimant is receiving contribution based, income-related or both benefits.[119] Receipt of IRESA provides claimants with an automatic 'passport' to other benefits such as housing benefit, council tax benefit, help with health costs and access to the social fund. Claimants who do not receive IRESA may still qualify for assistance with some of these benefits eg health costs, on low income grounds, however this information is lacking from award notices[120] and a separate claim is required.

People are also not informed that there may be other social security benefits that they could claim as an alternative to ESA. For example, carers and lone parents with young children, who are unable to work because of sickness or disability, may claim IS instead. When the person who is incapable of work has a partner, there may be several benefit options available depending on the particular circumstances of the couple eg if the partner is unemployed they might claim JSA, or if the partner is a carer they could claim IS. This demonstrates the need for potential benefit claimants to seek independent and authoritative advice based on a 'better-off' calculation.

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[119] NAWRA Conference, Chesterfield 27 November 2009.

[120] Several clients of CBWR&CAB.

Transition from other benefits

The process of claiming IfW benefits is easiest for people who move on to benefit from employment after exhausting their 28-week entitlement to SSP. They should have been issued with form SSP1 which comprises a statement from their employer stating that they are not entitled to SSP. They would still need to make a claim for IfW benefit in the usual way.

However large numbers of people claiming on the basis of MH difficulties have not been in recent employment. They may have been dismissed from their jobs, been made redundant or been unemployed for some time. Such events are known to contribute to a person's likelihood of becoming mentally ill.[121] Administrative data shows that, every year, about five per cent of claimants of Jobseeker's Allowance (JSA) moved onto incapacity benefits (around 200,000 people). Of these, 22 per cent had been on JSA for between one and two years, and a further 23 per cent who had been on JSA for two years or more.[122]

Data for the year to the end of March 2001 showed that 27 per cent of those moving from JSA to IB/IS had MH problems and six per cent were alcohol or drug users. Further analysis revealed that a 'depressive episode' was the largest single category listed (15 per cent), with 'other anxiety disorders' shown as six per cent.[123]

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121 J Moncrieff and J Pomerleau, 'Trends in Sickness Benefits in Great Britain and the Contribution of Mental Disorders' Journal of Public Health Medicine (2000) 22 59; C Beatty and S Fothergill, 'The Diversion from "Unemployment" to "Sickness" across British Regions and Districts' Regional Studies 39(7) 837 Oct 2005; M Howard and others, *Poverty: the Facts* (4th edn CPAG London 2001); D Evans and WL Claiborn (eds), *Mental Health Issues and the Urban Poor* (Pergamon Press Inc 1974) 11.

122 K Ashworth, Y Hartfree and A Stephenson, *Well Enough to Work?* (DSS Research Report No 145 CDS, Leeds 2001).

123 A Hedges and W Sykes, *Moving between Sickness and Work* (DWP Research Report No 151 CDS, Leeds 2001).

The Welfare Reform Green Paper[124] proposed that maximum use should be made of the rules whereby JSA claimants are allowed two spells of short-term sickness of two weeks within a twelve-month period.[125] It suggested that JSA claimants would have to exhaust these permitted spells of short-term sickness before they were able to claim incapacity benefits. More 'proactive' sickness management arrangements eg return from illness interviews, revision of Jobseeker's Agreements and referral for special assistance were also proposed.[126] The plans were criticised in Mind's written evidence to the Work and Pensions Committee which argued:

> … that the primary motivation for this change is to prevent movement from JSA to IB, rather than providing appropriate support for people to get back to work where they can do so. These proposed changes should only go ahead if JSA staff are provided with comprehensive, ongoing training on mental health issues[127]

and have not been implemented.

Although, in theory, transfer from SSP to ESA should be a simple seamless process, in practice there have been problems, most created by the script used by call centre operators which does not appear to be able to cope with those whose SSP is ending.

Late claims and limited opportunity to backdate

> [A] classic issue with people with mental health problems is, if they are in crisis, then they will not communicate. They will not open their post, they will not answer the phone, they will not leave the house etc. That is very common for people with mental health problems in crisis. Of course, if you do not respond to communication from the Jobcentre Plus, then your benefit may be cut or sanctioned etc. You can, of course, be in

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124 Secretary of State for Work and Pensions, *A New Deal for Welfare: Empowering People to Work* (Cm 6730, 2006) [61].

125 JSA Regs reg 55(1).

126 DWP (Cm 6730, 2006) (n 124) 38.

127 Work and Pensions Committee, *Incapacity Benefits and Pathways to Work* Third Report of Session 2005–06, HC 616-II Ev 170.

> a position where you can look for a reconsideration of whatever the decision is, or show good cause, but in the meantime you will lose benefit.[128]

Many people with MH problems become confused as to date and time. This could result in missing time limits imposed by the claim system, or they might fail to understand their importance. Claimants of IB/ESA were/are permitted to backdate a claim by up to three months, providing the qualifying conditions during that period are satisfied, and they did/do not need to provide a reason for their late claim.[129] The main qualifying condition is, of course, that they were incapable of work, and claimants requesting backdating should supply a medical certificate covering the whole period. The form required to certify incapacity for work for an earlier period is a pink Med 5[130] which the doctor could issue in 'special circumstances' if they were satisfied that their patient was incapable throughout the period.[131] However, many mentally ill people, especially younger ones, are not registered with a GP or have a phobia of doctors, and may not be able to supply a certificate.[132] Regulations provide that when it would be 'unreasonable' for a certificate to be supplied, that other 'sufficient evidence' of incapacity will be accepted.[133]

The case study, below, is an example of how a person with mental health difficulties may delay a claim for benefit.

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128 Sue Christoforou (Mind) in evidence given to the Economic Development, Culture, Sport & Tourism Committee, Greater London Assembly, 19 October 2006.

129 SS(C&P) Regs reg 19(1) and sch 4 paras 2, 16; CIB/2805/2003. The precise legal construction is that the 'time prescribed for claiming benefit is "the day in respect of which the claim is made and period of 3 months immediately following it"'. Thus a claim made on 15 June 2010 could be paid from 13 March 2010.

130 Replaced from 6 April 2010 by a Statement of Fitness for Work. See n 90.

131 SS(ME) Regs reg 2 and sch 1(A).

132 Evidence from Stockton CAB Young Persons Mental Health Project (personal email correspondence from Mike Robinson 9 June 2007).

133 SS(ME) Regs reg 2(1)(d).

Case Study H[134]

Cathy is a lone parent who had suffered from depression for several years. Her entitlement to income support came to an end in November 2009 when her youngest child attained the age of ten. At roughly the same time, her eldest son committed suicide, and one week later her father died of a heart attack.

Cathy was in a state of complete despair and confusion when she sought advice about debts in January 2010. It became clear that, since her IS finished, Cathy's only income had consisted of child benefit and child tax credit. She had been too preoccupied with her other problems, and too unwell, to make an ESA claim.

Cathy was assisted to claim ESA, and backdating was requested to the date from which her IS had ended.

The situation was more complicated for claimants who could not satisfy the NI contribution conditions and who claimed income support instead. Income support can only be backdated in exceptional circumstances. One such circumstance is that the claimant was ill or disabled and consequently could not reasonably have been expected to make the claim earlier, and 'it was not reasonably practicable for the claimant to obtain assistance from another person to make his claim'.[135] Claimants who satisfy these conditions may have their claim backdated for a maximum of three months.[136] The Chief Commissioner in Northern Ireland gave these provisions detailed consideration and stated that:

> 'reasonably practicable for him to obtain assistance' must mean something other than 'can reasonably have been expected to make the claim earlier', otherwise there would be no need for the two sub-paragraphs to consist of different terminology in qualifying reasonableness.[137]

He also considered, specifically, the case of mentally ill claimants and decided that having MH problems did not necessarily mean that assistance could not be sought from another person. Because individual circumstances vary so much each case needs

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134 Client CG of CBWR&CAB.

135 SS(C&P) Regs reg 19(4) and 19(5)(b).

136 SS(C&P) Regs reg 19(4).

137 C12/98 para 11.

to be considered on its merits. Commissioner Levenson has interpreted the position further by holding that someone other than the claimant, even a close family member, should not be expected to take the initiative and offer help.[138]

The challenging behaviour of mentally ill claimants

Citizens Advice has drawn attention to the difficulties facing claimants who have been banned from the offices of statutory agencies because of their behaviour. They describe the difficulties experienced by people who are vulnerable to emotional or mental difficulties when faced with open plan offices, lack of privacy, crowds and long waiting periods, and who may then exhibit challenging behaviour.[139]

The case study which follows was described in a CAB Social Policy Report, and is illustrative of the challenging behaviour which some people with MH problems may exhibit, which may lead to their being excluded from Jobcentres.

Case Study I[140]

A woman with mental health problems, living on income support with a disability premium, attended a Hampshire Jobcentre Plus office for a pre-arranged interview. Despite the fact the Jobcentre had been warned that she was vulnerable they made no preparations and moved her around from counter to counter and from person to person. The claimant became increasingly agitated, eventually sweating, dribbling, crying and lying on the floor.

People sometimes go without money rather than subject themselves to the Jobcentre environment.[141] Citizens Advice points out the need to address these issues, rather than excluding certain people from their offices.

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138 CIS/2057/1998.

139 L Cullen, *Out of the Picture: CAB Evidence on Mental Health and Social Exclusion* (Citizens Advice 2004) [4.14.]

140 ibid.

Anti-fraud campaigns and people with mental health problems

Agencies supporting clients with MH difficulties report that their service users are questioning their entitlement to benefits, because of anti-fraud advertising campaigns. The following quotation was made by the carer of a user of Neath Mind.

> *She thinks she shouldn't be getting the benefits she's on. Every time there's something on the news about benefit fraud she rings up, desperate that they are talking about her.*[142]

There is some evidence that claimants with MH difficulties may also be restricting their activities to ensure that they are not suspected of committing fraud. This issue was raised at a meeting of the All-party Parliamentary Group on Mental Health held on 18 March 2006, and attended by John Hutton, then Secretary of State for Work and Pensions. The Chair, Lynne Jones MP, suggested that the DWP's anti-fraud advertisements were frightening for claimants and could give the impression that claimants could not leave the house or play sport without fear of being accused of fraud. In response, the Secretary of State (who stated that he had not seen the adverts) noted that the issue of fraud was a serious one but recognised that many people with depression were being prescribed exercise by their GP and should not be afraid of being seen at the gym.[144]

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[141] ibid.

[142] Carer of client of Neath Mind, quoted in Stenger (n 52) 11.

[144] Notes of APPGMH meeting <http://www.poptel.org.uk/lynne.jones/d0515.mar2006.2.htm> accessed 6 April 2008.

Mind also comments on the effect on claimants with MH difficulties who, following an assessment, have been held to be fit for work. Having 'bared their soul' to the DWP they have been disbelieved; did that mean they were committing fraud?[145]

> *By the time the tribunal came round I'd stopped caring about the money. It felt really personal – like they were calling me a cheat and a liar. All I'd actually done was tell them about me and my life … yet it felt like they were utterly dismissing me – like I didn't count.*[146]

Mind has expressed concern regarding proposals to conduct spot checks on claimants who, having fulfilled all eligibility criteria, are getting benefit. They describe adding to regular PCAs as 'unnecessary' and predict that introducing

> fear and uncertainty into the lives of those claimants, … may well result in the deterioration of some claimants' mental health.[147]

Citizens Advice has suggested that the focus on fraud was designed to enlist support for reform from the general public rather than having any basis in evidence of widespread abuse. References to random checks and DWP-sponsored media programmes served only to alarm people currently receiving IfW benefits and misinform them about the aims of reform.[148] Some allegations of fraud were being made on minimal evidence, such as the case of one claimant of income support on the basis of mental illness who is reported as having his benefit suspended as fraudulent simply because he stuck airmail stickers on the envelope.[149]

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145 Stenger (n 52) 12.

146 Carer of client of Neath Mind, quoted in Stenger (n 52) 11.

147 Work and Pensions Committee, *Incapacity Benefits and Pathways to Work* HC 616-II (2005–06) Ev 172.

148 Citizens Advice submission to the GLA Review of Incapacity Benefit in London, August 2006 p 5.

149 Cullen (n 138) [4.7.]

One statutory body reports on the problems created by reports of fraud allegedly perpetrated by sufferers of mental illness.[150]

Case Study J[151]

A claimant with mental health problems, who was receiving income support on the basis of incapacity, was seen to be leaving his house at regular times and was reported to the fraud section by a neighbour. In fact, the claimant was making an effort to return to work by volunteering. However, his income support was immediately stopped and the process of challenging the accusation resulted in considerable stress and a lot of time.

Not only did he lose income support, but also housing benefit and council tax benefit. As a result he ran into rent arrears and was threatened with eviction. His health deteriorated and he was forced to give up his volunteer activity.

The DWP declares that more than 677 calls a day are made to their fraud hotline, with a further 476 benefit thieves reported online daily, a total of 1153 per day (420,845 annually). For the year 2008-09, the DWP claimed to have caught 56,493 benefit thieves, representing 13 per cent of informees, of whom 6000 were convicted (1.5 per cent)[153] and others will have received a formal caution. Thus much of information received seems to be groundless. The Care Services Improvement Partnership describes false allegations of benefit fraud as an ongoing problem which 'wastes resources as much as hoax calls to the emergency services'.[154] Other critics have claimed that the hotlines reduced social cohesion and made innocent citizens the victims of deranged neighbours determined to cause misery.[155]

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150 Evidence to the GLA Review of Incapacity Benefit in London, Brendan McLoughlin, Care Service Improvement Partnership, 2006.

151 ibid.

153 <http://campaigns.dwp.gov.uk/campaigns/benefit-thieves/> accessed 17 February 2010.

154 Written evidence to the GLA Review of Incapacity Benefit in London (CSIP 2006) 2.

155 P Wintour, 'Benefit Informers Could be Given Share of Cash Saved' *The Guardian* (London 9 February 2010) 1.

The reality is that the estimated fraud rate for incapacity benefit is only 0.5 per cent, the second lowest of any benefit. (The lowest estimated rate is for State Retirement pension, for which the fraud rate is too low to measure.)[156] In October 2010 the Government issued a strategy document[157] proposing a tougher stance on fraud, which suggests introducing a £50 civil penalty for 'failure to take reasonable care' when making a benefit claim,[158] abolishing cautions as a penalty for fraud[159] and increasing the administrative penalty from 30 to 50 per cent, with a minimum penalty in the region of £350.[160] Claimants with MH problems are likely to form a significant proportion of those held to have failed to take reasonable care over a claim. More claimants may be deterred from initiating a claim for a benefit to which they would be entitled.

Receiving and maintaining entitlement

Once having made a claim, receipt of IfW benefits depends on the claimant fulfilling important criteria:

1. (a) National Insurance contribution conditions, to qualify for incapacity benefit and contribution-based ESA; or

   (b) satisfaction of both the income and capital criteria, to qualify for IS and income-related ESA.

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156 DWP, *Fraud and Error in the Benefit System: October 2008-September 2009* (DWP Information Directorate 2010).

157 Fraud and Error Strategy Division, *Tackling Fraud and Error in the Benefit and Tax Credits System* (DWP 2010).

158 ibid [7.4].

159 ibid [7.5].

160 ibid [7.7].

2. Being declared incapable of work/having limited capability for work, usually following an assessment of capacity. (This criterion applied to all the IfW benefits.)[161]

National Insurance contribution conditions and assessment form the subjects of Chapters Four and Five respectively.

A further problem for claimants is that awards of IfW benefits are reviewed regularly, so that the claimant may be subject to frequent assessments, with no guarantee that the decision-maker will make the same determination as previously. This, and other problems raised by assessment of incapacity, is covered in detail in Chapter Five. Continued receipt of benefit may also depend on the claimant's participation in interviews and other work-related activities. These will be considered in Chapter Six.

Summary

Whereas all claimants may experience difficulties in establishing a claim for incapacity benefits/ESA, people with MH difficulties are disproportionately affected. Their difficulties stem from the nature of their illness, administrative procedures, the complexity of the benefits system and lack of awareness and training by DWP staff.

Some of the problems encountered eg finding out about benefit entitlement, are common to both IB and its replacement, ESA. Other problems, such as having to make claims over the telephone, have been exacerbated since ESA was introduced. The integrated nature of ESA does not appear to have simplified the claim process.

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[161] SSA 1998 s 31; SSCS(D&A) Regs regs 10,11.

CHAPTER FOUR

NATIONAL INSURANCE CONTRIBUTIONS

Introduction and overview

This chapter considers the contributory nature of incapacity benefit and employment and support allowance (ESA), and in particular the way in which the contribution conditions can affect people with mental illness. It shows that large numbers of claimants, many with MH problems, do not qualify for contributory benefits and may need to rely on means-tested benefits. Entitlement to means-tested benefits may also be precluded because of their own or their partner's financial resources or their partner's employment. Some claimants do not qualify for any payment at all, and receive only national insurance (NI) credits.

Types of benefit for incapacity

The UK social security system which is in place today has evolved into a complex structure of many benefits. The benefits paid for IfW can be broadly classified into three groups, as shown below.

Table 1: Types of benefit available to people who are incapable of work

Type of benefit	Example
Contributory	incapacity benefit contribution-based employment and support allowance
Non-contributory	severe disablement allowance
Means-tested	income support income-related employment and support allowance

As outlined in Chapter Two, the principle on which IB and its predecessors was based was that employees were required to make a contribution from their wages, so that they could receive an income from the State when they were unable to work either through illness or disability, or in old age. The proposal for a flat-rate benefit in return for a flat-rate contribution was one of the main planks of the modern welfare state proposed by Lord Beveridge.[1] It gave rise to the 'insurance myth' that contributions paid for future benefits. This was never the case, as contributions are used to meet current benefit needs. The revenue of the NI fund has only ever met its expenditure in two of the tax years since 1948, and has required considerable Treasury supplements.[2]

Further evidence of erosion of the contributory principle is shown by the fact that claimants of contributory JSA, IB and ESA who receive private or occupational pensions above £85[3] have half of the amount by which their pension exceeds the threshold deducted from their contributory benefit.[4] For IB and ESA permanent health insurance payments above the threshold also incur deduction.[5]

During the run-up to the 2010 general election the then Prime Minister, Gordon Brown, stated that a one per cent increase in NI contributions for employees, employers and the self-employed from April 2011 would be used to 'protect our schools, our hospitals and our policing'.[6] The Conservative Party, meanwhile, made proposals to increase the employee NI thresholds. The coalition agreement reached between the

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1 W Beveridge, *Social Insurance and Allied Services* (Cmd 6404, 1942).

2 *1988/89 and 1990/91*. A Budd and N Campbell, *The Roles of the Public and Private Sectors in the UK Pension System* (HM Treasury 1997) [30].

3 2010/11 rate.

4 JSA 1995 s 21, sch 1 para7, JSA Regs regs 80, 81; SSCBA 1992 s 30DD; WRA 2007 s 3, ESA Regs reg 74.

5 IB Regs reg 20; ESA Regs reg 72.

6 *Hansard* HC Deb vol 508 col 963.

Conservative and Liberal-Democrat Parties after the election abandoned that proposal, and pledged to use the money saved thereby, not for social security benefits, but to increase income tax personal allowances to help lower and middle income earners. It now seems that all the UK's main political parties view NI as yet another form of taxation, and condone weakening of the link between NI and social security.

In September 2009 the Centre for Social Justice proposed a simplified social security scheme with a single primary benefit comprising two components, Universal Work Credit and Universal Life Credit,[7] and which removes the distinction between contributory and non-contributory benefits.[8] In May 2010 Iain Duncan Smith, Chair of the Centre for Social Justice, was appointed Secretary of State for Work and Pensions, so he is now in a position to make his proposal a reality. The 2010 Comprehensive Spending Review which set out the Government's four-year spending plan confirmed its intention to introduce Universal Credit over two Parliaments.[9]

The Spending Review also announced that the Government planned to limit entitlement to contributory ESA for those in the work related activity group to a maximum of one year,[10] thus eroding the contributory principle even more.

National Insurance contribution conditions

With the exception of people who were incapable of work from youth, to whom special rules apply,[11] entitlement to IB depended on the claimant fulfilling two

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7 S Brien and ID Smith, *Dynamic Benefits: Towards Welfare that Works* (Centre for Social Justice 2009) 264ff.

8 ibid 267

9 Chancellor of the Exchequer, *Spending Review 2010* (Cm 7942, 2010) 7.

10 ibid [1.61].

11 SSCBA 1992 s 30A(1)(b) and (2A), sch 3 para 2.

contribution tests. The same conditions applied to contribution-based ESA (CESA)[12] until 30 September 2010.

1. They must have actually paid, in one of the last three complete tax years before the relevant 'benefit year',[13] either Class 1 (employee) or Class 2 (self-employed) NI contributions, producing an earnings factor at least 25 times that year's lower earning limit.[14]

2. They must have either paid, or been credited with, contributions producing an earnings factor equal to 50 times the lower earnings limit in each of the last two complete tax years before the relevant benefit year.[15]

From 1 October 2010 the first contribution condition was tightened by reducing the number of tax years in which contribution payments could be made, from three to two.[16]

The rationale of these conditions is that recipients of contributory benefits should have a recent connection to the world of work, either as an employee or a self-employed person.[17] The effect, however, is to exclude large numbers of potential recipients.

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12 WRA 2007 s 1(2)(a), sch 1 paras 1-3.

13 SSCBA 1992 s 21(6). A benefit year begins on the first Sunday in January of one year and ends on the Saturday immediately preceding the first Sunday in January of the following year. Sometimes it is advantageous for a claimant who might wish to make a benefit claim in December to delay their claim until after the first Sunday in January so as to rely on NI contributions in later contribution years. This reiterates the importance of authoritative advice to benefit claimants.

14 SSCBA 1992 s 21 and sch 3. A relevant benefit year for CESA is the benefit year in which the claimant's current period of limited capability for work (LCW) began, or if linking rules apply, the year in which the first linked period of LCW began. For example, a claim made for LCW beginning in June 2010 would rely on NI contributions made in tax years 2006/07, 2007/08 and 2008/09.

15 SSCBA 1992 s 21 and sch 3.

16 WRA 2009 s 13(1-4); Welfare Reform Act 2009 (Commencement No 3) Order 2010 SI 2010/2377 art 2(1)(b).

17 In this respect IfW benefits differ from JSA, for which the contribution conditions exclude Class 2 (self-employed) NI contributions.

Groups likely to fail the contribution tests include:

- married women paying reduced rate NI contributions
- part-time and low paid workers earning below the threshold for NI contributions
- those with a patchy employment record, including many mentally ill people whose fluctuating condition resulted in intermittent work
- people who had never been employed, such as those whose illness began in youth[18]
- people who have gone abroad
- those who have been in prison (a study of sentenced prisoners showed that 60 per cent of them had personality disorders and 40 per cent had neurotic disorders).[19]

The second contribution condition additionally excludes people who in the previous two to three years have neither worked nor claimed NI credits, many of whom will be female carers. Carers who receive carers' allowance[20] are credited with contributions equal to that year's lower earnings limit,[21] and these assist towards the second contribution condition for IfW benefits. Carers not in receipt of carers' allowance, used to receive Home Responsibility Protection which assisted them in satisfying NI requirements for a State Retirement Pension,[22] but they did not get credits

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18 some mental illnesses such as schizophrenia become apparent in youth.

19 N Singleton and others, *Psychiatric Morbidity of Prisoners in England and Wales* (ONS, London 1998).

20 for which they must be caring for a severely disabled person, who receives DLA/AA, for a minimum of 35 hours a week. Social Security (Invalid Care Allowance) Regulations 1976 SI 1976/409 (as amended) reg 4(1).

21 Social Security (Credit) Regulations 1975 SI 19975/556 (as amended) reg 7A(1).

22 SSCBA 1992 s 21(3) and sch 3, par 5(7)(b); Social Security Pensions (Home Responsibilities) Regulations 1994 SI 1994/704.

which help to meet requirements for IfW benefits. Home Responsibility Protection was abolished from 6 April 2010,[23] being replaced by Class 3 NI credits, however these still do not qualify recipients for ESA.

There is some evidence that carers often feel isolated and overburdened and may themselves develop mental health problems because of the pressures they face.[24] A survey commissioned by the Department of Health[25] came to the following conclusions.

- Women providing care were more likely than men to report mental health problems. 21 per cent of the women in the sample had a score on or above the threshold of 12 on the CIS-R (the questionnaire used to assess neurotic symptoms) compared with only 12 per cent of the men.
- Taking account of age, female carers were found to be more likely to have high levels of neurotic symptoms than women in the general population but for men no significant difference was found.
- People who spent 20 or more hours per week caring had worse mental health than those spending less time providing care. Members of the former group were about twice as likely to have scores of 12 or more.

A further problem is created by the requirement for contributions to be credited for 50 weeks in each tax year. A gap in excess of two contributions means that the entire year cannot be counted. Such gaps can occur when people

- take holidays when on JSA
- go abroad

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23 Social Security (Contributions Credits for Parents and Carers) Regulations 2010 SI 2010/19.

24 Professor Graham Thornicroft, Director of Research and Development Institute of Psychiatry at <http://www.kcl.ac.uk/phpnews/wmview.php?ArtID=414> accessed 6 May 2007.

25 — *Mental Health of Carers* (Department of Health and ONS 2002).

- change jobs and neglect to 'sign on' during the intervening period
- switch between employment and benefits, and claim late
- claim an alternative benefit eg move from JSA to maternity allowance.

Although it is possible to make up missed contributions, this cannot be done **after** a relevant benefit is claimed, which is frequently when the shortfall emerges. People who are mentally ill often delay their claims for benefits,[26] sometimes for considerable periods, resulting in deficits in their NI records. They may also have been dismissed from work for misdemeanours such as poor timekeeping or inappropriate behaviour, before it was obvious that they were mentally ill, and had a sanction applied to their JSA.[27] No credits can be made for periods during which people are 'sanctioned'.[28] The case study, below, illustrates one such set of circumstances.

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[26] Some of the reasons why people with MH problems may make a late claim for benefits eg lack of motivation and interest, were discussed in Chapter Three, and illustrated by Case Study H; A Davis, *Users' Perspectives and Problems 2: What the Research Tells Us* in G Zarb (ed), *Social Security and Mental Health*: *Report on the SSAC Workshop* (SSAC Research Paper No 7, 1996) 24.

[27] Jobseekers Act 1995 ss 19(6)(a).

[28] SS(Cr) Regs reg 8A(5)(c).

Case Study A[29]

Stephen is a shy person who was employed as a gardener by a local authority. He found it difficult to socialise with his colleagues and he experienced isolation and harassment at work. He made several complaints to his supervisor, but this only made the bullying worse. One day, he was subjected to taunting by a workmate and he 'snapped', punching him in the face. Stephen was instantly dismissed.

Stephen made a claim for JSA and received a 26-week sanction because he was dismissed for misconduct.

Stephen's mental health deteriorated throughout this period and he was unable to find employment. He remained on JSA for another year, but then became so ill that he sought medical help and his doctor declared that he was unfit for work. Stephen made a claim for ESA, but failed the second NI contribution test as he had a gap in his record for the most recent relevant contribution year. Stephen received income-related ESA.

Stephen conceded that he had been mentally ill for several years, but had been reluctant to seek help.

However, the first contribution condition is relaxed for certain carers, those receiving working tax credit which includes a severe disability element and recipients of CESA in the last complete tax year before the benefit year of the new claim.[30] For these people, sufficient contributions paid in any one tax year will be enough.[31] The effect of this regulation is to make it possible for people who had a previous spell of limited capability for work and who then break their claim, to requalify. People with mental illness who suffer relapses following a return to work are helped by this provision.

The case study which follows illustrates how it is possible, inadvertently, to create a gap in one's NI contribution record.

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29 Client SG of CBWR&CAB.

30 there were similar provisions for IB claimants.

31 ESA Regs reg 8; SS(IB) Regs reg 2B.

Case Study B[32]

In July 2007, shortly after starting work following a period of unemployment, John injured his back in an industrial accident. At the end of his SSP period he claimed IB, and following a medical examination was found not to be incapable of work. John appealed that decision and was paid IS with a 20 per cent reduction of his personal allowance pending the outcome of his appeal. The appeal was unsuccessful, so that John did not receive NI credits for the period from the date of decision to the date of the appeal hearing. After the appeal John signed on for JSA, and eventually returned to employment in August 2008.

In January 2009 John sustained a second, more serious, back injury. He was in great pain and also developed depression. When his SSP came to an end he claimed ESA. Entitlement to benefit depended on his NI contribution record for the tax years 2005/06, 2006/07 and 2007/08. Although John satisfied the first contribution test, having been in full employment throughout 2005/06, he had neither earned enough nor received sufficient NI credits to meet the second test in 2007/08. John received IRESA.

Incapacity in Youth

Special rules apply to people who become incapable of work in youth. They are entitled to benefit where:[33]

- they are aged 16 or over
- have been incapable of work for 196 days
- were under 20 when their period of incapacity began (under 25 if they have been in education or training)
- if aged 16 – 19, are not in fulltime education.[34]

This measure provides a concession to those who become incapable of work before they have an opportunity to establish a NI contribution record, for example many patients with schizophrenia which generally manifests itself during the late teens and

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32 Client J MacK of CBWR&CAB.

33 in addition to the usual residence, presence, immigration and capability assessment rules applying to all claimants.

34 SSCBA 1992 ss 30A(1)(b) and (2A); WRA 2007 sch 1 para 4(1).

early twenties[35], and to those on the autistic spectrum which develops in childhood.

The effect of failing the contribution tests

Claimants who failed to meet the NI contribution tests were not entitled to IB and were forced to rely either on means-tested benefits such as income support (IS), or if their income and/or capital exceed the statutory limits, on their own resources. Because IS consists of personal allowances, premiums[36] and allowable housing costs, claimants receiving IB could also have their benefit topped-up by IS. However, as shown in Table 2, for the first year of incapacity, after which IS includes a disability premium, a single claimant aged between 25 and 60, and who did not qualify for any IS premiums or housing costs was significantly worse off than someone receiving IB by virtue of their NI contributions.

Table 2 – Incapacity benefit and income support rates
Single claimant aged 25 – 60, no premiums or housing costs

	2009/10	2010/11
IB – short-term, lower rate	£67.75	£68.95
IB – short-term, higher rate	£80.15	£81.60
IB – long term	£89.80	£91.40
IS personal allowance	£64.30	£65.45
IS with disability premium	£91.80	£93.45

With the introduction of ESA as a single benefit the situation changed slightly. Claimants who cannot fulfil the NI contribution conditions, but who meet all other

35 Sane website <http://www.sane.org.uk/AboutMentalIllness/Schizophrenia> (28 June 2009).

36 eg as a carer.

conditions, and in particular the income and capital tests, receive income-related employment and support allowance (IRESA)[37] and, unless they are covered by the transitional rules for transfer from incapacity benefits,[38] are not eligible for IS. As with IS, IRESA consists of personal allowances, premiums and allowable housing costs, so that claimants receiving CESA may have their benefit topped-up by an income-related component. Table 3 shows the comparative rates for CESA.

Table 3: Contributory employment and support allowance rates
Claimant aged 25 or over

	2009/10	2010/11
ESA assessment phase	£64.30	£65.45
ESA work-related activity group	£89.80	£91.40
ESA support group	£95.15	£96.85

Thus, for claimants who are able to meet the income and capital tests, there appears to be little advantage in having qualified for ESA via the contributory route, since claimants in identical personal and financial circumstances receive exactly the same amount of benefit, whether their benefit is contributory or income-related. On the contrary, those who receive IRESA qualify automatically for a number of 'passported' benefits eg help with prescription, dental and optical charges,[39] and have access to the Social Fund which provides budgeting loans, community care grants, cold weather payments and help with maternity and funeral expenses. Those who receive CESA alone need to make a separate claim for health costs assistance on low income grounds,

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37 WRA 2007 s 1(2)(b), sch 1 part 2; ESA Regs part 10.

38 Employment and Support Allowance (Transitional Provisions) Regulations 2008 SI 2008/795.

39 *Help with Health Costs (HC11)* (Department of Health 2009) 18.

and have no access to social fund grants or budgeting loans. Recipients of CESA who do not also receive a means-tested benefit such as housing benefit or council tax benefit are ineligible for funeral payments,[40] whereas, on the death of a close relative, IRESA recipients could receive a funeral payment of up to £700 in addition to certain specified costs.[41]

The effect of failing both the contribution tests and the means-test

For some claimants inability to satisfy the NI contributions conditions is not fatal to receipt of benefit, because they are able to fall back on means-tested provision. The problem created by failing **both** the contribution and means tests occurs equally under the incapacity benefits and ESA regimes, and results in non-payment of any IfW benefit. The entitlement conditions for means-tested benefits are complex and the situation is complicated by the fact that couples' resources are aggregated.[42] Detailed consideration of the rules is beyond the scope of this thesis, but in summary claimants can be ineligible for means-tested benefits when:

- income exceeds their applicable amount[43]
- capital exceeds £16,000[44]
- their partner is engaged in remunerative work.[45]

All claimants who 'pass' the PCA/LCWA, whether or not they receive any actual payment, still receive NI credits. Such credits assist towards qualifying for a retirement

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40 Social Fund Maternity and Funeral Expenses (General) Regs 2005 reg 7(4).

41 Social Fund Maternity and Funeral Expenses (General) Regs 2005 reg 9.

42 SSCBA 1992 s 136(1); IS Regs reg 23(1);WRA 2007 sch 2 para 6(2).

43 SSCBA 1992 s 124(1)(b); WRA 2007 sch 1 para 6(1)(a).

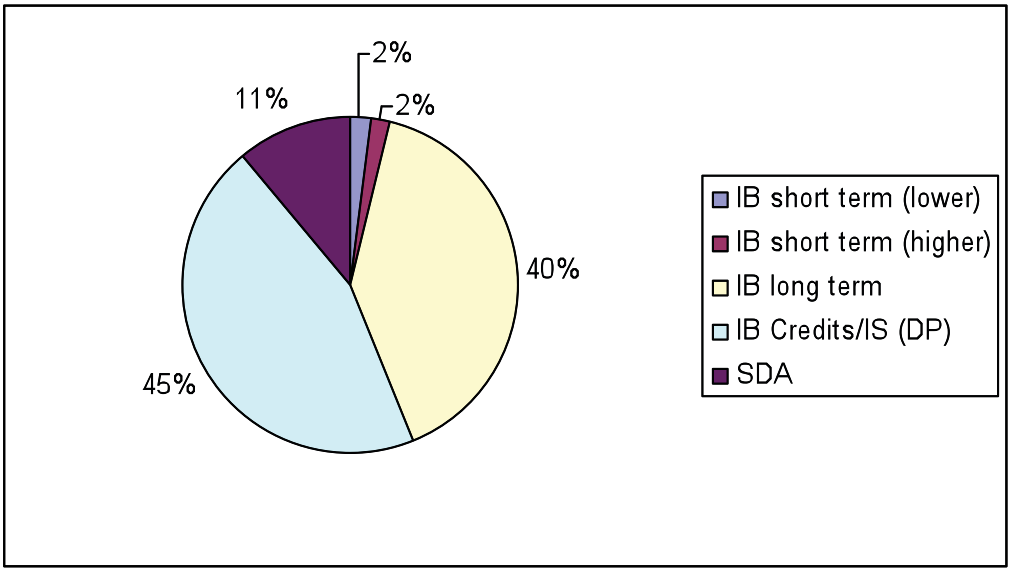
44 SSCBA s 134(1); IS Regs reg 45; ESA Regs reg 110.

45 SSCBA 1992 s 124(c); WRA 2007 s 6(1))(f). Working ≥ 24 hours per week.

pension,[46] but a period of several years of NI credits alone will not assist a person to qualify for other contributory social security benefits.[47] It is possible for a person who is patently not able to work not to receive any payment, either because their own or their partner's circumstances make them ineligible.

Statistics for February 2005 showed that nearly half of those who were incapable of work on MH grounds did not actually receive IB because they did not have the requisite NI contributions. Eleven per cent were still receiving SDA (no longer available to new claimants), most of whom started their claim in youth and had either learning difficulties, inherited mental illness or early onset of severe mental conditions.[48]

Figure 1: Type of benefit received by mental health claimants[49]



46 SS(Cr) Regs reg 8B(1) and (2)(a). With the exception of married women who elected to pay reduced rate NI contributions: reg 8B(3).

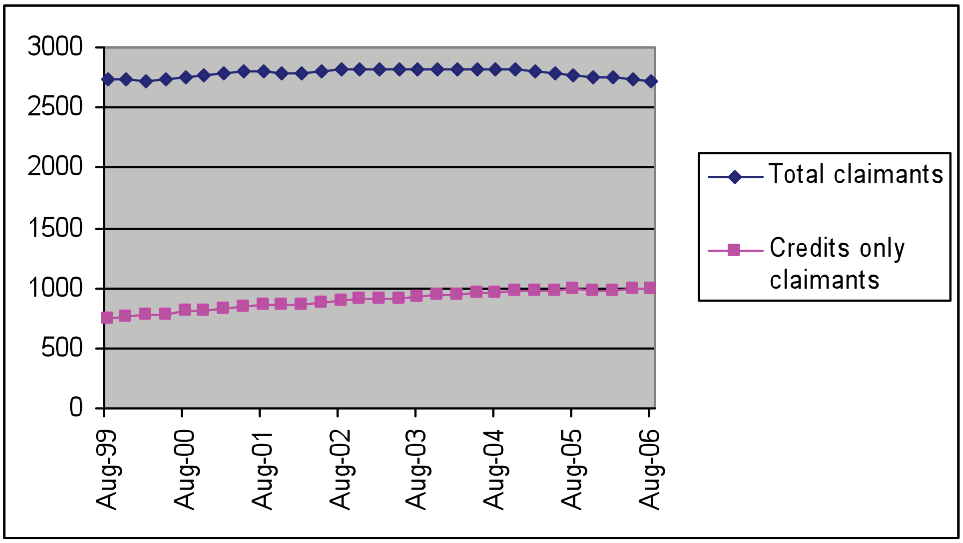
47 Currently CESA, JSA(C), bereavement payment and bereavement allowance for spouse, widowed parent's allowance.

48 *Incapacity Benefits and Mental Illness* <http://www.cesi.org.uk> accessed 16 July 2007.

49 ibid.

Statistics show that not only the number, but also the proportion of credits-only claimants is continuing to rise. In August 2006, 36.2 per cent of incapacity benefits claimants were credits-only.[50] These figures are undoubtedly an underestimate of the total number of people who are incapable of work but not receiving benefits, as many do not register for credits. The Labour Force Survey shows that many women who are ill are categorised as 'inactive' because they are 'looking after family or home'.[51]

Figure 2: Incapacity Benefits Claimants, August 1999 - August 2006 (thousands)



Source: DWP Quarterly Statistical Summary.

Statistics for ESA should not be compared directly with those for incapacity benefits because they do not yet include long-term claimants. The table below shows the numbers of claimants (in thousands) for each of the specified quarters.

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[50] DWP Quarterly Statistical Summary <http://www.dwp.gov.uk/asd/asd1/stats_summary/Stats_Summary_Feb_2007.pdf> accessed 7 May 2007.

[51] Labour Force Survey Quarterly Statistics ONS.

Table 4: ESA claimants, February 2010 (thousands)[52]

		Benefit Type		
Quarter	**Contribution based only**	**Both**	**Income related only**	**Credits only**
February 10	163.16	40.51	212.69	63.06
February 10	34.03%	8.45%	44.36%	13.15%

These figures show that only just over a third of claimants qualify for ESA by virtue of their NI contributions alone, that more than half of claimants receive an income-related component and around 13 per cent of claimants receive no monetary payment. The DWP has not yet issued statistics analysed by health condition, however it is reasonable to assume that those with MH conditions are disproportionately represented amongst those failing the NI contribution tests.

Conclusion

Many claimants with MH problems find that they are ineligible for contributory IB/ESA and are not saved by the exceptions for those aged under 20. Some are able to fall back on means-tested provision but others may be excluded from payment altogether, either because of their own, or their partner's financial resources or their partner's employment status.

Benefits for people who are too sick or disabled to work have historically been based on a contributory principle: payments into the scheme by employees and/or employers, so that benefit is received when they are no longer capable of work. Now

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[52] DWP Quarterly Statistical Summary, <http://83.244.183.180/ESA/esa_cases201002.xls> accessed 6 September 2010.

that only a minority of claimants qualify for ESA on the basis of contributions alone, and the payment rates for contributory and income-related ESA are the same, the question of whether the contributory route is still appropriate raises itself.

However, even when a claimant satisfies the contribution and/or means tests for receipt of an IfW benefit, they must still establish their incapacity/limited capability for work. The tests used to assess incapacity and limited capability for work form the subject of the next chapter.

CHAPTER FIVE

THE ASSESSMENT TESTS

Introduction and overview

After the NI contribution conditions, the next major obstacle to entitlement to incapacity for work benefits is the assessment of capability for work. For IB/IS the test is the Personal Capability Assessment (PCA), and for ESA it is the Limited Capability for Work Assessment (LCWA). As was outlined in Chapter Two, the policy underpinning the introduction of the PCA was to determine capacity for work using an objective test which counteracted what the Government saw as broadening of the definition of incapacity under the invalidity benefit regime.

Since 1995, the evaluation scheme used in the UK as a gateway to all benefits paid on grounds of long-term IfW has been a system of functional descriptors. The functional descriptor system uses a list of abilities (or disabilities) consisting of a series of statements for each, describing levels of ability/disability. A claimant's abilities/disabilities are matched either to the statements or the closest which describe their situation. An advantage of this system is that it can be applied to mentally ill claimants as it is possible to write statements which describe the difficulties they may face. Such a scheme is able to allocate 'points' which measure the extent to which a person's capacity is limited, but because the UK tests can only be either passed or failed, assessment has proved to be the main hurdle to incapacity for work benefits.

Known initially as the All-Work Test, the assessment under the incapacity benefits regime was later renamed the PCA, but was substantially unchanged. The first part of this chapter outlines the general principles of the PCA, details the descriptors

used for MH assessment and discusses the relevant case law. The next section explains the LCWA and compares it with the PCA. Finally, it identifies difficulties faced by the mentally impaired during assessment, points out the problems which are common to both regimes and considers the particular difficulties raised by the LCWA. It shows that for claimants with MH difficulties, the MH descriptors which form Parts II of the PCA/LCWA constitute a significant barrier to securing their entitlement to benefit, and provides evidence that the LCWA is a stiffer test than its predecessor.

The own occupation test

Chapter Two described the two different tests applicable for determining capacity for work for the purposes of incapacity benefits:

(a) the Own Occupation Test (OOT) - applied to the recently employed; and

(b) the PCA – a test of functional capacity, applied to all long-term (more than 28 weeks) claimants and those not recently in employment.

The majority of those claiming incapacity benefits on MH grounds continue their claims for long periods. Fewer than ten per cent of such claimants have been claiming for less than six months, whereas 24 per cent have claims lasting between two and five years, and a further 45.5 per cent have claimed for longer than five years.[1] Since 27 October 2008 there have been no new claims for incapacity benefits. For these reasons, and because ESA uses a functional test from the outset, this thesis omits a detailed examination of the assessment process used for the OOT.

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[1] Incapacity Benefit Caseload May 2007 <http://83.244.183.180/100pc/ib/icdgp/ctdurtn/a_carate_r_icdgp_c_ctdurtn_may07.html> accessed 15 April 2008.

Principles of the personal capability assessment

The PCA is a test 'of the extent to which a person who has some specific disease or bodily or mental disablement' is/is not, capable of performing various defined activities.[2] Thus, descriptors can only be applied when the claimant has some specific illness or disablement. This requirement, particularly in relation to claimants with symptoms of anxiety, has been tested in the Upper Tribunal and in the Court of Session. A doctor who had examined a claimant under the PCA reported that 'based on the medical evidence on file, the history obtained and my assessment today, there was no evidence of any mental health problem'. Consequently, a decision-maker disentitled the claimant from NI credits. That decision was upheld by an appeal tribunal then by a Commissioner. Following the decision of the Chief Commissioner in *CIB/4053/2003* which held that a tribunal had correctly distinguished between what is a physical or mental disablement and what is an understandable reaction to a chronic physical problem[3], the Court of Session[4] stated that the claimant's symptoms of unhappiness, anxiety, upset and distress were common emotions and, in the absence of medical diagnosis, not mental illnesses or disablements.[5] Hence, no points could be allocated on the MH descriptors.[6]

The main intentions of the PCA were to produce an assessment procedure which

- could be readily understood by both claimants and decision-makers
- would be perceived as fair

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2 SS(IW)Regs reg 24.

3 para 9.

4 *D.McF v Secretary of State for Work and Pensions* [2010] CSIH 26.

5 para 12.

6 This decision will also apply to the LCWA for ESA.

- would determine capacity for work solely by considering the effects of a person's medical condition on their functional limitations
- reduced the GP's role in controlling access to long-term incapacity benefits.[7]

The PCA was intended to be objective and to pay no regard to social factors such as age, skills, education, lack of suitable jobs, employer discrimination and failure to make appropriate adjustments, and availability of transport. The purpose of objectivity was to overcome what were seen by the Department as the drawbacks of the informal assessment used for IVB, which allowed personal factors such as age and education to be taken into account.[8] Speaking on the Social Security (Incapacity for Work) Bill, one opposition MP commented:

> The very concept of an objective medical test of incapacity is unsustainable. … The capacity of a person for work is not susceptible to the kind of objective assessment that the Government hope will be made. We are talking about the interaction of the infinite variety of people with the infinite variety of their circumstances. … The objectivity that the Government seek in this context is a chimera … [9]

The test which resulted was an empirical assessment which set a threshold of incapacity that must be met as a condition of entitlement to the incapacity benefits. The threshold set within the PCA was designed to reflect the point at which a person's ability to perform physical and mental activities was substantially reduced to a point where they should not be required to seek work as a condition of benefit, rather than the

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7 Benefits Agency, *A Consultation on the Medical Assessment for Incapacity Benefit* (Department of Social Security 1993).

8 see Chapter Two pp 50, 57.

9 Alan Howarth *Hansard* HC Deb vol 245 col 139 (21 June 1994).

point at which work became impossible.[10] Provision was also made for claimants to be exempt from assessment by virtue of the severity of disablement,[11] and in 'exceptional circumstances' for people to be treated as incapable of work, even though they did not reach the PCA points threshold.[12]

For those who are subject to the PCA, incapacity is assessed according to performance against a list of physical and another list of mental activities.[13] A further list of 'descriptors' is used to measure the level of difficulty experienced when undertaking the physical activities, and to allocate point scores to each descriptor. The mental health descriptors are not ranked, and each set of activities covers a range of different problems that might be encountered with each activity. A person is judged to be 'incapable of work' if they score fifteen points from the physical activities or ten points from the mental activities or fifteen points in a combined score.[14] Where combined scores are involved, a score of between six and nine points on the mental health descriptors is treated as a score of nine points, which is then added to the points awarded on the physical activities.[15] Thus a person with moderate MH difficulties scoring less than six points on the mental activities has their score totally disregarded.[16]

Appendix I contains a full list of the mental disabilities which may make a person incapable of work and the descriptor scores, reproduced from the Schedule to the Social Security (Incapacity for Work)(General) Regulations SI 1995/311.

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10 Chief Medical Adviser, *Medical Evidence for SSP, SMP and Social Security IB Purposes: A Guide for Registered Medical Practitioners (IB204)* (DWP 2004) s 2.

11 SS(IFW) Regs reg 10. Discussed in detail later in this chapter.

12 SS(IFW) Regs reg 27. Discussed in detail later in this chapter.

13 SS(IFW) Regs schedule.

14 SS(IFW) Regs reg 25(1).

15 SS(IFW) Regs reg 26(1)(a).

16 SS(IFW) Regs reg 26(1)(b).

Exemptions from the PCA

As recognition that there are some people whose medical condition is such that it would be pointless and distressing for them to be subject to formal assessment procedures, certain groups of claimants are treated as being incapable of work and are exempted from having to undergo the PCA. Those who are exempt are not sent a questionnaire about their impairment of activities, neither are they required to attend in person for a medical examination. There are two types of medically exempt categories:

- conditions which can be determined by a decision-maker, with or without further medical evidence
- conditions which require the decision-maker to consider the advice of a doctor[17] approved by the Secretary of State.[18]

People claiming on grounds of mental illness are exempted from formal assessment by a decision-maker when they:

1. receive disability living allowance (DLA) care component at the highest rate, or comparable benefits under the industrial injuries or military pension schemes.[19] Those meeting these criteria would have substantial care and/or supervision needs, by day and at night;[20]
2. are classed as at least 80 per cent disabled for the purposes of SDA,[21] industrial injuries disablement benefit or similar military pensions;[22]
3. are suffering from dementia.[23]

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17 SS(IFW) Regs reg 2(1) defines 'doctor' as a registered medical practitioner.

18 SS(IFW) Regs reg 2(1).

19 SS(IFW) Regs reg 10(2)(a).

20 SSCBA 1992 s 72(1)(b) and (c).

21 SS(IFW) Regs reg 10(2)(ab).

22 SS(IFW) Regs reg 10(2)(aa).

(Further exemptions, available for certain physical illnesses, fall outside the scope of this thesis.)

Exemption requiring the decision-maker to consider the advice of an approved doctor is possible for those who:

> could provide supporting medical evidence that they were suffering from
>
> a severe mental illness, involving the presence of mental disease, which severely and adversely affects a person's mood or behaviour, and which severely restricts his social functioning, or his awareness of his immediate environment.[24]

In *CIB/3328/1998* Deputy Commissioner White commented that the drafting of this paragraph of regulation 10(2)(e)(viii) 'left a lot to be desired'.[25] Although the wording of the paragraph implies a distinction between mental illness and mental disease, neither term is defined in the regulations. The Deputy Commissioner failed to find any difference in meaning of the two phrases and concluded that they held no special meaning.

Guidance on the interpretation of Regulation 10(2)(e)(viii) is contained in the *Incapacity Benefit Handbook for Approved Doctors*.[26] This suggests that severe mental illness is characterised by a need for ongoing psychiatric care such as:

- residence in a sheltered environment where regular medical or nursing care are supplied
- day care at least one day a week in a centre where qualified nursing care is available
- home care with intervention, at least one day a week, by a qualified

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23 SS(IW) Regs reg 10(2)(d)(iii)

24 SS(IW) Regs reg 10(2)(e)(viii).

25 p 3 para 2.

26 Corporate Medical Services (DWP 2004) [2.2.3.1.]

mental health care worker

- long term medication with anti-psychotic preparations including depot neuroleptic, mood-modifying drugs or equivalent modern oral medication.

The *Handbook* also provides guidance on the meaning of 'social functioning'. It suggests that the severe mental illness criterion is met only when a person's behaviour is so adversely affected that their ability to function socially is severely restricted or they are likely to pose a real threat or danger to themselves or others, such as work colleagues or members of the public.[27]

The usual procedure adopted when 'severe mental illness' is at issue, is for the claimant's GP to be sent a form (IB113) on which they provide a detailed description of their patient's diagnosis, symptoms and treatment.[28] Stenger has criticised the reliance on doctors trained in General Practice to confirm grounds for exemption, when very often Community Psychiatric Nurses, Social Workers or other Mental Health Workers had a clearer picture of how peoples' problems affected them.[29]

Some commentators raised concerns about certain people being exempted from assessment without their knowledge.[30] Claimants in this position described feeling depressed and disorientated because they had been excluded from a process that had reached a verdict on their ability to function without considering their views. The then Chief Medical Adviser to the DSS, has stated that this was not a directive from the DSS

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27 ibid [2.2.3.1.1.]

28 A specimen form is available at <http://www.dwp.gov.uk/medical/publications/ib113.pdf> accessed 21 January 2008.

29 J Stenger, *The Big Book of Benefits and Mental Health 2006/07* (Neath Mind 2006) 42.

30 Ann Davis, University of Birmingham reported in G Zarb (ed), *Social Security and Mental Health*: *Report on the SSAC Workshop* (SSAC Research Paper No 7, 1996) 31.

but the route expressly requested by Parliament during the passage of the IfW legislation to exempt the severely mentally ill without troubling them.[31] However, the author of this thesis has been unable to confirm that this was the case, and an official at the Social Security Advisory Committee suggests that Professor Aylward may have been misreported.[32]

However, welfare rights advisers report cases in which strong medical evidence of severe mental illness has been submitted on behalf of claimants, but they still get sent for a medical. Because of their MH issues they may fail to attend the examination, and then find themselves disentitled from benefit.[33]

The PCA questionnaire

Once it is ascertained that the PCA applies to a claimant they are sent a questionnaire, the IB50 form, which seeks their view as to their abilities in each of the physical functional areas of the assessment.[34] However, for the MH test there are no specific questions about MH, and the claimant is asked only to provide a statement within a rather small box. Many regarded this as a key failing. In evidence to the Work and Pensions Select Committee Citizens Advice stated:

> Bureaux continue to report that clients, particularly those with mental health problems, are having difficulty with the revised claim form for Incapacity Benefit (IB50). The section for mental health has been shortened considerably, from almost a full page to a very small box. This regularly leads to uncertainty about how much detail and information is required. The lack of tick boxes for mental health descriptors, as there are

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31 Dr Mansel Aylward, ibid 40.

32 Private communication, Jamie Allen, SSAC, 20 August 2008.

33 see eg Rightsnet discussion forum <http://www.rightsnet.org.uk/dc/dcboard.php?az=show_topic&forum=111&topic_id=5057&mesg_id=5057&page=> accessed 14 April 2010.

34 SS(IFW) Regs reg 6(1)(b).

> for physical descriptors, results in similar confusion, particularly as it can be very difficult to describe mental health problems in general terms.[35]

During the development of the LCWA, the mental health technical group reviewed the IB50 questionnaire, commented that the approach being used for the PCA was not appropriate for people with MH conditions, and recommended a more structured, user-friendly questionnaire for the ESA assessment. This recommendation was adopted.[36]

The IB50 was returned to the DWP with a doctor's statement (Med 4)[37] which contained

- the diagnosis of the main incapacitating condition
- other relevant medical conditions
- space for 'doctor's remarks' which included
  - an indication of the disabling effects of the condition
  - current treatment and progress
  - an indication of whether, as a result of their medical condition, the claimant would be unable to travel to an examination centre
  - a record of the advice given regarding their ability to perform their usual occupation.[38]

If the claimant fails to return the questionnaire and medical certificate within four weeks of the IB50 being issued they are sent a reminder, and if it us still not returned

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35 Work and Pensions Committee, *Incapacity Benefits and Pathways to Work* HC 616 III (2005–06) Ev 186 [4.15.]

36 Physical Function and Mental Health Technical Working Groups, *Transformation of the Personal Capability Assessment* (DWP 2006) [46].

37 From 6 April 2010, Med 4 certificates were replaced by Statements of Fitness for Work; Social Security (Medical Evidence) and Statutory Sick Pay (Medical Evidence) (Amendment) Regulations 2010 SI 2010/137.

38 IB204 (n 10) s 2.

two weeks later (without 'good cause'),[39] they are treated as being capable of work, and disentitled from incapacity benefits.[40]

A decision-maker uses the information contained in the IB50 and certificate to decide whether the claimant may be exempted from the PCA and, if not, whether the claimant scores enough points to be counted as incapable of work. When the decision-maker is unable to reach a definite conclusion about incapacity the claimant is referred for medical examination by an approved doctor.[41]

The questionnaire and claimants with mental health problems

Completing an IB50 questionnaire is a daunting task, even for claimants without MH problems. It consists of ten pages of detailed questions about physical difficulties, followed by a single page headed 'Information about anxiety, depression and other mental health problems'. Most of this page is devoted to the supply of information about frequency of treatment and contact details for treatment providers. The claimant is expected to write about any problems they have with their nerves, any other MH condition, the type of treatment received, problems with normal day-to-day activities caused by their MH condition and problems of dealing with people, within a box measuring sixteen centimetres by seven centimetres.

Stenger has criticised the self-assessment questionnaire on the following grounds:[42]

- its length; many people got no further than the first couple of pages,

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39 Good cause is discussed in detail later in this chapter.

40 SS(IFW) Regs reg 7.

41 SS(IFW) Regs reg 8.

42 *The Big Book of Benefits and Mental Health 2006/07* (Neath Mind 2006) 42.

assuming that they have described their condition in sufficient detail

- lack of accompanying information explaining how incapacity was assessed
- failure to provide space for comment on the way their MH difficulties affect them[43]
- the small space available for explaining their MH condition
- the lack of balance between physical and mental disabilities.

Comments made in Chapter Three about the difficulties people with MH problems face with the SC1 claim form for incapacity benefit apply equally to the IB50. Apathy, fear or paranoia may contribute to poor form-completion and delay in submission, which results in disentitlement from benefit.

In the run-up to the 2007 Welfare Reform Act, a report to the All-Party Parliamentary Group on Mental Health (APPGMH) by Citizens Advice, identified changes to the IB50 form as a key issue for claimants.[44] The comparable form introduced for ESA showed a number of important improvements eg providing an opportunity for claimants with MH problems to explain their difficulties.

Medical examination

Unless the IB50 provides clear evidence of either exemption from the PCA or reaching the minimum points threshold, the claimant is referred for medical

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[43] Claimants with physical difficulties are afforded this opportunity. Stenger suggests that this discriminates against people with MH problems since their feelings and voices are not properly heard during the assessment process.

[44] Notes of APPGMH meeting of 7 March 2006, <http://www.lynnejones.org.uk/d0515.mar2006.htm> (19 January 2008).

examination.[45] When the All Work Test was first introduced, those conducting the medicals were all registered medical practitioners,[46] mostly retired GPs. Only twelve years later, was provision made, with effect from 3 July 2007, for other 'healthcare professionals' (HCP) such as nurses, occupational therapists and physiotherapists to also undertake assessments.[47] Although the IfW Regulations were amended, a possible oversight resulted in failure to amend the relevant part of the Decision and Appeals Regulations (which refers to an incapacity determination following examination by a doctor)[48] until 30 October 2008.[49] This makes an incapacity decision, resulting from an examination conducted by a HCP before 30 October 2008, open to challenge as possibly invalid. In *CSIB/340/2009* Judge May decided that because the claimant's medical examination had not been conducted by a doctor, and since the amendment came into force after the date of the decision under appeal, there had been no valid supersession under regulation 6(2)(g). This was reiterated in *CIB/2230/09*, a case involving a claimant with depressive illness who hade been examined by a registered nurse, although Judge Mesher pointed out that other grounds for supersession may exist. However, he acknowledged that tribunals should evaluate 'the weight to be given to the comparative expertise and professional standing especially as to the identification of mental health problems' of the HCP.[50]

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45 SS(IFW) Regs reg 8.

46 SS(IFW) Regs regs 2(1), 8(1).

47 Social Security (Miscellaneous Amendments)(No 2) Regs 2007 SI 1626/2007 reg 2(2).

48 SSCS(D&A) Regs reg 6(2)(g).

49 Social Security (Miscellaneous Amendments)(No 5) Regs 2008 SI 2667/2008 reg 3(3)(a).

50 para 18.

Guidance issued to examining HCPs requires the MH assessment to be undertaken in all cases where the claimant has a diagnosed mental illness or disablement. The MH assessment is also applied when the claimant:

- is taking any medication which impairs cognitive function to a degree which causes mental disablement
- has alcohol/drug dependency which results in mental illness or disablement
- has physical or sensory disabilities which produce mental disablement by impairing cognitive and/or mental function eg tinnitus
- has mild/moderate learning disability
- has previously unidentified mild/moderate mental illness or disability discovered during assessment.

In *CIB/14202/96* Commissioner Goodman reiterated that the test was one of a person's incapacity, *by reason of some specific disease or bodily or mental disablement*,[51] to perform the activities presented in the Schedule. Thus, 'Mental Disabilities' could qualify for points only if they resulted from recognisable mental disablement, in the nature of an illness, and were not 'mere matters of mood'. By extension, the Guidance for Approved Doctors stated that the MH assessment should be conducted only where there is mental disablement. Being 'fed up' with their physical condition is a normal emotional response and would not warrant application of the MH assessment unless the psychological response was abnormal.[52]

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51 SS(IFW) Regs reg 24.

52 Corporate Medical Services, *Incapacity Benefit Handbook for Approved Doctors* (DWP 2004) [3.5.2.]

In evidence to the Social Security Advisory Committee the Benefits Agency's Medical Policy Manager pointed out that the process required that all the questions in the MH assessment would need to be answered so as to build a composite picture of mental function. However, the descriptors were never intended to be a clinical tool for diagnosing a particular mental illness.[53] He also stated that the correct choice of mental descriptor would only be obtained by the doctor adopting an empathetic approach to the interview and by being aware of cultural issues which could often cloud the presentation of mental illness. This was emphasised in the Guidance which stated that the interview should be conducted in 'a friendly, professional and non-confrontational way'.[54]

MH charities and welfare rights advisers have levelled considerable criticism at the medical examination of claimants with MH problems for PCA purposes. These include:

- the fact that examinations were usually conducted by doctors trained in general practice, who had minimal knowledge of how people's day-to-day activities may be affected by mental illness[55]
- lack of direct questions, and false conclusions being drawn from answers to indirect ones[56]
- reluctance of people with mental illness to discuss their problems with strangers[57]

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53 Dr Philip Sawney reported in G Zarb (ed), *Social Security and Mental Health*: *Report on the SSAC Workshop* (SSAC Research Paper No 7, 1996) 41.

54 Corporate Medical Services, *Handbook* (n 52) [3.1.3.2.]

55 Stenger (n 29) 42.

56 ibid 51.

57 Rightsnet discussion forum <http://www.rightsnet.org.uk/dc/dcboard.php?az=show_topic&forum=111&topic_id=356&mode=full> accessed 21 January 2008.

- cursory examinations, some as short as 15-20 minutes,[58] although Commissioner Parker pointed out that the duration of an interview and examination, while not determinative in itself, 'may be relevant as an indicator that the examination was not properly conducted.'[59]
- failure by the HCP to accept a claimant's verbal evidence. This is particularly relevant to claimants with fluctuating conditions[60]
- HCPs who are brusque and intimidating[61]
- use of computers during the examination which hampers communication between the HCP and the examinee[62]
- computer software which results in impersonal and inconsistent reports.[63] The advantage is, of course, that the reports are printed and therefore legible, unlike many of the earlier handwritten reports.[64]

One MH charity has warned that many people with mental illness withhold information about how their condition affected them, from doctors in general, when completing the IB50 questionnaire and during PCA examinations. This could be because they are embarrassed about their illness or afraid that they might be sectioned

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58 Gary Martin (Citizens Advice) in evidence to Economic Development, Culture, Sport and Tourism Committee, Greater London Authority 19 October 2006 – unpublished transcript of evidence from GLA.

59 *CSIB/69/03* para 21.

60 — 'Memorandum to the House of Commons Social Security Committee Enquiry into Medical Services" GMB Research Department (January 2000) [3.2].

61 ibid [3.3].

62 Stenger (n 29) 52.

63 ibid.

64 Further discussion of the assessment software occurs on p 151 of this thesis.

into hospital or have their children taken into care, even though these things are very unlikely.[65]

The case study which follows illustrates one claimant's experience of a PCA medical.

Case Study A[66]

A claimant suffering from serious mental health problems reported to his CAB that his PCA medical had been completed in five minutes. The form officially recorded the length of examination as twelve minutes, yet the client stated that the doctor had left the room during the examination. The doctor had asked only closed questions, and had produced an inadequate and inaccurate report.

The claimant had 'failed' his PCA, but as a result his condition deteriorated rapidly, putting him in a category of at high risk of suicide. Three days later his IB was reinstated.

HCPs conducting PCA mental health assessments are instructed not to ask direct questions using the statements as a checklist because this would 'invariably produce false results'.[67] Instead they are told to use open questions such as:

- What do you think is wrong with you?
- How have things changed for you?
- How do you pass the time?
- Tell me about your social activities.
- What stops you from doing things?
- How do you think work would alter things for you?

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65 — Personal Capability Assessment (PCA) (Rethink leaflet RET0303 2008) 2.

66 A Barton, *What the Doctor Ordered? CAB Evidence on Medical Assessments for Incapacity and Disability Benefits* (Citizens Advice 2006).

67 Corporate Medical Services, *Handbook* (n 52) (DWP 2004) 99.

It is easy for such questions to be misunderstood, particularly by people with a mental illness. This is illustrated in the next case study.

Case Study B[68]

One CAB reported the experiences of a client who suffered from a back problem in addition to anxiety, panic disorder and depression. He attended a medical examination for incapacity benefit and stated that the doctor had focussed on his back problems and had not directly addressed his mental health difficulties.

Only later did the client realise that not all the questions had been about his back, but that he had answered them as though they were, with no reference to his mental health problems. He remarked that he had felt pressurised by the inflexible questioning and had not been coherent in answering.

The client's claim was refused. The stress of applying for benefit and the subsequent appeal had led to a worsening of his mental health and he felt that the process had put him back several months.

HCPs who conduct examinations are not DWP employees but work for a private company, Atos Origin, which is contracted to the DWP for the provision of medical services. Reporting on the experiences of its members of PCA medical, the trade union GMB went so far as to state that these tended 'to suggest not a catalogue of errors but an organised abuse of process'.[69] One such situation is described below.

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68 Barton (n 56).

69 — 'Memorandum to the House of Commons Social Security Committee Enquiry into Medical Services' GMB Research Department (2000) [4].

Case Study C[70]

A man who had received incapacity benefit on grounds including mental ill-health for many years was called for examination by a Medical Services doctor. He was awarded zero points and his wife wrote to their MP complaining that the doctor had 'dismissed all previous pathology, everything our GP has written, everything we said or filled in on the form, awarded him no points for any form of disability as if the permanent problem that he has had for the past 14 years did not exist'. Although the doctor's report contained comments under the mental health descriptors the claimant was adamant that these questions were never asked during a 26-minute interview. Instead, the report contained remarks about his wife being an 'articulate and high powered wife who only works to get away from her husband'. The man's trade union described these comments as 'offensive, unsubstantiated and irrelevant to the question of his incapacity' and which indicated 'an unacceptable level of unprofessional conduct'.

Stenger puts the position into perspective.

> Not all the doctors are bad, and not all medical examinations result in people losing their incapacity status. The picture welfare rights workers get of the system is probably heavily skewed by the fact that we are never contacted for help by people who keep their incapacity status, who found the doctor charming and sympathetic, and who felt they had been given plenty of time to explain their difficulties … [71]

In evidence to the All-Party Parliamentary Group on Mental Health Dr Boardman suggested that the review of the PCA could learn much from the literature on research interviews, since this might help the reliability of the process and the quality of the interview.[72] There is no evidence that, during the course of the PCA review leading to the introduction of ESA, any such work took place.

Computer aided assessment

The computer software known as Logic-integrated Medical Assessment (LiMA) which is used by HCPs has come under extensive criticism from welfare rights advisers,

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70 ibid [4.3.4.]

71 Stenger (n 29) 51.

72 Notes of APPGMH meeting of 7 March 2006, <http://www.lynnejones.org.uk/d0515.mar2006.htm> accessed 19 January 2008.

the Commissioners and in Parliament. The program operates by providing the examiner with prompts relevant to common diagnoses, and standard phrases for use in their report. Although it is possible to override these phrases and substitute alternatives, any such action requires justification.[73]

The LiMA pilots were accompanied by one of the greatest number of postings ever made to the Rightsnet discussion forum on one topic.[74] One adviser, commenting on differences between a claimant's earlier assessment and a more recent computer-aided one suggested that:

- the computer organisation of data (ie under headings and categories) unduly influences the assessment
- the omission of expressions of restricted ability has a distorting affect on the assessment
- linear computer processes mitigate against the exercise of subtle human judgements, which can assess the combined effects of conditions, and form an invaluable part of the assessment.

In *CIB/476/2005* Commissioner Williams expressed concern that there could be repeated omissions as well as repeated errors in the report,[75] and that the electronic default phrase 'Claimant states no other problems' was 'trebly ambiguous'.[76] In *CIB/511/2005* Commissioner Howell stated:

> The use of this system, in which statements or phrases appear to be capable of being produced mechanically without necessarily representing actual wording chosen and typed in by the examining doctor, obviously carries an increased risk of accidental

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73 Corporate Medical Services, *LiMA v2 Technical Manual* (DWP 2004) 30.

74 eg Rightsnet discussion forum <http://www.rightsnet.org.uk/dc/dcboard.php?az=show_topic&forum=111&topic_id=433&mode=full> accessed 14 July 2005.

75 para 16.

76 para 17.

> discrepancies or mistakes remaining undetected in the final product. Tribunals ought in my view to take particular care to satisfy themselves that reports presented to them in this form really do represent considered clinical findings and opinions by the individual doctor whose name they bear, based on what actually appeared on examination of the particular claimant.[77]

Commissioner Williams commented further on the application of LiMA to the MH assessment, in *CIB/664/2005*. Having made a meticulous study of the LiMA Technical Manual, he noted that the program pre-selected evidence seen by informal observation in preference to that which the claimant told the doctor or the doctor's own clinical findings. Thus the IB85 report submitted by the examining doctor was not the evidence considered by the doctor (which was itself a computer-generated selection in the first instance) but a selection from that evidence of the 'most convincing' case. The Commissioner also proposed that the Manual should therefore be available to all appeal tribunals that wish to consider it and, to ensure 'equality of arms', to all claimants and representatives.[78]

During Parliamentary debates on the Welfare Reform Bill, concern was expressed regarding LiMA's pre-coded answers[79] and resulting lack of flexibility to cope with non-standard responses by claimants.[80] When one MP attempted to find out the proportion of claimants found incapable of work using LiMA, compared to those before the pilots were introduced, the Department responded that this information was not centrally collected and could be obtained only at disproportionate cost.[81]

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77 para 3.

78 para 20.

79 Baroness Thomas of Winchester, *Hansard* HL vol 689 col GC205 (28 February 2007).

80 Lord Oakeshott of Seagrove Bay, *Hansard* HL vol 689 col 95 (29 January 2007).

81 Paul Holmes *Hansard* HC vol 417 col 1340W (10 February 2004).

One welfare lawyer has identified two technical errors in the drop-down menus available to HCPs.[82] If a claimant is recorded in the PCA as 'adjusts daytime activities to take account of sleep problems' this is equated to 'sleep does **not** interfere with daytime activities'. 'Would like to work when illness is better' invariably finds the descriptor 'is **not** afraid that work would bring back or worsen his illness' although that may not apply to the claimant.

Failure to attend a medical examination

Unless they have agreed to accept a shorter period of notice, claimants must be given seven days written notice that they are required to attend a medical examination.[83] Should they fail to attend the medical, without 'good cause' then they are treated as being capable of work, and their incapacity benefits cease.[84] Matters to be taken into consideration in deciding whether the claimant had good cause for non-attendance include their state of health and the nature of their disability.

For the reasons discussed above and in Chapters One and Three, people with MH problems may have difficulties in attending medicals at the appointed time. If they are particularly unwell they may just not turn up or may attempt to have the medical postponed. Such actions are irrational, because it is to the advantage of a claimant seeking entitlement to incapacity benefits to be examined when they are at their worst.

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82 Ariadne, Basingstoke CAB in Rightsnet discussion forum <http://www.rightsnet.org.uk/dc/dcboard.php?az=show_topic&forum=111&topic_id=3108&mesg_id=3108&listing_type=&page=> accessed 7 August 2008.

83 SS(IFW) Regs reg 8(3).

84 SS(IFW) Regs reg 8(2).

Claimants who engage in substance abuse, who may lead chaotic lifestyles, are at particular risk of failing to attend medicals. The next case study is typical of such instances.

Case Study D[85]

David was a CAB client who was an alcoholic and almost permanently intoxicated. He came in to the CAB office with a carrier bag full of unopened mail, and told the adviser that he had had no money for several months. Investigation revealed that he had been receiving income support on the grounds of incapacity, but that benefit had been terminated when he failed to attend a PCA medical.

David had appealed against that decision and attended an appeal tribunal on his own, but had been unsuccessful in convincing a tribunal that he had 'good cause' for failing to attend the medical because he had not received the letter of notification. When the adviser went through the carrier bag of mail she found one, unopened, white envelope with Atos Origin[86] printed on the flap. David said that he didn't recognise that name and had assumed that it was junk mail so hadn't bothered to open it. He was, however, unable to explain why he had kept all his unopened mail.

By the time David sought help from CAB he was out of time for a request for set-aside of the decision or appeal to the Commissioners. He was assisted to make a new claim for benefits and the importance of opening mail and attending future medical examinations was explained to him.

Domiciliary medicals

Legislation does not specify where medical examinations are to take place, only that claimants must, unless exempted or deemed incapacitated, submit themselves for medical examination. Many claimants suffering from mental illness, particularly those with agoraphobia, might prefer to be examined at home rather than at a designated centre. The Handbook for Approved Doctors points out that, occasionally, a claimant who is unfit to travel or to visit a medical examination centre may request a domiciliary visit, and an examination in the claimant's home would become necessary.[87] Instances

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85 Client FB of CBWR&CAB.

86 Atos Origin is the company contracted to conduct medical examinations for benefit purposes.

87 para 3.10.

of domiciliary examinations for incapacity benefits are believed to have been exceptionally rare.

However, it is necessary to question the rationale of domiciliary visits. Any person who is genuinely unable to travel to a medical centre for examination is surely also unable to travel for work. In which case, the function of the visit should be simply to establish whether the claimant is fit to attend a medical centre. Should it be found that the claimant is well enough to go to a designated centre then they could be required so to do. In theory it is possible for a person, who is for some ill-health related reason unable to travel to work, to fail to reach the PCA points threshold and to be found not incapable of work.

Some of the PCA mental health descriptors seek to establish how the claimant copes with stress, changes in routine and going out unaccompanied. Were the claimant to be examined at home they might react differently to the way they would behave at an external examination centre, so that the examining HCP would not obtain the full picture.

The Mental Health Descriptors

The 25 MH descriptors used for the PCA are contained in Part II of the Schedule to the Social Security (Incapacity for Work)(General) Regulations 1995, and are reproduced in full in Appendix 1. They fall into four general categories: completion of tasks, daily living, coping with pressure and interaction with other people.

Since inception, a vast amount of caselaw has built around the PCA, and this is detailed in the commentary to the Incapacity for Work Regulations in D Bonner,

R Hooker and R White *Social Security Legislation 2010, Volume I: Non Means Tested Benefits* (Sweet & Maxwell 2010).[88] The section which follows focuses on many of the issues about the PCA relevant to people with MH difficulties, and expands on some of the problems raised in Chapter Three. In undertaking caselaw analysis, use has been made of the website for the Administrative Appeals Chamber of the Upper Tribunal (formerly the Office of Social Security and Child Support Commissioners),[89] the commentary in Bonner, Hooker and White, and other legal commentaries.

The points score for mental health descriptors

Several authorities have questioned whether points scored on the MH descriptors are too low, and thus do not accurately represent incapacity for work.[90] For the physical activities of the PCA, (89 descriptors in 14 activity groups), individual descriptors are worth 15, 12, 10, 8, 7, 6, 3 or 0 points.[91] Thus, claimants scoring points on the physical activities are able to achieve the threshold by scoring on only one descriptor, or by adding together points for a handful of descriptors. For example, a person who

- could not walk more than 50 metres without stopping or severe discomfort,[92] or
- could not walk up and down a flight of 12 stairs,[93] or
- had an involuntary episode of lost or altered consciousness at least once

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88 [8.137 ff], [8.162 ff].

89 <http://www.osscsc.gov.uk/>.

90 Stenger (n 29) 2006) 42: J Scott, Work and Pensions Committee, *Incapacity Benefits and Pathways to Work* HC 616 III (2005–06) Ev 4.

91 SS(IFW) Regs sch Part I.

92 SS(IFW) Regs sch Part I para 1(c).

93 SS(IFW) Regs sch Part I para 2(b).

a month,[94]

would reach the PCA fifteen-point threshold on a single descriptor.

Unlike the physical descriptors, the MH descriptors are not ranked on a rising scale of impairment. Since the maximum score for any one descriptor in the MH activities is two, claimants need to score on at least five descriptors to reach the ten-point threshold, a situation which Stenger describes as 'discriminatory'.[95]

Thus, someone who

- could not answer the telephone and reliably take a message,[96] and
- could not concentrate to read a magazine article or follow a radio or television programme,[97] and
- overlooked or forgot the risk posed by domestic appliances or other common hazards due to poor concentration,[98] and
- did not care about their appearance and living conditions,[99] and
- avoided carrying out routine activities because he was convinced that they would prove too tiring or stressful,[100] and
- frequently found that there were so many things to do that they gave up because of fatigue apathy or disinterest,[101] and

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94 SS(IFW) Regs sch Part I para 14(c).

95 Stenger (n 29) 42.

96 SS(IFW) Regs sch Part II para 15(a), 2 points.

97 SS(IFW) Regs sch Part II para 15(c), 1 point.

98 SS(IFW) Regs sch Part II para 15(f), 1 point.

99 SS(IFW) Regs sch Part II para 16(d), 1 point.

100 SS(IFW) Regs sch Part II para 17(c), 1 point.

101 SS(IFW) Regs sch Part II para 17(e), 1 point.

- was scared or anxious that work would bring back or worsen illness,[102] and
- was too frightened to go out alone,[103]

would STILL be found fit for work.[104] A person who does qualify for incapacity benefits on MH grounds is therefore likely to be at a greater disadvantage in the labour market than someone with physical disabilities.

Relevance of the 'working situation'

When a person is sufficiently unwell to score points on certain descriptors, this alone raises questions as to their suitability for employment. How is someone who is too frightened to go out alone[105] going to get to and from work? What would be the impact on colleagues of employing someone who gets upset by ordinary events resulting 'in disruptive behavioural problems'?[106] What are the health and safety implications of employing a person who cannot concentrate sufficiently to read a magazine article or follow a radio or television programme,[107] or who is prone to accidents due to agitation, confusion or forgetfulness?[108][109] How would someone who prefers to be left alone for six hours or more each day[110] relate to colleagues?

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102 SS(IFW) Regs sch Part II para 17(f), 1 point.

103 SS(IFW) Regs sch Part II para 18(f); 1 point.

104 Total, 9 points, one point short of the threshold.

105 SS(IFW) Regs sch Part II para 18(f).

106 SS(IFW) Regs sch Part II para 18(b).

107 SS(IFW) Regs sch Part II para 15(c).

108 SS(IFW) Regs sch Part II para 15(g).

109 The 'exceptional circumstances' provisions (see p 170) may have been applicable in these cases.

110 SS(IFW) Regs sch Part II para 18(e).

However, despite the fact that the PCA is the test for establishing capacity for work, it was never intended that the individual descriptors should be applied by considering employment situations. Unlike the IVB regime which considered work which the claimant 'could reasonably be expected to do'[111] the PCA is meant to assess functional abilities relevant to daily living.[112] That the PCA bears no relevance to the work environment has been confirmed in a number of Commissioners' Decisions.

In the Northern Ireland Decision[113] *C1/95 (IB)* Chief Commissioner Chambers held that no regard should be had to a 'working situation'.[114]

In *CIB/14587/1996* the appellant's representative contended that the claimant's ability to bend and kneel should be should be judged in an employment context. Rejecting this argument, Commissioner Rice pointed out that any consideration of the nature of the work concerned was avoided by requiring 'the tests to be evaluated from the standpoint of general every-day living'.[115] Although all published Commissioners' Decisions, in which the point at issue was whether or not the legislation contemplated an employment context, relate to the physical descriptors, there is no reason to view the MH descriptors any differently.

Fluctuating conditions

A common feature of mental illness, particularly bipolar disorder,[116] is that the sufferer's condition changes. This is, indeed, recognised in some of the PCA

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111 *R(S) 11/51 (T)*.

112 Corporate Medical Services, *Handbook* (n 52) [3.1.8.]

113 only persuasive in Great Britain.

114 para 7.

115 para 12.

116 see p 24.

descriptors for example: 'Is frequently distressed at some time of day due to fluctuation of mood.'[117] However, interpretation of the precise wording has been a matter of disagreement by Commissioners.

Commissioner Walker maintained that 'frequent' implied a substantial or significant number of times during the day,[118] and that the significance of either the mood changes or the amount of distress was irrelevant. When Northern Ireland Commissioners disagreed over whether distress once per day was, or was not, 'frequent' a Tribunal of Commissioners decided that providing the frequency of distress fell within reasonable bounds that was acceptable.[119]

Adopting a different approach to the phrase 'at some time of day' Commissioner Bano stated:

> In the context of mental disability, distress which occurs at night has a different significance from distress which occurs during the day, and I consider that the words 'at some time of the day' in descriptor 16(c) indicate that it is only diurnal episodes of distress due to fluctuation in mood which are to be taken into account. In my view, the descriptor is satisfied if day-time episodes of distress due to fluctuation of mood occur frequently over a period of days, irrespective of whether they take place more or less often than once a day. However, whilst the duration or severity of any particular incident may be relevant in deciding whether it is sufficiently significant to be taken into account, I respectfully question whether such matters are relevant in deciding whether distress is frequent.

Two other descriptors also use the word 'frequently', thereby implying that the person's mental condition may not always be the same. Discussion of the descriptor 'Frequently feels scared or panicky for no obvious reason'[120] has focused more on the meaning of 'obvious reason' than on the frequency of panic attacks. The consensus

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117 SS(IFW) Regs sch Part II para 16(c), 1 point.

118 *CSIB/2/96.*

119 *R0001/02(IB) (T)*; only persuasive in Great Britain.

120 SS(IFW) Regs sch Part II para 17(b), 2 points.

view is that this implies that the fear/panic should be outside the normal range of human reaction.[121]

Further recognition that a claimant's condition may fluctuate is shown by one of the descriptors in the Completion of Tasks activities: 'Agitation, confusion or forgetfulness has resulted in potentially dangerous accidents in the 3 months before' the decision date.[122] Similarly, 'Frequently finds that there are so many things to do that he gives up because of fatigue, apathy or disinterest'[123] refers to a person who sometimes feels so overloaded with tasks which they need to accomplish that they do none of them.[124]

People with MH problems may have variable mood within a single day, short-term fluctuation with 'good' and 'bad' days, or they may have periods of days, weeks or months when they are well, followed by an acute phase in which their MH deteriorates. In the case of bipolar disorder their mood varies from severe depression to manic behaviour.

The PCA is intended to assess how the claimant functions over a period of time and is not supposed to be a 'snapshot' of functional capacity at the time of the examination;[125] the HCP examining a claimant on a particular day is expected to make a judgement as to their capacity for work over a period.[126] However, statute requires that incapacity benefit can only be paid for any DAY which forms part of a period of incapacity for work, and that such a period consists of four or more consecutive days of

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121 *C47/97(IB)*; *CIB/7510/99*; *CIB/4404/2002.*

122 SS(IFW) Regs sch Part II para 15(g), 1 point.

123 SS(IFW) Regs sch Part II para 17(1), 1 point.

124 *CIB/2008/1997.*

125 Corporate Medical Services, *Handbook* (n 52) [317].

126 *IB204* (n 10) s 2.

incapacity.[127] It also provides for a linking rule by which periods of incapacity separated by eight weeks or less, are treated as one period of incapacity.[128]

For decision-makers, the practical difficulties of reconciling fluctuating conditions with the legislation are considerable. In the case of a person who can sometimes carry out an activity, and sometimes not, the concern is whether they would be able to undertake the activity 'most of the time' or 'with reasonable regularity'.[129] Commissioner Howell further interpreted 'most of the time' as meaning that the claimant would normally be able to perform the activity in question, if and when called upon to do so, and added that 'most of the time' did not imply attempting to 'calculate the percentage of successful or failed attempts over any real or imagined period'.[130]

Most of the information available to a HCP about variability comes directly from the claimant. Guidance lists the factors that should have been taken into account, and although fluctuations over time are included, the advice relates exclusively to performance of the physical descriptors and makes no mention of fluctuating MH conditions.[131]

> The approved doctor's choice of descriptors should reflect what the person is capable of doing for most of the time. In other words could the person normally carry out the stated activity when called upon to do so.
>
> For conditions which vary from day to day a reasonable approach would be to choose the functional descriptors which apply for the majority of the days. Examining doctors should make it clear in the report to the DM[132] how they arrived at their advice.
>
> In such cases the doctor has to consider carefully whether the claimed level of disability on 'good' and 'bad' days is likely to be consistent with the clinical picture presented, the

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127 SSCBA 1992 s 30C(1).

128 SSCBA 1992 s 30C(1)(c).

129 *C1/95 (IB)* para 7, persuasive in Great Britain but endorsed in *CSIB/17/96*.

130 *CIB/13161/96* and *CIB/13508/96* para 41.

131 *IB204* (n 10) [3.1.9.].

132 decision-maker.

diagnosis(es) and the overall pattern of activity in their everyday life.

The above implies that approved doctors should provide the DM with advice on:

- the claimant's functional limitations on the majority of the days.
- the limitations found on the remaining days where the claimant's condition is worse or better, with an indication of the frequency with which these days arise.

For conditions which vary through the day the choice of descriptor should reflect that level of activity which can be performed for a reasonable continuous period within the day. Again it should be made clear in the report to the DM how the doctor arrived at their advice.[133]

In *R(IB) 2/99 (T)* a Tribunal of Commissioners considered how the question of good and bad days should be applied in the PCA. It adopted a broad approach and held that it was not necessary for the test to be literally satisfied each day. There were some cases where a claimant could properly be regarded as incapable of work both on days when the PCA was obviously satisfied, and on other days in between those days.[134]

Drug and alcohol abuse

Payment of social security benefits to claimants who abuse alcohol and/or drugs has been controversial, and denial of benefits to these claimants has been justified on the grounds that they would only spend the money on their drug of choice. Such suggestions have even been made by some Social Security Commissioners. In a case concerning entitlement to disability living allowance (DLA) Commissioner Fellner accepted that alcohol dependency was capable in itself of being a physical or a mental disability, or both,[135] but stated that:

Whether in a rational society the law should require the payment of money to people who may simply spend it on more of what is doing them, and those with whom they come in

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133 *IB204* (n 10) [3.1.9.].

134 para 15.

135 *CDLA/778/2000* para 19.

contact, such terrible harm is not for me to say.[136]

In another DLA case Commissioner Bano commented that the extent of care needs of a person who abuses alcohol:

> will depend on factors such as the availability of alcohol, the extent of the claimant's willingness to control his or her alcohol consumption, and the claimant's financial resources (which will of course actually be increased if benefit is awarded).

Attitudes such as these are behind Government proposals to require all 'problem drug users' identified at a WFI to be referred to a drug treatment provider, with a benefit sanction for those refusing to co-operate.[137]

Nonetheless, it is now widely accepted that harmful use of, and dependency on, alcohol or psychoactive drugs, whether prescribed or not, are diseases in their own right. The World Health Organisation International Classification of Diseases (ICD-10) places Mental and Behavioural Disorders due to the use of alcohol, opiods and other drugs of abuse in Classes F10-19[138] so alcohol/drug dependency should qualify as specific diseases or bodily or mental disablements for the purposes of incapacity benefits.

The IfW Regulations includes provision for people to be disqualified if they have become incapable of work through their own 'misconduct'.[139] This clause is a carry-over from earlier legislation which was intended to punish reprehensible behaviour that could lead to poor health. Although it was decided that the disqualification could be

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136 para 22.

137 Secretary of State for Work and Pensions, *No One Written Off: Reforming Welfare to Reward Responsibility* (Cm 7363, July 2008) [2.33.]

138 International Classification of Diseases <http://www.who.int/classifications/apps/icd/icd10online/> accessed 20 September 2008.

139 SS(IFW) Regs reg 18(1)(a).

applied to alcoholism,[140] there is no record of any similar decisions being applied in more modern cases. In the light of the current view of alcohol and drug misuse as diseases, this is to be expected.

One PCA descriptor refers specifically to a person who 'needs alcohol before midday'.[141] Surprisingly few appeals relating to this descriptor have reached the Social Security Commissioners. In *CIB/17254/1996* the Commissioner distinguished between wishing for something and needing it, stating:

> Although the claimant may well like a drink before midday, it is clear that he is able to resist the temptation to have one, and in so doing he shows that there is no need for him to have a drink.

In a Northern Ireland Decision, Commissioner Brown gave consideration to the meaning of 'needs' and held that it imparted an element of 'necessity or compulsion' rather than a desire for something, and pointed out the descriptor was aimed at people who were alcoholic and who do not have their alcoholic desires under any sort of reasonable control so that they are compelled or obliged to drink before midday.[142] The claimant's representative had suggested that a point should be awarded for descriptor 16(c)[143] because the mental stress associated with his abstinence should be taken into account and not to do so would encourage alcohol abuse as being a method of illustrating incapacity for work. Rejecting this argument, the Commissioner pointed out that a deliberate resort to alcohol would be unlikely to qualify a claimant for the

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140 *R(S) 2/53*.

141 SS(IFW) Regs sch Part II para 17(b), 2 points.

142 *R1/00(IB)* para 10.

143 Is frequently distressed at some time of the day due to fluctuation of mood.

relevant benefit, because of the requirement that functional limitations arise from a specific disease or bodily or mental disablement.[144]

In *C23/02-03(IB)* the Commissioner accepted that, subject to the point that a period of abstinence might be too short to be of significance, *R1/00(IB)* was a precedent for the view that an alcoholic cannot qualify for an award of points under descriptor 16(b) during a period of abstinence. The descriptor also did not assist a person whose consumption of alcohol, however great, took place during the afternoon and evening, so that they were intoxicated in the morning and did not wake until after midday.

Both the decisions cited above agreed that a person abusing alcohol might be able to qualify for points under other descriptors. For example, the mental stress associated with resisting the temptation to drink might fall under 'Is frequently distressed at some time of day due to fluctuation of mood'[145] or 'Sleep problems interfere with his daytime activities'.[146] Alcohol intoxication may also affect a person's interaction with others so that their mental problems impair their ability to communicate[147] or they 'Prefer to be left alone for 6 hours or more each day'.[148] Someone who is seriously dependent on alcohol may be reduced to such circumstances that they no longer care about their appearance or living conditions.[149]

However, even if a claimant qualifies for all the descriptors cited above, they would attain only seven points on the PCA, and in the absence of other physical or MH problems which would score points, could be held capable of work. This, again,

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144 ibid [14].

145 SS(IFW) Regs sch Part II para 16(c), 1 point.

146 SS(IFW) Regs sch Part II para 16(e), 1 point.

147 SS(IFW) Regs sch Part II para 18(c), 1 point.

148 SS(IFW) Regs sch Part II para 18(e), 1 point.

149 SS(IFW) Regs sch Part II para 16(d), 1 point.

illustrates the lack of relevance of the PCA to working situations, where a person with these difficulties would be virtually unemployable.

People who are dependent on heroin, cocaine or similar drugs are in a parallel position. Although there is no descriptor analogous to 16(b) for morning drug-takers, the chaotic lifestyles of frequent drug abusers might have qualified them for: 'Needs encouragement to get up and dress'[150] or 'Does not care about his appearance and living conditions'.[151] Despite serious drug dependency they may fail to reach the PCA threshold.

Interestingly, the advice to HCPs is that in considering the choice of MH statements to apply to a claimant who misuses alcohol or other substances, it was important to assess:

- the claimant's ability to interact with others
- any risk or hindrance they might pose to others at work
- whether they would be able to present themselves appropriately.[152]

Such advice runs perilously close to considering functional limitations in a workplace rather than everyday context, and points out the contradiction inherent in the PCA.

The LCWA for ESA contains no descriptors which are specific to alcohol abuse, and indications are that a low tolerance approach to substance misuse is being taken. The latest Welfare Reform Act contains provisions for mandatory assessment, testing and rehabilitation of ESA claimants who are suspected of being drug or alcohol

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150 SS(IFW) Regs sch Part II para 16(a), 2 points.

151 SS(IFW) Regs sch Part II para 16(d), 1 point

152 *IB204* (n 10) [3.7.9.].

abusers.[153] A Drug Strategy Consultation Paper issued in August 2010 proposed the imposition of benefit sanctions on claimants who do not take action to address their drug or alcohol dependency. This issue is addressed further in the next chapter, on conditionality, at page 268.

Complex medical conditions

There are a few conditions, involving both physical and mental symptoms, which present difficulties for examining HCPs and decision-makers. Examples include not only long-term alcohol and drug abuse, but also chronic fatigue syndrome (myalgic encephalitis or ME), fibromyalgia and traumatic brain injury. Regulations require that assessment of the ability to carry out the physical activities of the PCA must be based on a claimant's incapacity arising solely from a specific **bodily** disease or disablement, and performance of the mental activities must be based on incapacity due entirely to some **mental** disease or disablement.[154]

In some cases, claimants experiencing physical symptoms, might resent being questioned about their MH , and could accuse doctors of believing that their symptoms were 'all in the mind'.[155]

In one appeal concerning a claimant with ME, a Commissioner referred the case back to a differently constituted tribunal with directions that the tribunal was to determine whether the claimant's condition was entirely physical, entirely mental, or

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153 WRA 2009 s 11 and sch 3.

154 SS(IFW) Regs reg 25(3).

155 *IB204* (n 10) [4.3.2.].

partly physical and partly mental in origin, and to then apply the appropriate descriptors.[156]

The difficulty for many claimants lies in the scoring system used for 'compound' conditions, in which a total score of 15 points is required to reach the threshold,[157] but a score of fewer than six points on the MH descriptors is disregarded.[158] Hence a person with both moderate mental disabilities and moderate physical disabilities might be held not incapable of work. The following Case Study illustrates a common problem.

Case Study E[159]

Philip sustained a head injury at work. After the injury he complained of incapacitating headaches, dizziness, forgetfulness, short temper, panic attacks and difficulties in finding the right words and in expressing himself. He reported to the examining doctor that his memory problems and difficulty with concentration had resulted in several accidents in the kitchen and his locking himself out of the house.

The examining doctor had assessed him on the mental heath descriptors and awarded a total of four points for activities 15(f),[160] 17(b)[161] and 18(d).[162] He also scored three points on the physical descriptors because dizziness sometimes prevented him from bending and kneeling. Philip appealed the decision that he was not incapable of work.

The appeal tribunal was unable to award him a minimum of ten points on the PCA mental health descriptors or fifteen points on the combined descriptors.

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156 *CIB/6244/1997* para 25.

157 SS(IFW) Regs reg 25(3)(c).

158 SS(IFW) Regs reg 26(1)(b).

159 Client PF of CBWR&CAB.

160 Overlooks or forgets the risk posed by domestic appliances or other common hazards due to poor concentration, 1 point.

161 Frequently feels scared or panicky for no obvious reason, 2 points.

162 Gets irritated by things that would not have bothered him before he became ill, 1 point.

Exceptional circumstances

When IB and the PCA were introduced in April 1995 the Regulations[163] provided for some people with significant medical restrictions on their ability to work, but who were neither exempt from the PCA nor qualified under the functional assessment, to be treated as incapable of work. This 'safety net' provision, contained in Regulation 27, only came into play after the claimant had 'failed' the PCA, and it was expected to cover only a small number of claimants.[164] In its original version Regulation 27 read:

> **Exceptional circumstances**
> **27.** A person who does not satisfy the all work test shall be treated as incapable of work if in the opinion of a doctor approved by the Secretary of State—
> (a) he suffers from a previously undiagnosed potentially life-threatening condition; or
> (b) he suffers from some specific disease or bodily or mental disablement and, by reasons of such disease or disablement, there would be a substantial risk to the mental or physical health of any person if he were found capable of work; or
> (c) he suffers from a severe uncontrolled or uncontrollable disease; or
> (d) he will, within three months of the date on which the doctor so approved examines him, have a major surgical operation or other major therapeutic procedure.

In a case for judicial review,[165] which questioned the legality of allowing doctors, rather than adjudication officers, to make decisions on benefit, the original wording of this regulation was held to be ultra vires. The Department was concerned that the result of this judgement would be a broadening of access to this provision, inconsistency in decisions, unfairness from case to case and a likelihood of confusion over terms like

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163 SS(IFW) Regs.

164 Social Security Advisory Committee, *Draft Social Security Incapacity for Work)(General) Amendment Regulations 2003* (TSO, Norwich 2005) 5.

165 *R v Secretary of State for Social Security ex p Moule* [1996] EWHC Admin 74 (12 September 1996).

'substantial risk'.[166] In amending regulations which came into force in January 1997, new rules, designed to limit the scope of Regulation 27 by removing the original paragraph (b), were introduced.[167]

In *Howker v Secretary of State for Social Security*[168] the Court of Appeal declared this change invalid, because the implications of the change had not been correctly represented to the SSAC. When the Government, again, sought to amend the legislation, the SSAC reported:

> In particular it appears from what our respondents have told us that the PCA fails a number of people with mental health illnesses, as it does not easily lend itself to the extremely variable and complex symptoms of mental illness. People suffering from physical disabilities can be treated by means of conventional drugs and other therapies: the symptoms are normally predictable and the patient can easily describe the disabling nature of the particular condition. In the case of mental illness however the opposite is more often the case. The symptoms associated with mental illness are variable and unpredictable. The patient is often unable to cope with the rudiments of everyday life and often their insight into their illness is limited and this can make the ability to engage and participate in the process for claiming Incapacity Benefit limited.
>
> …
>
> Respondents therefore see regulation 27(b) as a very important safety net in an area of legislation that does not always meet the needs of claimants with mental illness.
>
> We have seen no evidence of any inappropriate broadening of the criteria leading to benefits being paid in 'undeserving' cases, as a result of the present position. In contrast, however, the respondents suggest that there are a significant number of individuals for whom the current version of regulation 27(b) is crucial to ensuring that income to a number of vulnerable and disadvantaged customers is not disrupted and their lives destabilised.

Having read the SSAC report, the Government withdrew its proposals for amending Regulation 27, thus leaving the 'substantial risk' provision of the original paragraph (b) in place.

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166 Social Security Advisory Committee, *Draft Social Security Incapacity for Work)(General) Amendment Regulations 2003* (TSO, Norwich 2005) 5.

167 The Social Security (Incapacity for Work and Miscellaneous Amendments) Regulations 1996 SI 1996/3207.

168 [2002] EWCA Civ 1623, 8 November 2002; reported as *R(IB) 3/03*.

No figures are available as to the number of people found incapable of work as a result of exceptional circumstances.[169] The experience of welfare right advisers is that although HCPs are asked to consider whether exceptional circumstances applied to claimants sent for medicals, this deemed incapacity provision is never invoked at first-stage decision-making. However, regulation 27 is frequently raised on behalf of claimants at appeal.[170] In particular, the post-Howker regulation 27(b) is often argued as a back-up position for claimants, especially those with MH problems, who fail to score sufficient points on the functional descriptors.

The application of the Exceptional Circumstances provision is illustrated by the outcome of the appeal tribunal previously cited in Case Study E, above.

Case Study F

Following a head injury, Philip complained of headaches, dizziness, forgetfulness, short temper, panic attacks and difficulties with language. The dizziness also sometimes prevented him from bending and kneeling.

The examining doctor had awarded him four points on the mental heath descriptors and three points on the physical descriptors for bending and kneeling.

Philip appealed the decision that he was not incapable of work but the tribunal was unable to award him a minimum of ten points on the PCA mental health descriptors or fifteen points on the combined descriptors.

However the tribunal decided that the examining doctor had failed to appreciate that Philip did not suffer from any form of mental illness but had sustained a traumatic brain injury, that there were exceptional circumstances which applied, and that were he to be found capable of work there was a risk either to Philip's health and safety or to that of others.[171] Philip was awarded incapacity benefit.

Some of the Department's qualms over the precise interpretation of 'substantial risk' were, perhaps, confirmed by the fact that, in the wake of the *Howker* judgement, several appeals relating to this reached the Social Security Commissioners. Although

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169 Social Security Advisory Committee, *Draft Social Security Incapacity for Work)(General) Amendment Regulations 2003* (TSO, Norwich 2005) 5.

170 See further, Chapter Seven.

171 See below.

most of these cases involved physical disablement the principles apply generally. Two such appeals were considered by Commissioner Parker who stated that:

> … the risk must arise from the broad results of a claimant being found capable of work and is not confined to the risks arising directly from the tasks within a claimant's job description. Thus, for example, if a claimant sustains the relevant risk because she has to get up quickly in the morning to go to work, rather than pace herself as would be the situation if no such necessity arose, this is a pertinent factor for consideration. Likewise, [the Secretary of State's representative] accepted that any apprehension sustained by a claimant with mental disablement at the prospect of having to look for work, is pertinent. But there must be a causal link between being 'found capable of work' and an ensuing 'substantial risk to the mental or physical health of any person if [the claimant] were found capable of work'. If the situation of risk is exactly the same whether or not the claimant is exposed to the rigours of work, regulation 27(b) has no application.[172]

The matter was finally resolved by a judgement of the Court of Appeal.[173] The claimant, who suffered from alcohol dependency syndrome had been refused benefit after failing to satisfy the PCA, and challenged a Commissioner's interpretation of regulation 27(b). Commissioner Williams had required the claimant to demonstrate additional risks relating to employment and the workplace, over and above those risks arising from his medical condition in his life generally. The Court of Appeal dismissed the claimant's appeal, finding that once it is appreciated that Regulation 27(b) is not a substitute for a PCA and that it applies only when a claimant's functional abilities in the performance of everyday tasks have been established

> it becomes clear that the risk to be assessed must arise as a consequence of work the claimant would be found capable of undertaking, but for Regulation 27. Were it not so, there would be no statutory purpose in requiring a claimant to have undergone an assessment before consideration of the effects of any disease or disablement on his or others' safety.[174]

The Court went on to consider how a decision-maker could identify the nature of the claimant's work and workplace, holding that

> The answer … lies in the purpose of Regulation 27(b), that is to assess risk at work. In order to determine whether there is any health risk at work or in the workplace it is

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172 *CSIB/33/2004* para 40 and *CSIB/719/2006* para 11.

173 *Charlton v Secretary of State for Work and Pensions* [2009] EWCA Civ 42.

174 para 33.

> necessary to make some assessment of the type of work for which the claimant is suitable. … The extent to which it is necessary for a decision-maker to particularise the nature of the work a claimant might undertake is likely to depend upon the claimant's background, experience and the type of disease or disablement in question. It is not possible and certainly not sensible to be more prescriptive. The most important consideration is to remember that the purpose of the enquiry is to assess risk to the claimant and to others arising from the work of which he is capable. No greater identification of the type of work is necessary other than that which is dictated by the need to assess risk arising from work or the workplace.[175]

The Court's decision did not, however, assist Mr Charlton who had never worked and had neither qualifications nor skills, but had no physical limitations on his ability to work. The Court concurred with the Commissioner who had earlier found as a fact that, provided the work was supervised and structured, the claimant could undertake that work without substantial risk to himself or to others.[176]

ESA regime: Assessing limited capability for work via the LCWA

Claimants with MH problems found themselves disadvantaged by the PCA scoring system which allocates few points to the MH descriptors, and which has a complex method of combining scores on physical and mental descriptors. Although the assessment used for ESA changed the scoring system for the better for claimants with MH problems, the advantage of this was outweighed by the much more stringent tests which the new assessment applies. The rationale of a stricter test lay in the Government's desire to 'write off' as few people as possible from the opportunity of employment.[177]

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[175] para 38.

[176] para 49.

[177] see eg Secretary of State for Work and Pensions, *No One Written Off: Reforming Welfare to Reward Responsibility* (Cm 7363, 2008).

The WRA 2007, which introduced ESA, replaced the previous concept of incapacity for work with the new criterion of having 'limited capability for work' (LCW). At the same time, the PCA was supplanted, for new claimants, by a Limited Capability for Work Assessment (LCWA), the purpose of which is to determine whether:

(a) a person's capability for work is limited by their physical or mental condition; and if so,

(b) whether the limitation is such that it is not reasonable to require them to work.[178]

Regulations stipulate that the assessment should determine the extent to which a person who has some specific disease or bodily or mental disablement is capable of performing prescribed activities, or is incapable of performing those activities because of such disease or bodily or mental disablement.[179] However, unlike the PCA, which stipulated that points could only be scored on the physical activities by virtue of physical disablement, and could only be scored on mental activities by virtue of mental disablement,[180] no such restriction is applied to the LCWA.[181]

Although the LCWA is an assessment of functional capacity which was modelled on the PCA, there were a number of significant changes. The Government described the LCWA as 'more relevant and robust' and stated that it would 'more accurately identify the effect of illness or disability on the individual's capability for work or work

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178 WRA 2007 s 8(1).

179 ESA Regs reg 19(2) and sch 2.

180 SS(IFW) Regs reg 25(3).

181 ESA Regs reg 19(5).

related activities'.[182] This description omitted to specify the comparator that was being used, but is assumed to be the PCA for incapacity benefits.

The table below outlines the chief differences between the two assessment processes.

[182] Department for Work and Pensions, *Memorandum submitted to the Select Committee on Work and Pensions* 2 July 2008 para 24.

Table 1: Differences between the LCWA and PCA

LCWA	PCA
Functional assessment from the outset.	Own Occupation test of capacity for those in recent employment.
Work Capability Assessment (WCA) comprising assessment of limited capability for work (LCWA), assessment of limited capability for work-related activity and work-focused health-related assessment (WFHRA).	Personal Capability Assessment (PCA).
No WCA exemptions. Small number of claimants treated as having limited capability for work.	PCA exemptions, and some claimants treated as incapable of work.
No automatic exemption from WCA for those with severe mental illness.	Exemption from PCA for those with a severe mental illness.
No WCA exemptions based on DLA entitlement. *Adversely affects severely mentally ill claimants.*	Exemption from PCA for claimants receiving DLA higher rate care component.
LCWA with 11 physical and 10 mental activities. (New descriptors).	PCA with 14 physical and 4 mental activities.
Descriptors score 15, 9, 6 or 0 points. Claimant awarded highest score applicable for each activity.	25 mental descriptors, which are not ranked, score 1 or 2 points, and which are additive.
Threshold, 15 points on physical, mental and combined descriptors.	Threshold, 15 points on physical descriptors, 10 points on mental descriptors, 15 points on combined descriptors.
Simple addition for combining mental and physical descriptors.	Formula for combining descriptors.
Claimants reaching the LCWA threshold have limited capability for work.	Claimants reaching the PCA threshold are incapable of work.

These changes are discussed in detail in the rest of this chapter. Many of them, and in particular the rewording of the MH descriptors, operate to make the LCWA a more stringent test of incapacity, particularly for claimants with mild to moderate depression and anxiety.

Unlike incapacity benefits, there are no blanket exemptions from assessment. Instead, certain groups of claimants are 'treated as having limited capability for work' and do not have to undergo the LCWA.[183] Far fewer claimants fall into this group than were exempted from the PCA. Thus, people with a severe mental illness are not automatically exempt from the LCWA, unless they are a hospital in-patient[184] or coincidentally meet the other criteria eg they are receiving maternity allowance.[185] Neither does receipt of disability living allowance higher rate care component (an indication that a person requires frequent attention by night and day) exempt a claimant from assessment as it did with incapacity benefits.[186] Some people with high levels of care needs and those with severe mental illness could be required to complete a self-assessment questionnaire (form ESA50) and attend a medical. Citizens Advice reports cases in which people with debilitating conditions or serious disabilities are being inappropriately subjected to the LCWA.[187]

Case Study G[188]

A 57-year old man suffered from vascular dementia and spinal tumours. He walked with great difficulty and had cognitive impairment. In recognition of his mobility and care needs he was awarded DLA at the higher rate of both mobility and care components. Despite extensive medical evidence he was sent an ESA50 which he failed to return, and he was then required to attend for a medical examination.

The LCWA comprises a series of mental and physical activities with descriptors specifying varying degrees of difficulty for each activity. The LCWA descriptors

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183 ESA Regs regs 20, 25, 26.

184 ESA Regs reg 25.

185 ESA Regs reg 20(e).

186 SS(IFW) Regs reg 10(2)(a)(i).

187 S Royston, *Not Working: CAB Evidence on the Work Capability Assessment* (Citizens Advice 2010) 26.

188 Client BH of CBWR&CAB.

score 15, 9, 6 or 0 points[189] so that the claimant is awarded points applicable to the highest scoring descriptor in each activity.[190] Points for both the physical and mental activities are summed by simple addition, and the threshold for LCW is 15 points.[191] Simple addition of scores in the mental and physical assessment has been questioned, because of a body of evidence which shows clearly that the combined effect of more than one condition is frequently substantially greater than the sum of the factors.[192]

Case Study H[193]

A CAB in the Midlands saw a client with severe anxiety as a result of domestic violence. She also suffered from osteoarthritis, and was unable to read, write or do even simple arithmetic. She was awarded no points in her LCWA.

This lady faced multiple barriers to employment which were greater than the sum of the parts. Her adviser stated 'It is inexplicable how anyone could consider she is fit to actively seek work'.

ESA is designed so that the majority of claimants who reach the LCWA threshold and are designated as having limited capability for work, are then required to attend a work-focused health-related assessment[194] and to enter into work-related activity[195] including compulsory attendance at a series of work-focused interviews[196] and preparation for work, as a condition of continuing to receive their benefit. A small number of people with the most severe disabilities do not have these conditions applied and are placed in what is known as the 'support group', access to which is gained by

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189 ESA Regs sch 2.

190 ESA Regs reg 19(6).

191 ESA Regs reg 19(3).

192 KM Scott and others, 'Mental-physical Co-morbidity and its Relationship with Disability: Results from the World Mental Health Surveys' (2009) 39 Psychological Medicine 33.

193 Royston (n 187) 15.

194 WRA 2007 s 11.

195 WRA 2007 s 13.

196 WRA 2007 s 12.

'passing' another assessment known as the Limited Capability for Work Related Activity Assessment (LCWRAA). The support group is discussed in detail, later in this Chapter at page 201ff.

When ESA was introduced the Government estimated that around 60,000 more people a year would fail the LCWA than were failing the PCA under IB.[197] Those who fail the LCWA have a right to appeal that decision to a tribunal.[198]

The questionnaire

The first stage in the assessment process is a Limited Capability for Work Questionnaire (ESA50). The form has a number of purposes:

- to obtain early additional information from some claimants who will be treated as having LCW without being required to attend a medical assessment
- to collect information about their condition from all other claimants
- to consider whether the claimant is one of the small group who will be treated as having 'limited capability for work-related activity' (LCFWRA) without a medical examination
- to allow a HCP to check the answers given in the ESA50 during the LCWA, and help to decide whether the claimant has 'limited capability for work'
- as part of the evidence in any appeal relating to the claim.

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[197] DWP, *Explanatory Memorandum and Impact Assessment of the Employment and Support Allowance Regulations 2008* March 2008 p 3.

[198] Appeals form the subject of Chapter Seven.

The DWP's policy intention is that 93 percent of ESA claimants should be subject to medical assessment, compared to the 62 per cent examined under incapacity benefits.[199] Thus the ESA50 should be thought of more as a background document which will assist a HCP to reach conclusions as to a claimant's abilities, rather than as a genuine self-assessment of functionality. The removal of group exemptions means that a greater number of vulnerable claimants, including those with MH difficulties, are required to complete the ESA50, than had to complete IB50 questionnaires. This could turn out to be a mixed blessing. A well-completed questionnaire containing full details of a claimant's difficulties could provide a decision-maker with sufficient information to make a decision on capability for work and/or work-related activity, without the need for a medical. Thus a claimant could be spared a pointless examination. However, as discussed in Chapter Three, many claimants with MH problems struggle to complete forms accurately and on time, and find form-filling a stressful experience.

In November 2010 the DWP published the results of a survey conducted by Ipsos Mori looking at the views and experience of those making an ESA claim. The survey showed that of claimants with a MH condition, 47 per cent found the ESA50 questionnaire difficult to complete, and a further 10 per cent found it impossible.[200]

A further issue is that, in order to make the ESA50 form user-friendly,[201] the language of the form and the questions asked have been simplified. This created a lack of correlation between the wording of the questionnaire and the statutory wording, so

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199 Brian Pepper, Customer Relations Manager, Atos Healthcare, Welfare Rights Advisers Cymru Conference, January 2008.

200 H Barnes, P Sissons and H Stevens, *Employment and Support Allowance: Findings from Face-to-face Surveys of Customers* (DWP Research Report No 707, 2010) Table 3.9.

201 Physical Function and Mental Health Technical Working Groups, *Transformation of the Personal Capability Assessment* (DWP 2006) 17.

that the ESA50 alone frequently does not elicit sufficient information for a decision on capability to be made. Descriptors for the activity of 'Propriety of behaviour with other people' and an extract from the ESA50 form (Figure 1) illustrate this point.

The statutory wording of the descriptors for this activity[202] is:

(a) Has unpredictable outbursts of, aggressive, disinhibited, or bizarre behaviour, being either:

  (i) sufficient to cause distress to others on a daily basis, or

  (ii) of such severity that although occurring less frequently than on a daily basis, no reasonable person would be expected to tolerate them. (15)

(b) Has a completely disproportionate reaction to minor events or to criticism to the extent that he has an extreme violent outburst leading to threatening behaviour or actual physical violence. (15)

(c) Has unpredictable outbursts of aggressive, disinhibited or bizarre behaviour, sufficient in frequency and severity to cause disruption for the majority of the time. (9)

(d) Has a strongly disproportionate reaction to minor events or to criticism, to the extent that he cannot manage overall day to day life when such events or criticism occur. (9)

(e) Has unpredictable outbursts of, aggressive, disinhibited or bizarre behaviour, sufficient to cause frequent disruption. (6)

(f) Frequently demonstrates a moderately disproportionate reaction to minor events or to criticism but not to such an extent that he cannot manage overall day to day life when such events or criticism occur. (6)

(g) None of the above apply. (0)

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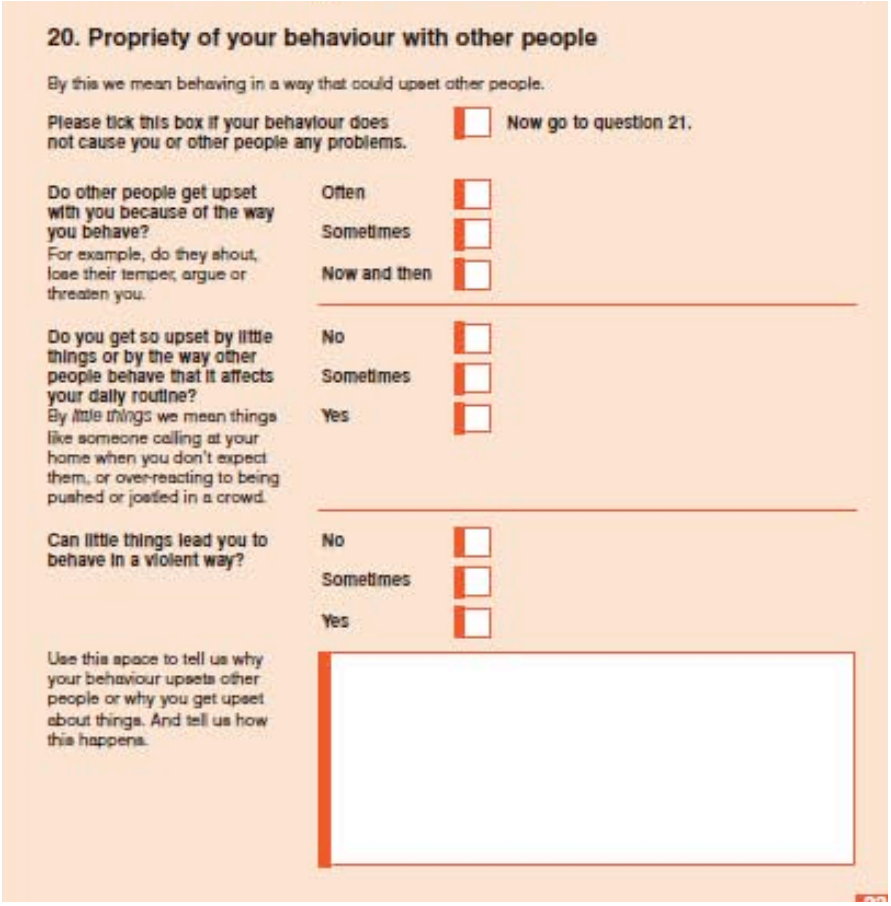
[202] ESA Regs sch 2, para 20.

Figure 1: Extract from form ESA50



20. Propriety of your behaviour with other people

By this we mean behaving in a way that could upset other people.

Please tick this box if your behaviour does not cause you or other people any problems. ☐ Now go to question 21.

Do other people get upset with you because of the way you behave?
For example, do they shout, lose their temper, argue or threaten you.

- Often ☐
- Sometimes ☐
- Now and then ☐

Do you get so upset by little things or by the way other people behave that it affects your daily routine?
By *little things* we mean things like someone calling at your home when you don't expect them, or over-reacting to being pushed or jostled in a crowd.

- No ☐
- Sometimes ☐
- Yes ☐

Can little things lead you to behave in a violent way?

- No ☐
- Sometimes ☐
- Yes ☐

Use this space to tell us why your behaviour upsets other people or why you get upset about things. And tell us how this happens.

Thus, an apparently straightforward question regarding this activity, such as 'Can little things lead you to behave in a violent way?'[203] does not match the statutory criteria for scoring points. Similarly, there is a mismatch between the ESA50 question 'Do other people get upset with you because of the way you behave? For example do they shout, lose their temper, argue or threaten you' and the legislative wording. One would expect tolerant and understanding family members and close friends to refrain from showing their stress by shouting or making threats, but that does not imply that the sick person's behaviour is not aggressive, disruptive or bizarre.

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[203] ESA50, p 24.

The discrepancies between the statutory terms of descriptors and the questions on the ESA50, and on the ESA85 completed by a HCP, were noted by Judge Williams when he considered the activity of Coping with Social Situations.[204] He concluded:

> [T]his inconsistency does require that a decision maker and a tribunal pay attention to the terms of the statutory test. This requires adequate fact finding. It may not be enough simply to adopt the evidence in either the ESA50 or the ESA85 as determining the statutory test.[205]

It is unlikely that a claimant filling in their ESA50 would be aware of the nuanced language, and detail required by the descriptors to be able to provide sufficient information in response to the questions, for a decision-maker to be in a position to award appropriate points to the claimant. It will be difficult for a decision-maker to correlate the responses given by a claimant on the form, with the statutory criteria of the LCWA.

Many of the activities provide answers to questions which do not include a full range of options. For example, 'Execution of tasks' asks 'Do you have difficulties finishing routine daily jobs?' The only responses offered are 'usually', 'not very often' and 'it varies'. How can a person who *always* has difficulty finishing routine tasks respond appropriately to the question? The same three options are proffered for the activity of initiating and sustaining personal action, which asks 'Can you organise yourself to start and keep on with routine jobs?' There is no 'never' option. Anyone would find inadequately produced forms of this type confusing. There are particular difficulties for those with MH problems, at whom these questions are specifically aimed, who have poor concentration and may have difficulty interpreting material.

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204 *JE v Secretary of State for Work and Pensions (ESA)* [2010] UKUT 50 (AAC).

205 para 18.

An illustration as to how a person suffering from anxiety/depression might complete the first two pages of the MH section of the ESA50 is shown below.[206]

[206] Adapted from Stenger (n 29).

Part 2 – Mental, cognitive and intellectual functions continued

16. Initiating and sustaining personal action continued

Do you need encouragement from someone else to start and keep on with routine jobs?

- **Every day** ☑
- **Most of the time** ☐
- **Not very often** ☐
- **it varies** ☐

Use this space to tell us how often you need other people to encourage you to organise yourself to start and keep on with your routine activities.

As shown above, daily.

It's not a question of someone needing to encourage me to 'organise' myself, it's a question of not having the motivation to start, or the concentration to see things through.

17. Coping with change

Please tick this box if you do not have problems coping with change. ☐ **Now go to question 18.**

Can you cope with small changes to your routine if you know about them before they happen?
By *changes to your routine that you knew about before they happen*, we mean things like having a meal earlier or later than usual because you are going out.

- **Usually** ☐
- **Not very often** ☐
- **It varies** ☐

Please note - I cannot cope with changes - expected or unexpected - AT ALL, EVER.

Can you cope with small changes to your routine if they are unexpected?
By *unexpected changes* we mean things like appointments being cancelled, or your bus or train not running on time.

- **Usually** ☐
- **Not very often** ☐

Use this space to tell us more. Explain your problems, and give examples if you can.

Routine is vital to me and I become anxious or distressed even if I know things are going to change beforehand. If I have to do anything I have to plan it down to the last detail, often getting up hours in advance. I have to have company to go to appointments even if they are not changed. I cannot use public transport - partly because of the distress if things do not go to plan.

Part 2 – Mental, cognitive and intellectual functions continued

18. Going out

Please tick this box if you are confident enough to leave home on your own. ☐ **Now go to question 19.**

Do you feel confident enough to leave home on your own and go out to places you know?

- **Usually** ☐
- **Not very often** ☑
- **It varies** ☐

Please note - I hope that I was right to carry on answering this question. Questions 17 and 18 seem to ask the same thing.

If you said **not very often or it varies**, do you only feel confident about going to a place you know if

- someone goes with you every time? ☑
- someone goes with you sometimes? ☐
- someone goes with you the first few times until you get used to it? ☐

Do you feel you cannot go out even if someone was there to go out with you?

- **No** ☐
- **Yes** ☐

Use this space to tell us why you can not always get to places that you know well.

I feel like this most of the time, so I ticked 'yes'. Even when I have company it can sometimes feel too overwhelming or threatening, even if it's somewhere that I know well.

19. Coping with social situations

Please tick this box if you have no problems mixing with other people. ☐ **Now go to question 20.**

Does the thought of meeting new people or going to new places make you anxious or scared?
By *social situations* we mean things like going to a new place, parties or meetings.

- **Often** ☐
- **Sometimes** ☐
- **Not very often** ☐
- **I never go out** ☐

I have this problem all the time but I do sometimes go out - on my rare 'good' days, with company, but never to social situations. I didn't know which box to tick.

It is evident that, in order to provide full details of how their illness affects them, they need to make several alterations to the form, crossing out inapplicable sections and adding in further information. It is unlikely that most claimants, let alone those with mental illness, would have the confidence to do this. This illustrates the importance of seeking assistance from an experienced welfare rights adviser.

The difficulties which claimants with MH problems experience in completing even simple forms were discussed earlier in Chapter Three. For example they may lack the motivation to even begin the task or to see it through, may not be able to concentrate on it or can misinterpret the questions. With an ESA50, lack of insight into their condition further disadvantages them. At a conference for welfare rights advisers, experts in benefits for claimants with MH problems reported that it is now even more difficult than before to discuss these matters with their clients and to obtain information which is relevant to the actual descriptors.[207]

A further issue is that the examples for the definition of 'little things' given in the ESA50 form have no statutory basis, and will probably be properly defined by future caselaw. There are several similar occurrences in the form, eg 'making a sandwich' is used as an example of a 'simple task' in the activity of 'learning or comprehension in the completion of tasks'.[208] Will it be left to the Upper Tribunal (Administrative Appeals Chamber) to explain what type of sandwich is envisaged and to decide whether this is, in fact, a simple task?

It should also be noted that the ESA50 mental function questions, answered straightforwardly, would supply only limited information which would assist a decision-

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[207] J Stenger and T Messere, 'ESA – Where Are We Now?' NAWRA Conference, Swansea 6 March 2009.

[208] p 18.

maker in deciding whether the claimant should be placed in the support group (SG). (Details of the support group follow later in this chapter at p 201) For example, claimants who 'owing to a severe disorder of mood or behaviour' fail to

- clean their torso
- convey food or drink to their mouth, or
- chew or swallow food or drink.

would be assigned to the SG.[209] However, although the ESA50 asks about routine activities there are no specific questions about cleaning the body, eating or drinking.

Welfare Rights advisers have noted that decision-makers do not always draw appropriate conclusions from the information claimants provide on their ESA50s, with the result that claimants are sent for medicals unnecessarily.[210] One adviser, who works in an Assertive Outreach project for people with severe and enduring MH problems and which has a strict vetting process for clients, reported to the Work and Pensions Select Committee that decision-makers failed to discern that a client of Assertive Outreach would not only have significant MH problems but would also be receiving a high level of support, and would inevitably score at least 15 points in the LCWA.[211]

One question on the ESA50 (which has also crept into a new version of the IB50) is 'Do you think any of your health problems are linked to drug or alcohol misuse, or

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209 ESA Regs sch 3.

210 NAWRA Conference, Cardiff 5 March 2010.

211 P Hill, *Work and Pensions Committee Inquiry: Decision Making and Appeals in the Benefits System* Oral Evidence 26 October 2009 Q15.

misuse of any other substance?'[212] For a person whose health problems may be linked to misuse of drugs or alcohol this is a difficult question to answer, since they would either be incriminating themselves or lying. Answering the question in the affirmative provides no advantage to the claimant because, unlike the PCA which awards two points for 'Needs alcohol before midday',[213] there are no descriptors in the LCWA applicable to substance misuse. The Government was requested by the Parliamentary Joint Committee on Human Rights, not to proceed with its proposals requiring ESA claimants to declare dependency on alcohol and drugs, together with possible benefit sanctions and compulsory testing and treatment, because they could interfere with claimants' rights to private and family life under Article 8 of the European Convention on Human Rights. Of particular concern to the Committee was the fact that the Explanatory Memorandum to the Welfare Reform Bill 2009 provided very little explanation of the Government's view that the steps authorised by the proposed regulations were justified and proportionate to a legitimate aim. It noted that no evidence had been provided to support the assertion that benefit compulsion would lead more drug dependant claimants into treatment.[214] Despite these objections, the Welfare Reform Act 2009 contains a section requiring people who are dependent on, or have a propensity to misuse, drugs, when this affects their prospect of finding work, to answer questions about their drug use and to undertake various activities which might include (compulsory) detoxification and rehabilitation. Powers to extend these provisions to those who misuse alcohol[215] are also included.

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212 p 7.

213 IfW Regs sch para 16(b).

214 Joint Committee on Human Rights, *Legislative Scrutiny: Welfare Reform Bill; Apprenticeships, Skills, Children and Learning Bill; Health Bill* HL 78/HC 414 (2008-09) [1.46].

215 WRA 2009 s 11(3) and sch 3 paras 6, 7.

In one important respect, for claimants with MH difficulties, the ESA form is an improvement on its predecessor, the IB50 for incapacity benefits, in that it does provide an opportunity for claimants to comment on their own mental, cognitive and intellectual functions. Every question in the MH part of the form provides for a tick box description of the frequency of difficulties in the particular activity, and allows space for free text comment. However, at 28 pages and requiring detailed information on 21 activities (10 in the mental, cognitive and intellectual function section) it is a daunting task for anyone, and particularly those with MH problems. Recent research shows that 39 per cent of all claimants found the questionnaire difficult to complete and a further seven per cent described this task as impossible. For those whose primary condition is a MH problem these figures increased to 47 per cent stating it was difficult and 10 per cent who said it was impossible. Almost half of all claimants receive help to complete the questionnaire.[216] For those claimants, who have poor insight into their condition, the ESA50 alone may not adequately describe their problems.[217]

Anyone who fails, without good cause, to return their ESA50 within ten weeks having received a reminder to do so after six weeks, will find their benefit terminated. Instead of providing for a benefit sanction,[218] the legislation achieves this objective by treating the person as not having limited capacity for work,[219] thus precluding them from entitlement. Legislation also provides a non-exhaustive list of factors which decision-makers must take into account when determining whether a claimant has good

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216 H Barnes, P Sissons and H Stevens, *Employment and Support Allowance: Findings from Face-to-face Surveys of Customers* (DWP Research Report No 707, 2010) [3.3.3.].

217 — *The Work Capability Assessment – a Call for Evidence. Response* (Centre for Mental Health, Mind, Rethink and Royal College of Psychiatrists 2010).

218 Disentitlement from benefit entails total loss of payment and non-crediting of NI contributions. During a sanction period, entitlement to NI credits continues and loss in payment may be partial or total.

219 ESA Regs reg 22.

cause for their failure.[220] These include the nature of the claimant's disability and their state of health. It is hoped that this will be interpreted as requiring due consideration to be given to the position of claimants with MH problems who struggle to cope with their claims.

Design of the LCWA

In preparation for ESA, the DWP established two technical working groups (one for physical and one for mental activities) who were tasked to consult with interested parties, trial their models and arrive at an improved assessment test. This was despite the fact that the PCA, which the LCWA replaced for new claimants, had been described as one of the toughest gateways to incapacity benefits in OECD member states,[221] and as 'the best assessment of its type in the world'.[222] The LCWA was promised as a new, more relevant and robust medical assessment which would more accurately identify the effect of illness or disability on the individual's capability for work,[223] 'deal more effectively with the types of conditions that are prevalent today, and lead to assessments that are more equitable between groups with different impairments'.[224] A major factor leading to review of the MH assessment was the perceived inequity of the PCA which made the test for people with MH problems more onerous than that for people who only displayed physical difficulties, so that the LCWA was intended to be an improvement for this group of claimants.

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220 ESA Regs reg 24.

221 — *Transforming Disability into Ability: Policies to Promote Work and Income Security for Disabled People* (OECD 2003) 83 and DWP Pathways Presentation <http://www.dwp.gov.uk/pub_scheme/2005/mar/pdfs/pathways_presentation.pdf>.

222 Physical Function and Mental Health Technical Working Groups (n 36) 8.

223 Memorandum to the ESA Regs, para 24.

224 ibid [52].

The steady increase, both in real numbers and in the proportion of claimants with MH difficulties, was a major impetus for change. This was coupled with plans to provide improved support into employment, and the intention to remove large numbers of claimants with what the Government described as 'common mental illnesses' from benefits. The reduction in the number of claimants qualifying for benefit on MH grounds was to be achieved by making the assessment tests more difficult, rather than by an improvement in MH services. One advocate for claimants with MH problems has suggested that, in some cases, individuals with symptoms of anxiety and depression might find it more difficult for them to consider work than someone diagnosed as having schizophrenia, but whose symptoms are well-controlled by medication.[225]

The mental health activities

Part 2 of the LCWA is an assessment of mental, cognitive and intellectual function, comprising 10 activities.[226] In preparing for the LCWA, the technical working group sought to identify those mental activities which were particularly relevant to employment, taking into consideration any support or encouragement that might be required.[227] It also pointed out that an assessment should take into account:

- a 'whole person' approach
- a person's condition over a span of time
- the detrimental effect of medication
- the need for appropriate medical evidence.[228]

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225 Stenger (n 29).

226 ESA Regs sch 2 part 2.

227 Physical Function and Mental Health Technical Working Groups (n 36) 11.

228 ibid [12].

The assessment introduces new activities, not tested under the PCA, such as learning or comprehension in the completion of tasks, and is designed to be more relevant to people with learning difficulties, autism and acquired brain injury than the PCA.[229] Whereas the PCA examined only four general areas in the mental disabilities section (completion of tasks, daily living, coping with pressure and interaction with other people)[230] the LCWA comprises ten activities in the mental, cognitive and functional assessment.[231] These are:

- learning or comprehension in the completion of tasks
- awareness of hazard
- memory and concentration
- execution of tasks
- initiating and sustaining personal action
- coping with change
- getting about
- coping with social situations
- propriety of behaviour with other people
- dealing with other people.

Many of the descriptors are very long and cover several issues, all of which would need to apply to the claimant so as to score the relevant points. For example, in the activity of propriety of behaviour with other people, one descriptor reads:

> (c) Has *unpredictable outbursts* of aggressive, disinhibited or bizarre behaviour, sufficient in *frequency* and *severity* to cause *disruption* for the *majority* of the time.

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229 DWP, *Explanatory Memorandum and Impact Assessment of the Employment and Support Allowance Regulations 2008* March 2008 p 24.

230 IfW Regs sch part II.

231 ESA Regs sch 2 part 2.

Nine points would be scored only if the claimant displayed aggressive, disinhibited or bizarre behaviour, and all the italicised words applied. Interestingly, even behaviour which met these criteria would not, on its own, be sufficiently extreme to score enough points to reach the LWCA threshold.

Several of the descriptors make use of subjective language: describing tasks against which the claimant is tested as 'simple' or 'moderately complex', changes with which the claimant must cope as 'very minor' and outbursts as 'extreme' or 'moderately disproportionate'. Guidance suggests that a simple task requires one or two steps, and a moderately complex one, three or four.[232] Guidance also supplies an example of a strongly disproportionate reaction to very minor criticism: when a comment such as 'the soup could have been warmer' when eating the dinner prepared for them by the claimant, results in the claimant crying and storming out of the room.[233] A moderately disproportionate reaction would be sitting shaking and crying in response to minor criticism.[234]

Statutory wording for the activity of Memory and Concentration refers to the management of 'overall day to day life' by:

(a) verbal prompting by someone else in the claimant's presence, on a daily basis

(b) verbal prompting by someone else in the claimant's presence, for the majority of the time

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232 Department for Work and Pensions, *ESA Handbook MED-ESAHB~001* (Medical Services 2008) [3.6.2.].

233 ibid [3.6.10.].

234 ibid.

(c) making a daily written list.[235]

Guidance to HCPs for this activity states that

> It would seem unlikely that those who live alone without substantial carer input would have the level of disability reflected in [the scoring] descriptors.[236]

Although it might be inferred that claimants with these problems would probably be receiving significant care from others, research has shown that there is, in reality, a considerable degree of unmet need for such services.[237]

The advice in the HCP's Guidance runs counter to caselaw established for DLA and Attendance Allowance which accepts that the fact that a person is not actually receiving help is **not** an indication that such help is not required. In *CA/4332/2003* Commissioner Rowland said:

> It is important … to avoid treating differently those who in fact have done without supervision because they live on their own and those who have in fact generally been under supervision because they live with, say, their spouse. The issue is about what is reasonably required; not what is in fact received.[238]

In the first Upper Tribunal decision relating to ESA published on the Upper Tribunal's website, Judge May considered the activities of Memory and Concentration and, in particular, descriptor 14(c):

> Frequently forgets or loses concentration to such an extent that overall day to day life can only be successfully managed with pre-planning, such as making a daily written list of all tasks forming part of daily life that are to be completed.

Although the Judge accepted the submission on behalf of the claimant, that a list is not an essential pre-requisite of the descriptor, and that reference to a list is simply an

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235 ESA Regs sch 2 para 14.

236 DWP *ESA Handbook* (n 232) [3.6.4.].

237 see eg D Platt and P Snell, *The State of Social Care in England 2007-08* (Commission for Social Care Inspection 2009).

238 para 9.

illustration of what might be required, he dismissed the suggestion that daily tasks that are so routine as to be second nature should be disregarded.[239]

The lowest scoring descriptors (6 points) for the activities of Coping with Change and Social Situations read, respectively:

> 17(c) Cannot cope with minor, unforeseen changes in routine (such as an unexpected change of timing of an appointment on the day it is due to occur), to the extent that overall, day to day life is made significantly more difficult; and
>
> 19(c) Normal activities, for example, visiting new places or engaging in social contact, are frequently precluded, due to overwhelming fear or anxiety.[240]

Guidance suggests that claimants who attend for their WCA unaccompanied would be 'unlikely to meet the level of severity of functional restriction' of the scoring descriptors for these activities.[241] In the light of the fact that failure to attend an assessment could result in disentitlement from benefit,[242] claimants would generally make considerable efforts to ensure their presence, even if this means overcoming their fears to go alone. Unaccompanied attendance could be taken to indicate that the claimant was sometimes able to cope with change or social situations. If, in the absence of other evidence, the fact that a claimant attends the WCA unaccompanied is used to justify the descriptor 'None of the above apply,' then the claimant may have grounds for appeal.

When Judge Williams considered the Coping with Social Situations activity,[243] he described the test of 'normal activities' as 'potentially wide'.[244] Agreeing that the descriptor suggests that the activities to be contemplated are activities of 'normal' people, not the previous activities of the claimant, he pointed out that the wording of the

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239 *DK v Secretary of State for Work and Pensions* [2009] UKUT 230 (AAC).

240 ESA Regs regs 17,19.

241 DWP, *ESA Handbook* (n 232) [3.6.7., 3.6.9.]

242 ESA Regs reg 23(2).

243 *JE v Secretary of State for Work and Pensions (ESA)* [2010 UKUT 50 (AAC).

244 para 15.

descriptor suggests that the 'overwhelming fear or anxiety' does not have to be experienced in respect of all normal activities, neither does it have to occur continually to be significant.[245]

The Guidance to HCPs also contains several references which indicate stereotyping of people with MH conditions. For example it suggests that they will not make eye contact,[246] will sweat[247] and will have poor personal hygiene.[248] The problem with adopting such attitudes is that claimants may be extremely mentally ill without displaying these 'markers,' hence they could be wrongly assessed.[249]

Some of the areas which are assessed in the PCA, such as awareness of hazard and memory, are also included in the LCWA, however the different structure, scoring and complete re-writing of descriptors makes it difficult to compare the two assessments. Similarly, much of the PCA caselaw relating to mental activities, which turns on the precise meaning of the wording of descriptors, and the legal commentaries thereon, will not be directly applicable to the new assessment.[250]

There are several PCA descriptors, which might apply to people with symptoms of anxiety and depression, for which there is no comparable descriptor in the LCWA. These include 'Often sits for hours doing nothing',[251] 'Mental condition prevents him

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245 ibid.

246 DWP, *ESA Handbook* (n 232) [3.6.9.].

247 ibid [3.6.5., 3.6.9.].

248 ibid [3.6.11.].

249 Stenger (n 29) 59.

250 D Bonner, R Hooker and R White, *Social Security Legislation 2008/09, Supplement, Volume I: Non Means Tested Benefits* (Sweet & Maxwell, London 2009) 296.

251 IfW Regs sch para 15(b), 2 points.

from undertaking activities previously enjoyed'[252] and 'Prefers to be alone for 6 hours or more each day'.[253] The text of some of the LCWA descriptors indicates that they are aimed specifically at those whose symptoms are at the serious end of the mental illness scale. Examples include use of the terms 'severe disorder of mood or behaviour',[254] 'overwhelming fear or anxiety'[255] and 'outbursts … of such severity that no reasonable person would be expected to tolerate them'.[256] This approach is consistent with the Government's view that the 'common' MH conditions[257] of mild to moderate anxiety and depression[258] are potentially manageable and that health improvement will follow from enhanced provision of, and access to, appropriate intervention.[259]

This conclusion supports the hypothesis, set out in the Introduction to this thesis, that the changes introduced by ESA help only those with the most severe MH difficulties. Assessment of IB/IS recipients under the LCWA began on a trial basis in Aberdeen and Burnley on 11 October 2010[260] and large numbers of these claimants are expected to be removed from IfW benefit.[261]

Statistics published in August 2010 for claims made to November 2009 showed that for claimants scoring 15 points or more in the LCWA and whose primary condition

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252 IfW Regs sch para 15(e), 1 point.

253 IfW Regs sch para 18(e), 1 point.

254 ESA Regs sch 2 para 16.

255 ESA Regs sch 2 para 19.

256 ESA Regs sch 2 para 20(a)(ii).

257 Secretary of State for Work and Pensions, *A New Deal for Welfare: Empowering People to Work* (Cm 6730, January 2006) ch 2 para 34.

258 Physical Function and Mental Health Technical Working Groups (n 36) 8.

259 ibid [21].

260 Department for Work and Pensions, 'Government Reforms Begin with Fitness for Work Assessments' DWP Media Centre 11 October 2010.

261 DWP, *Explanatory Memorandum* (n 197).

was a mental or behavioural disorder, 57 per cent scored points on activities relating to understanding and focus, 78 per cent on adapting to change and 44 per cent on social interaction. Interestingly, a high proportion of claimants suffering from infectious and parasitic diseases also scored on these activities.[262]

Exceptional circumstances

As is the case for incapacity benefits, the ESA legislation provides for circumstances in which the claimant could fail to reach the LCWA points threshold, but nonetheless have limited capacity for work. The relevant provision is that

> the claimant suffers from some specific disease or bodily or mental disablement and, by reasons of such disease or disablement, there would be a substantial risk to the mental or physical health of any person if the claimant were found not to have limited capacity for work.[263]

Since this text is analogous to that of the IfW Regulations reg 27(b), caselaw relating to health and safety concerns will apply, also, to ESA.[264] In *Charlton*,[265] the Court of Appeal decided that in order to determine whether there is any health risk at work or in the workplace it is necessary to make some assessment of the type of work for which the claimant is suitable.

Hence the provisions of ESA Regulations reg 29 may be invoked by a number of mentally ill claimants who maintain that their condition would be made worse, were they to be found capable of work. Some, with conditions such as agoraphobia, may be

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262 ESA Official Statistics, August 2010 <http://research.dwp.gov.uk/asd/workingage/esa_wca/WCA_by_Health_Condition_and_Functional_Impairment.pdf> Table 8 accessed 1 September 2010.

263 ESA Regs reg 29(1) and 2(b).

264 Bonner, Hooker and White (n 250) 120.

265 *Charlton v Secretary of State for Work and Pensions* [2009] EWCA Civ 42.

able to use the concession made in *Charlton* that risks associated with travel to work, as well as the workplace itself, could be taken into account.[266]

Support group and the role of the LCWRAA

Under incapacity benefits, people who fell into certain categories were exempted from participating in the assessment process. These were detailed earlier in this chapter, at page 138, and included people who suffered from

> a severe mental illness, involving the presence of mental disease, which severely and adversely affects a person's mood or behaviour, and which severely restricts his social functioning, or his awareness of his immediate environment.[267]

ESA created a 'support group' of claimants designated as having 'limited capacity for work-related activity' who would not be required to attend work-focused interviews[268] or the work-focused health-related assessment (WFHRA).[269] The Government's intention was to align the criteria for entry to the ESA support group more closely with the impact that a person's condition has on their ability to undertake employment, rather than on the nature of their illness or disability.

Although the Regulations provide for exemption from work-related activity in a few limited cases eg the terminally ill,[270] there is no special exemption on MH grounds. This accords with the Government's view that nobody should be denied the opportunities of acquiring the skills necessary for work, and of employment. For most claimants the gateway to the SG is via another assessment, similar to the LCWA but with much more strict eligibility criteria. Known as an assessment of limited capability

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266 para 34.

267 IfW Regs reg 10(2)(e)(viii).

268 WRA 2007 s 12(1)(b).

269 WRA 2007 11(1)(b).

270 ESA Regs reg 35.

for work-related activity (LCWRAA) it determines whether a person's capability for work-related activity is limited by their physical or mental condition and, if it is, whether the limitation is such that it is not reasonable to require them to undertake such activity.[271] Claimants who satisfy the LCWRAA on MH grounds are those who are suffering from the more severe mental illnesses.

This conclusion supports the hypothesis, stated in the Introduction to this thesis, that the changes introduced by ESA help only those with the most severe MH difficulties.

The LCWRAA comprises eleven activities, five of which are purely physical, and claimants need to satisfy only one of the descriptors to 'pass' the assessment. Claimants who 'owing to a severe disorder of mood or behaviour' fail to

- control full voiding of their bladder or bowels, at least one a week
- clean their torso
- convey food or drink to their mouth
- chew or swallow food or drink
- learn or understand a simple task eg hot drink preparation
- initiate or sustain basic personal action, or
- communicate so that they can be understood by strangers

or who misinterpret communication to the extent that they become distressed, on a daily basis, would satisfy the LCWRAA and be assigned to the SG.[272]

There is a small degree of overlap with questions in the LWCA, scoring on which would immediately qualify the claimant for the SG. In the activity of Learning or

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271 WRA 2007 s 9.

272 ESA Regs sch 3.

Comprehension in the Completion of Tasks, 'Cannot learn or how to understand how to successfully complete a simple task … , at all' is used in both the LCWA (15 points) and the LCWRAA. The examples of what constitutes a simple task differ for the two assessments, confirming the intention that the LCWRAA is a stiffer test. For the LCWA it is setting an alarm clock,[273] and for the LCWRAA it is preparation of a hot drink.[274] For the LCWRAA activity of Personal Action the descriptors state 'Cannot initiate or sustain any personal action … ', 'Cannot initiate or sustain personal action without requiring daily verbal prompting given by someone else in the claimant's presence' and 'Fails to initiate or sustain personal action without requiring daily verbal prompting given by someone else in the claimant's presence owing to a severe disorder of mood or behaviour'.[275] These are analogous to the high-scoring LCWA descriptors which require that the claimant 'Cannot, due to cognitive impairment or a severe disorder of mood or behaviour, initiate or sustain personal action' or do this without daily verbal prompting … .[276]

Guidance to healthcare professionals emphasises that the criteria for inclusion in the SG 'reflect a very severe level of functional restriction';[277] the word 'severe' appears on numerous occasions, and in the explanation of six of the individual MH activities for the LCWA and LCWRAA.[278] In this respect the use of 'severe' is different to the way that 'severely disabled'[279] is interpreted for the purposes of

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273 ESA Regs sch 2 para 12(a).

274 ESA Regs sch 3 para 9(a).

275 ESA Regs sch 3 para 10.

276 ESA Regs sch 2 para 16(a) and (b).

277 DWP, *ESA Handbook* (n 232) [3.6.1.].

278 ibid [3.6.4. – 3.6.9.].

279 SSCBA 1992 ss 72(1), 73(1)(d).

disability living allowance (DLA). A tribunal of Commissioners confirmed that, for DLA, the test of severity does not condition the degree of disability, and that a person who meets the test criteria *is* considered to be 'so severely disabled that …'[280]

Regulations provide for claimants for whom there would be a substantial risk to their physical or MH, by virtue of a specific disease or bodily or mental disablement, were they to be found not to have limited capability for work-related activity, to be so treated, and placed in the SG.[281] The provision, analogous to regulation 29(2)(b) of the Exceptional Circumstances provisions, could be applied to claimants with MH problems for whom the stress of having to engage in work-related activity could worsen their condition. One welfare rights adviser who works exclusively with people with MH problems predicted that some of her service users who were not placed in the SG, would put a brave face on their difficulties and end up pursuing unsustainable work-related activity, only to fail, along with the negative impact that would have on their mental health, self-esteem and confidence.[282]

Claimants who are placed in the SG are exempt from any conditionality, and receive a support component which is slightly more than the work-related activity component.[283] One commentator, who examined the politics of social policy during an era of austerity and conservative governance, described policies of this type as strategies of division and compensation.[284] Others suggest that it is a strategy for weakening

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280 *R(DLA) 3/06*.

281 ESA Regs reg 35(2).

282 Stenger (n 29) 57.

283 WRA 2007 Sch 4 paras 12, 13. Support component - £31.40 pw; work-related activity component – £25.95 pw (2010/11 rates).

284 P Pierson, *Dismantling the Welfare State? Reagan, Thatcher, and the Politics of Retrenchment* (Cambridge University Press, Cambridge 1994) 171.

opposition to ESA by dividing opponents and concentrating resources on those held to be more deserving.[285]

The Government assumed that about 6,000 claimants annually, who would previously have been PCA-exempt, would not be placed in the SG.[286] When the ESA regulations were drawn up the Government anticipated that ten per cent of ESA claimants would be placed in the SG.[287] The most recent data available[288] for all claims made to November 2009, shows that overall, 5.8 per cent of claimants were allocated to the SG, but that only 4.6 per cent of those whose primary condition was a mental or behavioural disorder, and 6.5 per cent of other claimants were placed in that group.[289] This supports the hypothesis, expounded in the Introduction to this thesis, that only those with the most severe mental illness are advantaged by the introduction of ESA.

What are the possible WCA outcomes?

Every claim for ESA is submitted to Medical Services at the outset, via the ESA50 form and/or for medical examination. There are a number of potential outcomes as a result of these referrals:

- person does not have LCW, so is not entitled to ESA. (When ESA was introduced the Government estimated that around 60,000 more people a

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285 L Piggott and C Grover, 'Retrenching Incapacity Benefit: Employment Support Allowance and Paid Work' (2009) 8 Social Policy and Society 166.

286 DWP, *Explanatory Memorandum* (n 197) p 3.

287 DWP, *Equality Impact Assessment of the Employment and Support Allowance Regulations 2008* March 2008 p 7.

288 R Willis, *Employment and Support Allowance: Work Capability Assessment: Official Statistics by Health Condition and Functional Impairment* August 2010 Tables 5, 6.

289 These figures relate to **all** claims, not just those which proceeded to medical examination, and exclude the impact of appeals. 37 per cent of claims were closed before assessment was completed.

year would fail the LCWA than were failing the PCA under IB.[290] Many of those who fail the LCWA are people with mild to moderate anxiety and depression.)[291]

- claimant is placed in the support group under Regulation 35 provisions treating claimant as having LCWRA. (A small percentage of claimants with severe mental illness.)
- claimant has LCW and LCWRA, so will be placed in the SG. (Some claimants with severe MH problems.)
- claimant has LCW but not LCWRA. They will be required to engage in work-related activity. (Some claimants with MH problems.)
- if no good cause is shown for non-return of the questionnaire the claim will be disallowed[292]
- if no good cause is shown for non-attendance at the LCWA the claim will be disallowed[293]
- if no good cause is shown for non-return of the LCWRA questionnaire,[294] or for non-attendance for an LCWRA assessment, then the claimant is ineligible for the support component.[295]

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290 DWP, *Explanatory Memorandum and Impact Assessment of the Employment and Support Allowance Regulations 2008* March 2008 p 3.

291 This is consistent with the Government approach that the majority of people with mild to moderate mental illness are capable of work. In order to receive benefit, they should be registered as Jobseekers who are required to meet the labour market conditions of being available for work and actively seeking work. A small number of claimants who are refused ESA eg carers or lone parents, may be able to claim alternative benefits such as IS.

292 ESA Regs reg 22.

293 ESA Regs reg 23(2).

294 ESA Regs reg 36(1).

295 ESA Regs reg 37(1).

It could be expected that a high proportion of those failing to return questionnaires and/or attend medicals would have MH problems.

The decisions outlined above all carry rights of appeal to a first-tier tribunal. However, claimants who are found to have LCW but not LCWRA, and who are considering an appeal against the decision barring them from the SG face a dilemma. An appeal throws open all aspects of their assessment, so that a possible outcome could be that they are found not to have LCW and lose their entitlement to ESA altogether. In view of the fact that the enhanced payment to SG members is so low,[296] many claimants may opt for participation in work-related activity rather than risk an appeal. Claimants with MH problems could find themselves struggling to make a difficult decision without fully appreciating the implications, or may make an inappropriate and risky decision to appeal. The need for claimants in this position to seek authoritative advice cannot be over-emphasised, as illustrated in Case Study I.

[296] £5.45 (2010/11).

Case Study I[297]

Although aged only 57, Brian suffers from vascular dementia and has significant cognitive impairment as well as physical difficulties caused by blockage of blood vessels to his brain, including poor balance and gait and weakness in his right arm. He claimed ESA, and following assessment was found to have limited capability for work but not limited capability for work-related activity. Brian found this difficult to understand because, in the unlikely event that his condition would improve, his employer was holding his job open for him, and he appealed against the decision.

Brian then sought advice from a CAB which obtained medical evidence on his behalf. This indicated that although Brian's condition had deteriorated considerably since the date of decision on his claim, at the time he would not have met any of the LCWRAA criteria. Brian was advised to withdraw his appeal, and also to request a supersession of the decision not to place him in the Support Group, from a later date by which he could no longer walk.[298]

The introduction of more appealable issues than under incapacity benefits (including appeals against sanctions), and the more stringent assessment were expected to generate an increase in the number of appeals. The DWP estimated that there would be an extra 26,500 appeals annually, of which 21,000 would proceed to a tribunal hearing.[299] Appeals are discussed in greater detail in the next chapter.

Impact of the LCWA on claimants with mental health problems

In the period immediately following ESA inception in October 2008, both advice agencies and Jobcentre Plus struggled to cope with an increased workload. Citizens Advice reported the following national statistics.

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297 Client BH of CBWR&CAB.

298 A tribunal is precluded from taking into account any circumstances not obtaining at the time when the decision appealed against was made. SSA 1998 s 12(8)(b).

299 DWP, *Explanatory Memorandum and Impact Assessment of the Employment and Support Allowance Regulations* March 2008 p 10.

Table 2: Number of enquiries about incapacity benefits and ESA[300]

	2008 April - December	2009 April - December	% change
Incapacity benefits	59,012	31,164	
ESA	5,834	60,569	
Total	64,846	91,733	+41%

Between October and December 2009 CABx saw 22,618 clients seeking advice about ESA. This compares to a total of 102,500 people who had a claim for ESA assessed during a very similar time period (October to December 2009)[301] and represents 22 per cent of such claimants. This is a sizeable proportion which indicates more than just a minority of problem claims.

Of concern to advisers working with community MH teams is that a greater proportion of their clients than under IB is being asked to complete ESA50 questionnaires and attend for medicals, then find that ESA is refused.[302] It seems that whereas previously GPs were routinely sent IB113 forms at an early stage, so that exemptions could be quickly identified, the equivalent form ESA113 is not sent out until the claimant has completed and returned their ESA50 questionnaire, and the ESA113 form serves mainly to identify SG members. In many cases the claimant has poor insight into their condition so does not complete their ESA50 accurately. Citizens Advice reports a number of cases of people with severe MH problems who have been found not to have LCW.

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300 Royston (n 187) 5.

301 ibid.

302 ibid 11.

Case Study J[303]

A gentleman who had paranoid thoughts, hallucinations, heard voices and had previously attempted suicide was diagnosed with paranoid schizophrenia. He had been awarded DLA higher rate care component and lower rate mobility component. He was non-compliant with treatment and was detained under s 3 of the Mental Health Act. Despite the fact that because he was receiving hospital treatment he should have been automatically treated as having LCW,[304] he was sent an ESA50 form which he returned while he was still detained. He was acutely ill when he filled in the form and it gave an inaccurate picture of his condition. When, a few months later, he attended a LCWA, he was found fit for work.

Case Study K[305]

An adviser with a community mental health team recorded grave concerns about a client diagnosed with bipolar disorder but who had no insight into his condition. After a WCA, the client had been found fit for work. The client signed on for JSA, and was delighted because he believed this showed that he was correct all along and he was not ill. The client's psychiatrist, who maintained that his patient was seriously ill, wanted the decision to be challenged but it was not possible because the client did not want to appeal. The psychiatrist was very concerned about the damaging effect of this decision on his patient's future health, as it made it even more difficult to get him to accept the help he needed.

One outcome of the new assessment for ESA is that, in some cases, mentally ill claimants, who are found not to have limited capability for work, are being denied the treatment that they need because they are being forced into employment. A welfare rights worker in Reading reported[306] that several members of a therapeutic community[307] had failed their LCWA and would therefore be unable to continue attending the treatment centre. Their particular treatment required a commitment to

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303 Royston (n 187) 11.

304 ESA Regs reg 25(1).

305 ibid.

306 Tony Bowman Rightsnet discussion forum <http://www.rightsnet.org.uk/dc/dcboard.php?az=show_topic&forum=111&topic_id=4371&mesg_id=4371&page=> accessed 6 November 2009.

307 Therapeutic Communities are 'psychologically informed planned environments' where social relationships, structure of the day and various activities improve members' health and well-being.

attend, full-time, for six to nine months. There being no other alternative benefit available, these patients were forced to claim JSA, but complying with the labour market conditions made it impossible to commit to attendance and therefore to being community members. By contrast, incapacity benefits claimants with similar MH problems are able to avail themselves of the exemption from the PCA provided under Regulation 10(2)(viii) of the Incapacity for Work Regulations, for claimants suffering from a severe mental illness.[308]

Because ESA claimants are assessed at an earlier stage than under IB, and a greater proportion of claimants is being subject to examination, more healthcare professionals were recruited to conduct this increased number of medicals. There are reports of a number of doctors being recruited from Eastern Europe, some of whom have poor command of English.[309] In view of the complex language of many of the LCWA mental health descriptors this is a matter of concern.

Others complain that the HCPs are poorly trained,[310] have negative attitudes towards claimants,[311] were rude or insensitive,[312] and made assumptions without exploring the issues.[313] A Citizens Advice report into the WCA reported two separate cases in which the HCP had recorded that the claimants watched television all day, whereas their adviser, who was part of a community MH team, knew that neither person

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308 *CIB/3328/1998*.

309 Several clients of CBWR&CAB; NAWRA Conference, Chesterfield 27 November 2009.

310 Minutes of NAWRA Conference Edinburgh 4 September 2009 p 3.

311 ibid.

312 — *Responses to the Work and Pensions Committee Inquiry: Decision Making and Appeals in the Benefits System* (Citizens Advice 2009) 3 and (Mind 2009) Case study: James.

313 Royston (n 187) 19.

owned a TV.[314] Several organisations report examples of medicals in which HCPs gave insufficient consideration to MH issues,[315] ignored MH support workers[316] and paid more attention to their computer than the examinee.[317] It appears that HCPs are particularly struggling with the drop-down menus of their computer software, so that they are watching their monitors and not making eye contact with the claimant.[318] This is not only rude and insensitive, but very disconcerting, especially to people with MH problems. Although similar complaints were being made about PCA medicals, there is anecdotal evidence that the situation has deteriorated.[319]

Complaints have also been made that medical examinations are being rushed.[320] The DWP indicated that a WCA interview should take 75 – 90 minutes,[321] however advisers reported that a duration of half an hour was more common. It is questionable whether it is possible to undertake a full physical and MH assessment together with a WFHRA in that time. A hurried medical is particularly disadvantageous to claimants with MH difficulties who need an introductory period during which they gain confidence in their examiner, and for whom the professional needs time to explore their problems.

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314 Royston (n 187) 21; — *Responses to the Work and Pensions Committee Inquiry: Decision Making and Appeals in the Benefits System* (Mind 2009).

315 Royston (n 187) 27; — *Responses to the Work and Pensions Committee Inquiry: Decision Making and Appeals in the Benefits System* (Mind 2009).

316 Minutes of NAWRA Conference, Edinburgh 4 September 2009 p 4.

317 — *Response to the Work and Pensions Committee Inquiry: Decision Making and Appeals in the Benefits System* (Citizens Advice 2009) 4; Evidence taken before the Work and Pensions Committee, DWP Departmental Annual Report 2009, 14 October 2009 Q37.

318 NAWRA Conference, Chesterfield 27 November 2009.

319 NAWRA Conference, Chesterfield 27 November 2009.

320 Rightsnet discussion forum <http://www.rightsnet.org.uk/dc/dcboard.php?az=show_topic&forum=111&topic_id=4665&mesg_id=4665&page=> accessed 5 January 2010.

321 DWP, *Employment and Support Allowance: Technical Factsheet T14 Work Capability Assessment* (DWP 2009) 5.

Mind reported on one claimant's medical, in which his particular needs were not catered for.

Case Study L[322]

James suffered with depression and anxiety. He was called for his Work Capability Assessment and asked for it to be conducted in a private quiet space, and this was agreed. However, when he arrived he was told the interview would be conducted in the main office. When he insisted that he needed a private space a separate room, but with no door, was provided. James found this very distressing and asked if he would be able to take a break if he found the interview too stressful. He was told that this would be viewed as terminating the interview. The interview was then conducted over 75 minutes. He found the HCP's attitude to be very aggressive and the whole process very stressing.

Despite the significant changes to the MH assessment, compared to the PCA, organisations working with people with MH problems still maintain that the assessment process does not address the difficult issue of fluctuating medical conditions,[323] does not perform an adequate assessment of a person's functionality in relation to the average workplace,[324] and remains biased towards physical functions.[325] The Work and Pensions Select Committee have noted widespread concerns that decision-makers appear to give excessive weight to the conclusions of DWP medical assessments over other evidence claimants may provide[326] and judges who gave evidence to the committee suggested that a more inquisitorial approach by the Department would lead to fewer appeals.[327]

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322 — *Responses to the Work and Pensions Committee Inquiry: Decision Making and Appeals in the Benefits System* (Mind 2009).

323 ibid.

324 ibid; Royston (n 187) 26.

325 ibid; S Redman and others, *Don't Write Me Off* (National Autistic Society 2009) 25.

326 Work and Pensions Committee, *Decision Making and Appeals in the Benefits System* HC 313 (2009-10) [87].

327 ibid, Annex C: Note of Meeting with Judges from the Administrative Appeals Chamber of the Upper Tribunal, 22 October 2009 para 7.

The case study which follows illustrates the not uncommon experience of the medical assessment of a claimant with MH problems.

Case Study M[328]

Jenny was aged 56 and had spent the previous 25 years working in a senior administrative post for a charity. When a new boss was appointed she found all aspects of her work being criticised, and also that work that she had completed was being undone so that she felt undermined. On arrival at work one morning she was told that the charity was closing and she was being made redundant with immediate effect.

Jenny was devastated and suffered a mental breakdown, becoming depressed, supremely anxious and experiencing panic attacks. She was haunted by guilt that she was responsible for the charity's demise, unable to engage in social contact or leave her home without her husband going with her.[329] In addition to her mental health problems Jenny suffered from osteoarthritis affecting her hands.

Jenny made a claim for ESA, completed the ESA50 questionnaire, and was summoned to a medical examination. At the medical, the Bulgarian doctor, who had been registered with the GMC for only a year, conducted a thorough physical examination, although Jenny's ESA50 had indicated only minor problems with dexterity, lifting and carrying. Jenny reported that there had been only brief questioning about her mental state. The doctor awarded Jenny just 6 points for the descriptor 18(d): Is frequently unable to get to a specified place … without being accompanied by another person.

The doctor's advice was confirmed by a decision-maker, and Jenny submitted an appeal against the decision that she did not have limited capability for work. It took eight months from the date the appeal was made until the oral hearing. During this period Jenny was still required to submit sick notes and to engage in work-focused interviews, and the stress and uncertainty exacerbated her condition.

Jenny's Personal Adviser at Working Links (a contractor to the DWP) supplied a report on Jenny's progress which stated that "she was not ready for a pre-employment course". At the appeal hearing Jenny fiddled with her fingers, and was visibly nervous, hesitant and tearful. The hearing was curtailed after a few questions, following which the tribunal had allocated a minimum of 15 points on mental health descriptors alone.

Table 3 depicts the statistics published in August 2010 on the outcome of LCWA medicals for the period from ESA inception to the end of May 2010.

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328 Client JS of CBWR&CAB.

329 Client JP of CBWR&CAB.

Table 3: Outcome of medical assessment by medical condition[330]

Condition	SG %	WRAG %	Fit for work %
All	9.8	23.8	66.4
Mental and behavioural disorders	6.8	24.0	69.2
Other conditions	11.6	23.7	64.7

The figures show that a significantly smaller proportion of claimants whose primary condition is a MH problem than those with other conditions is placed in the SG, and a greater proportion is found fit for work. These figures support the hypothesis, set out in the Introduction to this thesis, that the changes introduced by ESA help only those with the most severe MH difficulties.

Of those claimants with MH problems who 'failed' the LCWA, the majority were scoring no points.[331] This result is surprising as one would expect a more even distribution of scores, and suggests that LCWA is an insensitive test which is failing to identify people who are genuinely incapable of work because of mental illness.

In March 2010 a Command Paper was published which set out proposed changes to the LCWA.[332] The changes included greater recognition of fluctuating conditions in the assessment, and expansion of the SG to include people with communication problems and severe disability due to MH conditions. The proposals were made as the

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330 calculated from ESA Official Statistics, August 2010 <http://research.dwp.gov.uk/asd/workingage/esa_wca/WCA_by_Health_Condition_and_Functional_Impairment.pdf> Table 5 accessed 1 September 2010.

331 A Markey and T Messere, 'Employment and Support Allowance: the First Year (Well, Almost)' NAWRA Conference, Edinburgh 4 September 2009. These outcomes accord with the author's own observations.

332 Secretary of State for Work and Pensions, *Building Bridges to Work* (Cm 7817, 2010) 23.

result of an internal review of the LCWA, a report on which was published at the same time.[333] With the change in Government in May, the future of these proposals is uncertain. In July 2010 the Department issued a call for evidence as part of an independent review into the LCWA by Professor Malcolm Harrington.[334] His report is not expected to be published until the end of 2010.

It has also been reported that whereas 25 per cent of claimants failed to attend PCA medicals, 30 per cent were not turning up to LCWA examinations.[335] One reason for this could be that people who would previously have been exempt (including those with severe mental illness), are now required to attend medicals, but are finding this difficult. Other possibilities are that poor administrative procedures result in claimants not receiving appointment letters, and claimants becoming so frustrated by postponements, sometimes after spending 90 minutes travelling to a medical examination centre,[336] that they decide not to attend on another occasion.

Outcomes for ESA claimants found capable of work

There are several possible outcomes for people who, after a WCA, are classed as capable of work:

- find employment and make a successful transition into work
- find employment, but their condition is made worse by stress and difficulties coping
- be entitled to means-tested benefits, sign on, and receive income-based

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333 J Bolton, *Work Capability Assessment Internal Review* (DWP, Health and Wellbeing Directorate 2009).

334 M Harrington, *The Work Capability Assessment – a Call for Evidence* (DWP 2010).

335 Minutes of NAWRA Conference, Edinburgh 4 September 2009 p 4.

336 client MP of CBWR&CAB.

jobseekers allowance

- be entitled to means-tested benefits but fail to claim
- were receiving contribution-based ESA, but have no entitlement either to contribution-based or income-based JSA.

Some people who are disentitled from ESA are too ill to cope with signing on. Others may initiate a JSA claim but run into problems meeting the labour market conditions of being available for and actively seeking work. A London CAB reported the following case.

Case Study N[337]

One client with serious mental health problems was being helped by a social worker and a housing support officer, in addition to her psychiatrist and the community mental health team. Although evidence from her psychiatrist stating that she was not fit for work was provided, she was found capable of work at a LCWA. Her mental state deteriorated further so that she came under the care of the crisis team who visited daily. She was completely incapable of leaving her home and did not attend her appeal. The tribunal found her capable of work, in her absence.

The client could not attend the Jobcentre to sign on and has been left living on DLA alone. DLA is intended to meet the extra costs of disability rather than as income replacement.

The NI contribution conditions for JSA are more stringent than those for ESA, in particular with respect to people who were previously self-employed, because Class 2 (self-employed) contributions do not count towards satisfaction of the conditions for JSA.[338] There are a number of claimants who qualify for CESA but who do not meet the contribution conditions for JSA, which in any case is only paid for a maximum of 26 weeks.[339] Furthermore JSA(IB) is means-tested and excludes anyone whose capital

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337 Royston (n 187) 24.

338 Jobseekers Act 1995 ss 1(2)(d) and 2.

339 Jobseekers Act 1995 s 5(1).

exceeds £16,000[340] or with a partner in full-time work.[341] Thus, many people who fail the LCWA find themselves moved from CESA to no benefit at all, although they can receive NI credits if they register for JSA and meet the labour market conditions.

There is a paucity of up-to-date research into the destinations of IfW benefit leavers, and the most recent statistics relate to the start of the incapacity benefits regime. These showed that, one month after leaving incapacity benefits, eight per cent were living at home without either income or benefits.[342] Another survey, which analysed data according to whether benefit leavers had left voluntarily or failed an assessment, showed that one month after failing a PCA, nine per cent of those who had been disallowed reported that they had zero income. Most of these people were relying on a partner's income.[343] Some of the IB/IS leavers, mainly those aged over 55, were receiving alternative benefits such as carers allowance or bereavement benefit.[344] The destinations of ESA leavers are not currently available from administrative data, although research into this issue is planned for 2011.[345] In a survey of people with an autistic spectrum disorder, one third was shown to be neither in employment nor receiving any social security benefit.[346]

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340 Jobseekers Act 1995 s 3(1)(e).

341 Jobseekers Act ss 12, 13. JSA Regs reg 107.

342 K Ashworth, Y Hartfree and A Stephenson, *Well Enough to Work?* (DSS Research Report No 145 Leeds 2001) 68.

343 R Dorsett and others, *Leaving Incapacity Benefit* (DSS Research Report No 86 CDS, Leeds 1998) 121.

344 N Coleman and L Kennedy *Destination of Benefit Leavers 2004* (DWP Research Report No 244 2005) Table C.1a.

345 Merits of Statutory Instruments Committee, *Drawing Special Attention to: Employment and Support Allowance (Transitional Provisions, Housing Benefit and Council Tax Benefit) (Existing Awards) Regulations 2010 etc* HL 7 (2010-11) Appendix 1, Q1.

346 S Redman and others, *Don't Write Me Off* (National Autistic Society 2009) 35.

Conclusion

The PCA, which acted as a gateway to the incapacity benefits, was a major obstacle to qualification for many claimants. Only the most severely mentally ill people were exempt from the assessment process, so that all others were required to grapple with the IB50 enquiry form and subject themselves to medical examination. Claimants with moderate MH difficulties found it hard to achieve the necessary 10 points on the PCA mental health descriptors. This was particularly so for people whose communication problems hampered their ability to convey their symptoms to doctors and decision-makers.

When ESA and the LCWA were introduced the situation was exacerbated. A greater proportion of claimants became subject to formal assessment but many more with mild to moderate MH difficulties 'failed' the assessment. Only 4.6 per cent of assessed claimants whose primary condition was a mental or behavioural disorder were placed in the SG. Many people with MH problems found their assessment medical unsatisfactory and maintained that the outcome was not a true reflection of their difficulties.

Many unsuccessful claimants went on to appeal against a decision that they were not incapable of work. Appeals form the subject of Chapter Seven. Chapter Six considers the difficulties caused to claimants in the work-related activity group by the conditions attached to continuing benefit entitlement.

CHAPTER SIX

CONDITIONALITY

Introduction and overview

The WCA, which acts as a gateway to ESA, places claimants into three groups: those who are disentitled from ESA altogether, a work-related activity group (WRAG) who receive ESA subject to their fulfilling various conditions as to behaviour, and a support group (SG) who receive benefit unconditionally.

Successive administrations since the 1997 Labour Government have repeatedly stated that welfare through work is the best way of achieving both poverty reduction and social inclusion.[1] Consistent with that view, Pathways to Work pilot projects were introduced which made entitlement to incapacity benefits conditional on attendance at interviews with a 'personal adviser' about employment. A work-focused interview (WFI) eventually became compulsory for all new claimants of incapacity benefits aged under 60. When ESA was introduced, conditionality was extended to all claimants in the WRAG, with requirements to engage in WFIs and work-related activities and to undergo a work-focused health-related assessment (WFHRA), all aimed at improving employment prospects. A claimant's failure to abide by the conditions results in financial penalties, known as sanctions. The increased rôle of the social security system as a means of social control to

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[1] see eg Secretary of State for Work and Pensions, *In Work, Better Off: Next Steps to Full Employment* (Cm 7130, 2007).

change claimants' behaviour, particularly when applied to people with MH difficulties, is controversial.[2]

This chapter explores the conditionality requirements under the IB/IS and ESA regimes. It establishes that increased conditionality has had a major impact on claimants with MH problems, particularly those suffering from mild to moderate anxiety and depression, who find it difficult to comply with the requirements, and who are therefore at risk of being sanctioned.

Conditionality under incapacity benefits

Several, slightly different schemes, were trialled in a number of selected areas. Questions relating to the ethical and human rights considerations of conducting experimental research on vulnerable people were raised by the Social Security Advisory Committee which criticised the inadequate scale and lack of robust evaluation of several DWP pilot schemes. While the pilots were legal, in that regulations had been agreed, it remained to be established whether a judge would uphold a claim by a sanctioned customer that their right to property (in the form of benefit) under Article 1 of the First Protocol of the Human Rights Act had been breached.[3]

All the schemes required claimants to participate in a work-focused interview (WFI). The purposes of a WFI are to:

- assess a claimant's prospects of employment

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2 see eg Sue Christoforou, Memorandum to the Work and Pensions Committee, Mind 27 February 2006 [2.1, 2.5].

3 Social Security Advisory Committee, *An Examination of the Ethical and Legal Issues of 'Piloting' in its Widest Sense in the Department for Work and Pensions* Occasional Paper No 2 (SSAC 2007).

- find ways of improving employability
- identify activities that will lead to employment
- identify suitable educational and training opportunities.[4]

Claimants are required to 'take part' in an interview, which means that they must

- attend at the designated time and place
- 'participate in discussions' about employability
- answer any questions relating to their education, work history, medical condition and limitations
- prepare an 'action plan'.[5]

In general there were no exemptions from the requirement to participate in WFIs, even for claimants who were exempt from the PCA. Concessions which could assist claimants with MH problems, who had difficulty complying with the WFI requirement, allowed for an interview to be deferred[6] (put off to another date) or waived altogether[7] if it was thought that an interview would either not assist the claimant or would be inappropriate.

When ESA was introduced in October 2008 the provisions for waiver and deferral of WFIs for incapacity benefits were brought into line with the ESA regime (see page 260) by the Social Security (Incapacity Benefit Work-focused Interviews) Regulations 2008,[8] with

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4 SS(JPI) Regs reg 2(1); SS(IBWFI) Regs reg 2; ESA Regs reg 55.

5 SS(JPI) Regs regs 4, 11; SS(IBWFI) Regs regs 3, 9; ESA Regs reg 57.

6 SS(IBWFI) Regs reg 7(1).

7 SS(IBWFI) Regs reg 6(1).

8 SI 2008/2928.

the exception that regulation 3(5) provides that claimants with severe conditions who are exempted from the PCA[9] are not required to attend WFIs.

Failure to take part in an initial WFI, without 'good cause'[10] for so doing, resulted in their being penalised.[11] In its Explanatory Memorandum to the SSAC regarding the forthcoming SS(IBWFI) Regs, the DWP promised safeguards to ensure that claimants 'with a stated mental health problem' would not be sanctioned when they were unable to comply.[12] One of the grounds for good cause was that the disability from which they were suffering made attendance impossible,[13] and it is probable that this was intended to cover those with MH difficulties. However, claimants had only five days from the scheduled date to inform the DWP of the reason for failing to take part in a WFI.[14] This tight time limit could be problematic for someone who is ill, particularly if they have MH difficulties.

The extended scheme for incapacity benefits, applicable to existing as well as new claimants in pilot areas, required attendance at further interviews[15] under threat of a benefit penalty equivalent to one fifth of the income support personal allowance for a single person.[16]

The following Case Study illustrates the problems created for a mentally ill claimant who failed to attend a WFI.

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9 IfW Regs reg 10.

10 SS(JPI) Regs reg 14; SS(IBWFI) Regs reg 11; ESA Regs reg 61.

11 SS(JPI) Regs reg 12(2)(a); ESA Regs 63(1)(b) and (2).

12 [27].

13 SS(JPI) Regs reg 14(i); SS(IBWFI) Regs reg 11(i); ESA Regs reg 61(3)(i).

14 SS(IBWFI) Regs reg 9(4).

15 SS(IBWFI) Regs reg 4.

16 SS(IBFW) Regs regs 9(4), 10(1), 10(2). £13.09 at 2010/11 rate.

Case Study A[17]

A CAB in Yorkshire reported the case of a Somali mother of four children aged between five and eleven years who was diagnosed with schizophrenia and depression, and whose only income was income support. She was unable to deal with her personal affairs and correspondence and did not open letters. Her IS had been reduced by 20 per cent of her personal allowance because she had not attended a mandatory work-focused interview, despite three written interview invitations

The CAB took the view that she was being penalised for her inability to comply, but despite the existence of discretion to do so, it was informed that no home visits could be made.

Mitchell and Woodfield have commented on the importance of not confusing increased attendance at WFIs with positive engagement. While financial penalties triggered greater attendance they did not always lead to increased engagement or enthusiasm on the part of the claimant.[18] The research also found that Incapacity Benefits Personal Advisers (IBPAs) believed that, despite sanctions, failure to attend WFIs was greater among claimants with unpredictable lifestyles associated with MH problems. IBPAs described others as having health conditions eg clinical depression that might affect memory and recall and which reduced the likelihood of customers remembering to attend.[19]

Mitchell and Woodfield describe the case of a female claimant with an anxiety-related condition who found it impossible to attend the Jobcentre.

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17 L Cullen, *Out of the Picture: CAB Evidence on Mental Health and Social Exclusion* (Citizens Advice 2004) [3.25.]

18 M Mitchell and K Woodfield, *Qualitative Research Exploring the Pathways to Work Sanctions Regime* (DWP Research Report No 475 HMSO, Norwich 2008) 9.

19 ibid 34.

Case Study B[20]

One claimant telephoned her IBPA to try to explain that she could not attend her first WFI because she suffered from severe anxiety and panic attacks. She felt that her IBPA had failed to listen to her because she only offered to postpone the meeting and not to waive it altogether. She went to her first WFI the day after the appointment but had felt 'frightened' despite having her partner with her. She then received a sanction but failed to attend any further WFIs. She said: 'I just thought "I can't do this anymore". I just want to go to sleep and tell everyone to leave me alone.'

The requirement for 'participation' has also provoked concern among MH workers. Mind has pointed out that claimants might not be able to communicate deteriorations in their MH to their advisers[21] and Lorna Reith of Disability Alliance has suggested that DWP staff lacked knowledge of mental illness and might therefore misinterpret its symptoms as being uncooperative.[22] Dr Jed Boardman of the Royal College of Psychiatrists outlined the difficulties inherent in making decisions about the behaviour of those with MH conditions:

> [A]nybody could be labelled as being awkward because they will not take part in something for good reasons to themselves which are related to their anxieties, their poor motivation because of their depression problems and so on. It is really almost a question of how you label that uncooperativeness. It is something I have to engage with with patients most days. Are they doing this because they do not want to, because they are being awkward, or because they simply cannot?[23]

The situation with regard to WFIs was summed up by Citizens Advice:

> [W]hen they are unwell, clients with mental health problems have trouble travelling distances, tend to be withdrawn, are afraid of meeting strangers, wary of contacts and don't expose themselves to situations, such as an interview, that could highlight their problems with communication and concentration. They sometimes do not open post, find it difficult to keep to deadlines and may be unable to attend interviews on appointed days. People with other conditions and disabilities could similarly have their ability to engage affected by

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20 ibid 44.

21 Work and Pensions Committee, *Incapacity Benefits and Pathways to Work* HC 616-II (2005–06) Mind Evidence Ev 181.

22 ibid Vol 2, Ev 181 and Q 163.

23 ibid Vol 2 Ev 212.

> changing medication or other therapeutic regimes, or fluctuating/deteriorating physical or mental well-being. It may be difficult for them to cope with compulsory attendance at an interview and to grasp the difference between having to draw up an action plan and the (currently) voluntary option of fulfilling the listed activities in that action plan.[24]

The Synovate Report for the GLA's Review of Incapacity Benefit reported on the claimant's view of WFIs, which often came as an 'unwelcome surprise':

1. They have been unlucky enough to have been temporarily or in many cases indefinitely prevented from generating their own income by illness, injury or disability.
2. They may have been told by their GP at an early stage that they are unfit for work and been given a certificate to this effect, leading them to believe that they are a genuine candidate for IB.
3. They have been through an impersonal and extensive process of claiming IB, the success of which feels like some final validation of them as a genuine claimant, and that the authorities believe that they are indeed unable to work.
4. Having finally attained some kind of peace of mind and stability, they find that they must attend a WFI or their benefit may be 'reviewed', which appears to be bringing their whole status back into question.[25]

Claimant advice organisations and mental health advocacy groups have been vociferous in their opposition to compulsory WFIs. Much of the evidence to the Work and Pensions Committee investigation of Pathways to Work argued that conditionality was

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[24] Citizens Advice submission to the GLA Review of Incapacity Benefit in London August 2006 7.

[25] G Jones and A Fenyoe, *Review of Incapacity Benefit: Qualitative Research Findings* Evidence to the GLA (Synovate Ltd October 2006) [3.1.3.].

particularly inappropriate for claimants with MH and fluctuating conditions.[26] Mind warned that it could cause deterioration in health and distress, and might lead to claimants taking up unsuitable work[27]. It gave the following illustration of such a case.

Case Study C[28]

A female claimant with mental health problems took on an unsuitable job out of fear of a total loss of income, only to become too unwell to continue working. Her health deteriorated to such an extent that she had to engage with secondary mental health services, whereas previously she had worked only with primary mental health services.

Similar concerns were expressed by Rethink who also pointed out that conditionality was especially unhelpful for those with severe mental illness, many of whom would have experienced compulsory hospital treatment.[29] Rethink cited this example of what could happen.

Case Study D[30]

A claimant with bipolar disorder who lived in Derby, was called in for a WFI and believed that she had to obtain employment, which she did. She was dismissed after only two days in post. She then left her home town in search of other work, abandoning her children.

Rethink predicts that people, who because of their health condition face continual rejection, will become demoralised, and this will have a detrimental effect on their health,

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26 Work and Pensions Committee, *Incapacity Benefits and Pathways to Work* HC 616 (2005–06) [171].

27 ibid HC 616-II Mind Evidence Ev 160 and Ev 175.

28 ibid HC 616-II Mind Evidence Ev 159.

29 ibid Rethink Evidence Vol 2 Ev 179.

30 ibid Mind Evidence Vol 2 Ev 159.

which will be in no-one's interest.[31] It is possible that repeated rejection of applications for employment is more stressful than actually working. Rethink recommends that people with severe mental illness should not be required to attend interviews with personal advisers when

- there is no realistic prospect of their ever returning to paid work
- they are unwell, in hospital or immediately following discharge from hospital.[32]

Mind points out that the DWP has not presented any evidence that compulsion and sanctioning are more effective than the use of incentives in motivating claimants.[33] However, the Sainsbury Centre for Mental Health (SCMH) endorsed levels of conditionality in the Pathways pilots, accepting that some conditionality was required in order 'to get people who had given up hope to start thinking seriously about work'. They felt that current levels of compulsion were 'perceived as supportive'.[34] Nonetheless, SCMH warned that increasing the levels of conditionality, such as requiring people to undergo psychological therapy,

> could have damaging effects on people's motivation and may backfire by focusing their attention on their eligibility for … enhanced benefit rather than actually getting a job.[35]

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31 — *Additional Submission to the Work and Pensions Committee* Rethink February 2006.

32 M Took, 'Social Security and Work for People with Severe Mental Illness: Rethink Policy Statement 41' (Rethink November 2001).

33 Work and Pensions Committee, *Incapacity Benefits and Pathways to Work* HC 616-II (2005–06) Mind Evidence Ev 175.

34 Work and Pensions Committee, *Incapacity Benefits and Pathways to Work* HC 616-III (2005–06) SCMH evidence Ev 256-257.

35 ibid Ev 257.

In evidence to the All-Party Parliamentary Group on Mental Health (APPGMH) Dr Boardman presented three arguments against conditionality:

- moving people onto a lower level of benefit because they fail to achieve a target is wrong in principle
- claimants with MH problems become distressed and enter unsuitable employment which they subsequently lose
- lack of evidence that compulsion works.[36]

Dr Boardman, however, conceded that the levels of conditionality used in the Pathways pilots were sufficient to get people moving and were perceived as supportive.

In oral evidence to the Work and Pensions Committee Richard Exell from the TUC said:

> [in the Green Paper] there is a list of what can go into people's Action Plans, … one of the things there is 'activities to stabilise health condition, including mental health problems, for example, use of cognitive behavioural therapy.' I am a survivor of mental health services myself and the thought of being told by a DWP Personal Adviser, who has had half a day's training on mental health issues, that I have got to take my pills, or see my therapist or lose my incapacity benefit is utterly horrific.[37]

While recognising the need for personal advisers to be properly trained in MH issues,[38] the Secretary of State has promised that people would not be compelled to undergo medical treatment.[39] Nonetheless, a claimant who, without good cause, fails to submit to

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[36] Notes of APPGMH meeting of 7 March 2006, <http://www.lynnejones.org.uk/d0515.mar2006.htm> accessed 19 January 2008.

[37] ibid Oral evidence Vol 2 Ev 89.

[38] ibid Oral evidence Vol 2 Ev 244.

[39] ibid Oral evidence Vol 2 Ev 242.

medical or other treatment (other than vaccination or major surgery) which could render them capable of work, could be disqualified from receiving benefit for up to six weeks.[40]

Failure by IBPAs to understand the symptoms of mental illness results in

- unhelpful, inappropriate language used in communication with sufferers of mental disorders
- proposal of ill-matched options in relation to work-related activity
- claimants being perceived as uncooperative
- unwillingness to meet specific needs, such as scheduling of appointments at convenient times (because of disturbed sleep patterns) and providing adequate advance notice to those with anxiety.[41]

In his evidence to the APPGMH Dr Boardman pointed out that there were more lessons to be learned from the literature on therapy, motivation and engagement than from the world of compulsion.[42]

Claimant's fears

Criticism has also been levelled at the tone of letters informing claimants that they would have to attend a WFI. Even IBPAs have reported that the standard wording 'terrified' some recipients.[43] Commenting on the negative impact of letters perceived by

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40 SS(IFW) Regs reg 18(1)(b) and 18(2).

41 Work and Pensions Committee, *Incapacity Benefits and Pathways to Work* HC 616-II (2005–06) Rethink memorandum Ev 180.

42 Notes of APPGMH meeting of 7 March 2006, <http://www.lynnejones.org.uk/d0515.mar2006.htm> accessed 19 January 2008.

43 T Knight and others, *Incapacity Benefit Reforms–the Personal Adviser Role and Practices: Stage Two* (DWP Research Report No 278 CDS, Leeds 2005).

claimants as threatening, Mind points out that this does nothing to foster the positive, supportive relationship that is necessary between IBPAs and claimants if the apparent philosophy underlying Pathways to Work is to be realised.[44] The Government's intention that IBPAs would collaborate with claimants to improve their employment prospects has been undermined by their failure to communicate effectively, thus creating mistrust between them.

People with mental illness also frequently fear taking any steps towards work, in case this triggers a review of their benefit entitlement. This applies, particularly to voluntary work, because capacity to engage in voluntary work is often perceived by Jobcentre Plus staff as an ability to engage in the competitive labour market.[45]

These apprehensions may lead people to over-medicate prior to their WFI in an attempt to overcome their nervousness. Thus, they may not present their usual condition at their appointment, leading to the IBPA drawing misleading conclusions.[46]

A spokesman for the National Association of Welfare Rights Advisers has pointed out that a person's unwillingness to engage in return-to-work activities may be a symptom of their illness - lack of motivation caused by depression and anxiety.[47] This is of particular concern because those who do not engage with personal advisers are at risk of sanction and benefit reduction.

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44 Work and Pensions Committee, *Incapacity Benefits and Pathways to Work* HC 616-II (2005–06) Mind evidence Ev 163.

45 ibid Rethink memorandum Ev 178.

46 ibid Ev 179.

47 Andy Platts, reported in J Lyall 'It's Great to Feel of Value Again' *The Guardian* (London 1 March 2006) Society 5.

Conditionality for ESA

Although the word 'Conditionality' is used in statute,[48] the Secretary of State for Work and Pensions described Conditionality as:

> … an ugly technical term so we should restate its meaning plainly. It is about encouraging people to take up support that we know works.[49]

Main phase ESA recipients who are not placed in the SG are obliged to fulfil various conditions so that they continue to receive benefit, with a threat of possible benefit reduction for failure to meet the conditions.[50] The introduction of ESA brought increased conditionality for claimants, compared to the IB/IS regime. Additional objectives for WFIs were instituted:

- identifying opportunities for rehabilitation[51]
- including self-employment in 'work opportunities'.[52]

In addition to the WFI requirements, claimants must:[53]

- submit to a WFHRA[54]
- engage in work-related activity[55]
- draw up an action plan.[56]

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48 WRA 2007 Part I ss 11-16.

49 J Purnell, 'A Welfare State as Valued as the NHS: The Progressive Case for Reform' Public Policy Research December 2008-February 2009 199.

50 WRA 2007 s 18; ESA Regs reg 63.

51 ESA Regs reg 55(d).

52 ESA Regs reg 55(e)

53 WRA 2007 s 12; ESA Regs reg 54.

54 WRA 2007 s 11; ESA Regs reg 47.

55 WRA 2007 s 13.

56 WRA 2007 s 14; ESA Regs reg 58.

In response to Mr Purnell's comment that conditionality meant 'encouraging people',[57] welfare rights workers questioned how a system of compulsion and sanctions could be encouraging people.[58] On the day that ESA came into force the BBC broadcast a programme devoted to the new benefit. Introducing the programme, Peter White, the BBC's disability affairs correspondent, expressed the fear that ESA would be 'pressuring vulnerable people to look for jobs that don't exist'.[59]

The work-focused health-related assessment (WFHRA)

Claimants who have been placed in the work-related activity group are required to take part in one or more WFHRAs conducted by a healthcare professional. This assessment is intended to explore not only the claimant's residual functional ability but also their approach and attitude to returning work. It investigates their motivation, aspirations, self-confidence and psychological barriers relating to returning to work, and may consider interventions such as condition management programmes which might be appropriate.[60] Regulations specify that the assessment should include an exploration of:

(a) difficulties which are likely to be experienced as a result of the claimant's physical or mental condition in relation to obtaining or remaining in work and how these might be managed or alleviated; and

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57 p 250 at n 49.

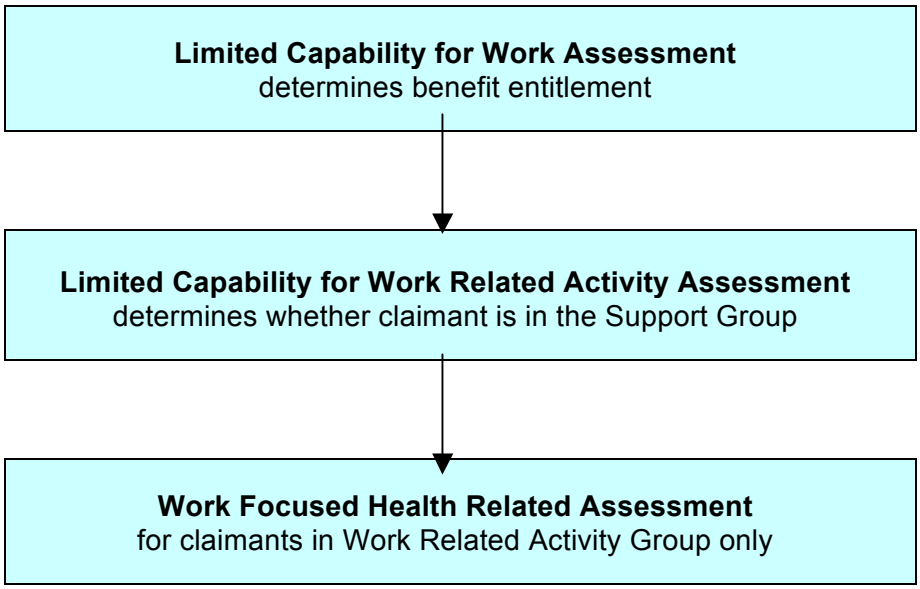
58 eg R Hession and N Coles, *Child Poverty, Welfare Reform and Take-up Potential* (NAWRA Swansea 6 March 2009).

59 *Employment and Support Allowance* You and Yours, BBC Radio Four, 27 October 2008.

60 Physical Function and Mental Health Technical Working Groups, *Transformation of the Personal Capability Assessment* (DWP 2006) 19.

(b) the claimant's views on the impact of the claimant's physical or mental condition in relation to obtaining or remaining in work and any aspirations in relation to work in the light of that condition.[61]

The WFHRA was supposed to take place at the same appointment as, and immediately after the LCWA and LCWRA, with the result that the WHFRA was being conducted for claimants who would enter the SG and thus were exempt from the WHFRA, and with those who might have been found capable of work and therefore not entitled to ESA at all. The intention was that claimants should participate in a WFHRA before making a decision about membership of the support group.[62] A more logical process would have been:



61 ESA Regs reg 48.

62 DWP, *Decision Makers Guide* (DWP 2008) [53004].

In view of the objectives of the WFHRA there is a potential conflict of interest between the WFHRA and the LCWA. The Technical Review Group considered that any perceived conflict of interest could be managed by appropriate explanation of the nature and purpose of the two assessments, and thought that this possible disadvantage was outweighed by the convenience to the claimant of having to attend only one interview.[63] It did, however, make for an appointment of 75-90 minutes duration.[64] For a person with MH problems, particularly if they also have difficulty communicating, this was quite an ordeal.

Within about a year from ESA introduction it became apparent that WFHRAs were no longer taking place at the same time as the LCWA. Major factors behind this about-face are believed to be the heavy workload placed on HCPs, the long waits for appointments and the large number of medicals cancelled and rescheduled because of overrunning. Another reason for the change is that when the LCWA and WFHRA were conducted at the same time, inconsistent results were often obtained, so that a person could be found fit for work by the LCWA but not immediately work-ready by the WFHRA.[65] Citizens Advice reported one such case.

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63 Physical Function and Mental Health Technical Working Groups (n 60) 20.

64 DWP, *ESA Technical Factsheet T14: Work Capability Assessment* (DWP December 2008) 5.

65 S Royston, *Not Working: CAB Evidence on the Work Capability Assessment* (Citizens Advice 2010) 7.

Case Study E[66]

A Leicestershire CAB saw a client who had been made redundant and who's wife had died four weeks later. He became very depressed and his GP, who felt that it would be some time before he could focus on work, signed a sick note for four months.

Four weeks after his wife had died he attended a LCWA and scored zero points, so was disentitled from ESA. However the recommendation of the WFHRA was that he would be work-ready in six months. The bureau reported that their client's stress and depression were made worse by the ongoing problem and the appeal process.

Such inconsistencies are explained by the different approaches taken by the two assessments. The LCWA is a functional assessment which seeks to identify those who (do not) have limited capability for work. It is based on the 'medical model' of disability in which disability is assumed to be a (more or less) direct consequence of impairment,[67] and it bears no relevance to workplace situations.[68] By contrast, the WFHRA considers the barriers to employment and the context of a person's journey towards work. It, therefore, relies more on the 'social model' of disability which argues that participation of disabled people in society is not restricted by their impairment *per se* but is imposed by the way that society is organised for the able-bodied.[69] The WFHRA is, in fact, the only part of the entire work capability assessment which comes anywhere near to looking at a claimant's situation as a whole. However, it is applied only *when and after* the claimant has been held eligible for ESA on the basis of a test of functionality.

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66 ibid.

67 G Waddell. and M Aylward, *The Scientific and Conceptual Basis of Incapacity Benefits* (TSO, Norwich 2005) 26.

68 see Chapter Five.

69 Waddell and Aylward (n 67) 27.

The following are examples of some of the questions that may be posed during a WFHRA:[70]

> How do you see your future, from a health and work point of view?
>
> What activities do you currently enjoy, thinking particularly about what may help your health and work prospects?
>
> What do you feel would help you to achieve your future plans in relation to work?
>
> What impact do you feel your medication has on your daily life?
>
> What impact do you feel your overall treatment has on your daily life?
>
> Are you trying other ways to help yourself get better or move towards work?
>
> Can you tell me about any other help that you have had in the past or are currently awaiting that would help you get back to work?
>
> Is there anything that you think would help you to move towards work, or work related activity?
>
> Is there anything that you think would help you to return to your most recent employment?

In the Assessment Report section the practitioner is asked to state whether without further intervention the overall condition is likely to: become more significant/improve/fluctuate/be severe/be enduring/unable to predict, and to suggest health and workplace interventions that may assist a return to work. Finally, they are asked to give an opinion as to whether a return to work could be considered within six months or longer.

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[70] DWP, *Work Focused Health Related Assessment, WFHRA 09/07* (DWP 2009).

Welfare Rights advisers and advocates for claimants with MH difficulties have criticised the assessment's assumption that all claimants are capable of visualising themselves in a workplace setting.[71] Others, with poor insight into their condition, may be over-optimistic as to their abilities, as illustrated in the following case study.

Case Study F[72]

Robert suffered from depression. He claimed ESA and attended a medical examination at which he stated that he was keen to return to work. He scored only six points on the LCWA, and the WFHRA report stated both that a return to work could be expected within three months and that there were no issues which would preclude this.

Robert secured a job in a warehouse, but after four weeks he found it too stressful, gave up work, and made a new ESA claim.

One concession which could apply to the most seriously mentally ill claimants is that the WFHRA may be deferred, pending a decision by the SoS on their capability for work-related activity, when the HCP conducting the WCA medical has reason to believe that the claimant would be incapable of such activity and therefore fall into the SG.[73]

Information that is collected during the WFHRA is used during WFIs as the basis of the dialogue between the claimant and their personal adviser. As with the WFI, there is a requirement for the claimant to 'take part' in the assessment,[74] which means that they must attend the appointment and participate in meaningful discussion. Many claimants with mental illness will be afraid that work would make their condition worse and will have no

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71 See eg Steve Johnson, Manager Walthamstow CAB on <http://www.rightsnet.org.uk/dc/dcboard.php?az=show_topic&forum=111&topic_id=2969&mesg_id=2969&page=6> accessed 17 July 2008.

72 Client RB of CBWR&CAB.

73 ESA Regs reg 59.

74 ESA Regs reg 51.

aspirations to employment.[75] How the system will cope with these claimants remains to be seen.

A claimant who fails to take part in the WFHRA, without good cause,[76] may face a benefit sanction.[77] The notion of 'good cause' is relevant to several other sanctionable offences, and is discussed later in this chapter at pages 263ff.

On 24 June 2010 the DWP wrote to members of the Jobcentre Plus customer representative group advising that the WFHRA of the WCA would be suspended from 19 July 2010. Conceding that ongoing external evaluation had shown mixed results for the WFHRA it stated that:

> The WFHRA's suspension for the next 2 years will provide an opportunity for DWP to reconsider the WFHRA's purpose and delivery. It also improves the capacity to focus on and cope with the demands of the reassessment of existing incapacity benefit customers.

Work-focused interviews under ESA

All ESA recipients who are not in the SG are required to participate in WFIs.[78] The WFI regime for ESA has been built on the model established by Pathways to Work for incapacity benefits, with a few changes, the most important of which are:

- the first interview takes place at an earlier stage in the process, ie in the eighth week of the claim[79]
- the personal adviser makes use of the WFHRA report to prepare a

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75 see Chapter One p 40.

76 ESA Regs reg 53.

77 ESA Regs reg 63.

78 WRA 2007 s 12; ESA Regs reg 54.

79 DWP, *Explanatory Memorandum and Impact Assessment of the Employment and Support Allowance Regulations 2008* (DWP 2008) 20.

'personalised' programme of work-related activity for the claimant and draw up an action plan[80]

- more interviews are required, a total of six.[81]

The WRA 2007 defines a WFI as an interview conducted by someone acting on behalf of the Secretary of State for the purposes of getting the interviewee into work or keeping them in work.[82] In practice, only the first of the interviews takes place at a Jobcentre. All subsequent interviews and activity designed to improve employability are the responsibility of external contractors. Some advisers reported problems with the arrangements for WFIs conducted by contractors. One claimant with serious and enduring MH problems found himself sanctioned for failing to attend a WFI. Although any decision to sanction a claimant can be made only by a DWP decision-maker,[83] the Department had imposed the sanction based only on information supplied by the contractor, and declined to remove it until the contractor reported that the claimant had started re-attending WFIs.[84]

None of the activities, training/educational, rehabilitation or employment opportunities are (yet) compulsory, and the WFI serves only to identify and record them in an action plan, a copy of which is given to the claimant.[85] However, in April 2009, Work and Pensions Minister, Tony McNulty, confirmed that, following recommendations in the

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80 ESA Regs reg 58.

81 DWP, *Explanatory Memorandum* (n 79) 20.

82 s 12(7).

83 ESA Regs reg 63(1)(b).

84 Rightsnet discussion forum <http://www.rightsnet.org.uk/dc/dcboard.php?az=show_topic&forum=111&topic_id=4422&mesg_id=4422&page=#4642> accessed 30 November 2009.

85 ESA Regs reg 58.

December 2008 Gregg report,[86] new ESA claimants in six pilot areas, other than those in the SG, will, from late 2010, be required to participate in 'Progression to Work' pilots.

> The claimants involved … will be required to actively engage with their adviser on an ongoing basis to consider, discuss and agree an action plan comprising activities they think will improve their prospects of moving back into work. They must then undertake these agreed activities as part of their own journey towards employment following directions from advisers where these are strictly necessary. This will be underpinned with recourse to sanctions for those failing to engage with support without good cause.[87]

The issue of Condition Management Programmes has proved controversial. MH charities have questioned whether personal advisers working for contractors, and who are not medically qualified, are the appropriate people to decide on whether a claimant should seek rehabilitation and/or treatment.[88] One social worker, who is also a chair of a Mental Health Trust, recommends that condition management should comprise evidence-based therapy provided through the NHS rather than a variety of counselling and support that may not be effective with the client group of concern.[89] However, historically, access to NHS services has always been based on clinical need.[90] It is of concern that benefit claimants nearest the job market could be given priority over those with more serious mental illnesses.

Early feedback on the ESA regime of WFIs by one mental health charity cited a number of problems.[91] They reported that many claimants were being called in for their

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86 P Gregg, *Realising Potential: A Vision for Personalised Conditionality and Support* (DWP 2008).

87 *Hansard* HC Deb vol 491 col 116W (20 April 2009).

88 Welfare Reform Mental Health Coalition 2nd Reading Briefing House of Lords April 2009 p 3.

89 M Meacher, *The Reform of Incapacity Benefit. Response to the DWP Green Paper: A New Deal for Welfare: Empowering People to Work* (East London and City Mental Health Trust 2006) 5.

90 See eg *Core Principles for Everyone Providing Care to NHS Patients* (DoH 2006).

91 J Stenger, Neath Port Talbot Mind, *Employment and Support Allowance – Where Are We Now,* NAWRA conference, Swansea 6 March 2009.

first interview when they were either desperately ill, had a short-term illness, had a job to which they could return or were not remotely work-ready. In most cases the WFHRA was not available at the first interview, so could not inform the discussion, and resources were thus being wasted. The report also questioned whether the first six months of illness, during which the person is getting to grips with diagnosis and is waiting for their response to treatment, is the best time on which resources should be focused. Regulations do, however, provide for a WFI to be deferred if, at that time, either it would not assist the claimant, or be appropriate in the circumstances.[92] Although this could be of assistance to claimants with MH problems who find it difficult to comply with the interview requirements, the concession is not as generous as the Pathways regime for incapacity benefits which,[93] in similar circumstances, provided for WFIs to be waived altogether. The grounds on which a WFI can be waived have been made stricter, so that the only situation in which a WFI for ESA can be waived is when the claimant is about to enter employment.[94]

In evidence to the Work and Pensions Committee a Mind representative stated:

> … people whose mental distress has been caused by work overload, bullying at work etc, or whose conscientious work ethic drives them into unacceptable levels of stress, have needed between six months and five years before they recover sufficient confidence to be able to consider a return to work goal. Then with help and support, such as current labour market information, opportunities for voluntary placements in order to build up work stamina and provide references, followed by job searching and application assistance, a successful return to work is almost always achieved.[95]

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92 ESA Regs reg 59(1).

93 Social Security (Incapacity Benefit Work-focused Interviews) Regs 2003 reg 6(1).

94 ESA Regs reg 60.

95 Sue Christoforou, Memorandum to the Work and Pensions Committee, Mind 27 February 2006 [3.2].

The issues regarding difficulties that claimants with MH problems have in attending interviews and making a meaningful contribution to them were discussed in Chapters One and Three.[96] For example, they may be reluctant to leave the security of their home, experience panic attacks on public transport or have poor insight into their condition. The intention of the ESA regime is to oblige claimants to attend more interviews and engage in work-related activities in order to put them under greater pressure to terminate their claims and enter employment. People with MH difficulties could respond to this pressure in several ways.

Some claimants, mainly those with less severe illness, will welcome the opportunity to return to work, view employment as a satisfying and stabilising activity, and will co-operate with the regime. Others will refuse, absolutely, to have anything to do with it, even with the threat of sanctions. The majority of mentally ill ESA claimants will probably comply with the system, albeit reluctantly.

In this way ESA claimants will become just another type of jobseeker. They will differ from recipients of JSA in that they are confirmed as having limited capacity for work. Employers always seek to recruit the most suitable person for the vacant post, and it is hard to imagine, in a competitive situation, that an ESA claimant will meet that criterion. Concerns as to whether increased conditionality was appropriate at a time of economic turndown were expressed by respondents to a survey commissioned by the DWP and undertaken in April/May 2009. Particularly worrying was the effect of the requirement to

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[96] pages 18-22, 101ff.

undertake work-related activity on mental health and wellbeing, when in the current state of the labour market there was a lack of realistic potential for employment.[97]

Sanctions

All claimants who are subject to conditionality, and who fail to comply with legislative requirements, may suffer 'appropriate consequences'[98] by way of loss of, or reduction in, benefit payment. This cut in benefit, known commonly as a sanction, is a key element in welfare reform as a means of coercing benefit claimants to change their behaviour.

Sanctions which were first introduced in 1913 to deny unemployment benefits to those held to have engaged in 'misconduct' or to have left work voluntarily, have now spread to lone parents and to incapacity benefits and ESA.[99]

> In return for the financial and employment support provided to people who are on benefits, it is right that they engage with Jobcentre Plus through interviews. A degree of engagement by customers is central to the success of the system. This is why participation in the work-focused health related assessment, and a series of six work-focused interviews will be mandatory for customers placed in the Work-related Activity Group.[100]

A sanction may be imposed when, without good cause, a claimant fails to:

- participate in a work-focused interview[101]
- participate in a WFHRA.[102]

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97 A Nunn and others, *Early Effects of the Economic Downturn on the Welfare-to-work System in Deprived Areas* (DWP Working Paper No 83 2010) 37, 41.

98 WRA 2007 ss 11(2)(f), 13(1)(e).

99 A Bee, *Sanctions in the Benefit System: Evidence Review of JSA. IS and IB Sanctions* (Occasional Paper No 1 SSAC 2006).

100 Department for Work and Pensions, *Memorandum submitted to the Select Committee on Work and Pensions* 2 July 2008 [36, 37].

101 WRA 2007 s 12(2)(g); ESA Regs regs 55, 57, 58, 63.

Although the Welfare Reform Act 2007 provided for sanctions to be imposed when a claimant fails to engage in work-related activity,[103] prescribing regulations have not yet been laid.

Good cause

Legislation does define 'good cause' for failure to comply with the conditionality requirements, although regulations supply non-exhaustive lists of factors which must be taken into account. For failure to take part in a WFHRA, account should be taken of the claimant's state of health at the time of the WFHRA[104] and the nature of their disability.[105] Should a claimant fail to participate in a WFI, then a decision-maker may consider whether their physical or mental condition made it impracticable to attend at the appointed time and place.[106]

A person with MH problems may be able to satisfy a decision-maker that their illness gave them grounds for failing to meet the relevant conditions, and hence avoid a sanction. For example a person suffering from agoraphobia might find it impossible to leave their home or could experience panic attacks on public transport. Someone who is depressed may forget that they have an interview or simply not be motivated to attend. Claimants wishing to avail themselves of the good cause provisions should obtain supportive evidence from their doctor, psychiatrist or community psychiatric nurse.

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102 WRA 2007 s 11(2)(f); ESA Regs regs 47, 51, 63.

103 WRA 2007 s 13(2)(e).

104 WRA 2007 s 11(2)(h); ESA Regs reg 53(3)(b).

105 WRA 2007 s 11(2)(h); ESA Regs reg 53(3)(c).

106 WRA 2007 s 12(2)(h); ESA Regs reg 61(3)(i).

Claimants who invoke the good cause provisions have only five days, from the date scheduled for their WFHRA[107] or, from the date they are informed that they missed a WFI,[108] to inform the DWP of the reason for their failure. This tight time limit could be problematic for someone who is mentally ill, particularly if they lack motivation.

Since claimants placed in the SG are not subject to conditionality they cannot be sanctioned, and any sanctions only take effect once the claimant is in the main phase of ESA, even if their failure to comply with conditions happened during the assessment phase. For a first 'offence' the ESA work-related activity component may be reduced by 50 per cent for four weeks, and then by 100 per cent for continued failure.[109] The basic ESA allowance is not subject to any sanction, and reduction stops once the claimant rectifies the situation.[110] Unlike the incapacity benefits regime, sanctions do not accumulate, so the maximum loss to a claimant is 100 per cent of the work-related activity component. Nonetheless, the Welfare Reform Act 2007 provided for wide powers,[111] and it would be possible for future changes to regulations to erode the basic ESA allowance also.

The conditionality and sanctions regimes were introduced despite widespread opposition by claimant advocates and, in particular, charities working on behalf of people with MH problems. Advocacy organisations point out that sanctions are unnecessary because surveys have shown consistently that the vast majority of incapacity for work benefits claimants have stated that they want to work. People with MH problems have the

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107 ESA Regs reg 53(1).

108 ESA Regs reg 61(1).

109 Work-related activity component = £25.95 (2010/11 rate).

110 ESA Regs reg 63.

111 WRA 2007 s 12(3) and (4) (WFI); WRA 2007 s 11(3) and (4) (WFHRA).

highest 'want to work rate' but the lowest 'in work rate' of any disability group, with just 24 per cent in employment.[112] Citizens Advice suggests that benefit sanctions may serve to confirm for people with MH problems that their illness is not understood by the agencies that profess to be helping them and add to their difficulties of coping on a low income.[113]

In a submission to the Work and Pensions Committee Mind stated that it was inappropriate for people who are unwell to be compelled to focus on returning to work at risk of losing a proportion of their benefit.[114] They added:

> Mind does not agree with the principle of deducting from, or restricting welfare benefits in an attempt to promote certain types of behaviour in claimants. Benefits are set at a rate deemed sufficient for a claimant to live on, taking into account their personal circumstances. … [T]here can be no justification to reduce income levels to below what Government has already decided is the minimum. Claimants have a right to the full applicable amounts of benefits they are eligible for. We believe it is wholly inappropriate to erode this right in an attempt to manipulate behaviour.[115]

Early reports from Pathways to Work areas were that personal advisers were taking a light-touch approach to sanctions, with only about 0.8 per cent sanctioned.[116] This was felt to be too few to be included in the DWP's first formal evaluation of the project.[117] Later research, reported in early 2008,[118] on 34 interviews with claimants who had experience of the sanctioning process was still only able to provide qualitative information. Of these 34 claimants, 12 had been referred for possible sanction, but not sanctioned, and only 22 had actually had a sanction imposed.

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112 *Labour Force Survey* ONS August 2003.

113 Cullen (n 17) [3.26.]

114 eg Sue Christoforou, Memorandum to the Work and Pensions Committee, Mind 27 February 2006 [2.1, 2.5].

115 ibid [2.10].

116 Citizens Advice submission to the GLA Review of Incapacity Benefit in London August 2006 p 8.

117 ibid.

118 Mitchell and Woodfield (n 18).

The Department predicted that sanctions would apply to, at most, 0.5 per cent of new claimants,[119] compare to JSA sanctions, where at any one time approximately 2 per cent of Jobseekers are under a sanction of some kind.[120] The first statistics on ESA sanctions, published on 18 May 2011 showed that between 1 March 2010 and 28 February 2011, 3.8 per cent of claimants in the WRAG had received a conditionality sanction, but of those whose main disabling was a mental or behavioural disorder, 4.4 per cent had been sanctioned.[121]

Research into the JSA regime has shown that although imposition of sanctions reduced the number of benefit claimants, there was little to suggest that sanctions increased the number of claimants entering employment.[122] One group of independent researchers concluded that 'extending conditionality on disabled people would bring substantial financial and political risks as well as threatening real harm to disabled people.'[123] In its 2008 annual report the Social Security Advisory Committee questioned the universal applicability of sanctions and stated:

> We have been disappointed that more evidence has not been presented to show that sanctions and compulsion are effective in generating long-term sustainable employment. While sanctions may lead to better compliance with the conditions of benefit entitlement, they might not encourage more effective engagement with the support services which could eventually lead the individual to sustained employment.[124]

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[119] DWP, *Explanatory Memorandum and Impact Assessment of the Employment and Support Allowance Regulations 2008* (DWP 2008) 10.

[120] DWP Quarterly Statistical Summary and JSA Sanction and Disallowance Statistics.

[121] DWP *Official Statistics: ESA Sanctions* (DWP 2011).

[122] A Bee, *Sanctions in the Benefit System: Evidence Review of JSA. IS and IB Sanctions* Occasional Paper No 1 (SSAC 2006) 61.

[123] K Stanley, LA Lohde with S White, *Sanctions and Sweeteners: Extending Conditions in the Benefits System* (IPPR London 2004).

[124] Social Security Advisory Committee, *21st Report August 2007–July 2008* (SSAC 2008).

More recent, qualitative research into Pathways to Work suggested that conditionality attached to the regime exacerbated MH issues and found that positive impacts on health from sanctioning and WFI attendance were rare.[125]

The Government has stated that 'sanctions are not designed to be punitive but an encouragement to engage actively with the conditionality requirements'.[126] Although not enshrined in the legislation, it has also promised safeguards to ensure that the system is fair, and has undertaken to visit all claimants with MH conditions when a sanction is to be applied to make sure they understand what is required of them.[127] Claimants also have a right of appeal against a decision imposing a sanction.[128]

After considering the detail of ESA legislation, the Joint Committee on Human Rights concluded that were adequate safeguards in place to guard against the arbitrary or discriminatory use of sanctions, and to protect vulnerable claimants and their families from extreme hardship. It was, therefore, unlikely that the legislation would give rise to any significant risk of incompatibility with Article 1, Protocol 1 ECHR (protection of property) or Article 8 ECHR (right to respect for private and family life).[129] It also decided that the appeal rights available satisfied the requirements of Article 6(1) ECHR for a hearing by an independent and impartial tribunal.[130]

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125 Mitchell and Woodfield (n 18) [5.3.3.]

126 DWP, *Memorandum submitted to the Select Committee on Work and Pensions* 2 July 2008 [40].

127 ibid [39].

128 SSA 1998 s 12.

129 Joint Committee on Human Rights, *Drawing Special Attention to: ... Welfare Reform Bill ...* HL 34/HC 263 (2006-07) [3.17, 3.18.]

130 ibid [3.26].

On 20 August 2010 the Home Office launched a Drug Strategy Consultation Paper which announced that the Government was considering proposals to impose benefit sanctions on claimants who do not take action to address their drug or alcohol dependency. Responding, the SSAC warned that the scheme could cause 'significant harm' including the 'disengagement of problem drug users from the welfare-to-work system with ... negative economic and social impacts'.[131] Martin Barnes, chief executive of DrugScope, said:

> The benefit system can and indeed does have a very important role in terms of advice and support to encourage people both to access treatment and employment. But we seriously question both the fairness and the effectiveness of actually using the stick of compulsion - benefit sanctions - to link a requirement to undergo medical treatment with a condition of receipt of benefit. I just don't see that as compatible with using the benefits system to require people to undergo a complex form of drug treatment intervention.[132]

Even though the sanctions regime was exonerated by the Joint Committee on Human Rights, it raises the issue as to whether it is appropriate to use the social security system, whose main objective is the relief of poverty, as a means of coercing sick people to engage in a particular mode of behaviour. Taking money away from people who are ill, who find it difficult to co-operate with agencies, and who are not guilty of any criminal offence seems to be a disproportionately harsh action which has more to do with social control than social welfare. One author notes that that even at the 'low point' of British social security, the Victorian poor law, it was need (destitution) that defined entitlement to relief, not behaviour.[133]

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[131] SSAC, *Drug Addicts Could Lose Benefits* The Press Association 20 August 2010.

[132] ibid.

[133] C Grover, 'Social Security Policy and Vindictiveness' Sociological Research Online 15(2) 8 <http://www.socresonline.org.uk/15/2/8.html> accessed 19 October 2010.

Has Pathways to Work been effective?

The Pathways to Work programme (Pathways), based on proposals outlined in the Green Paper *Pathways to Work*,[134] began in October 2003 as a pilot scheme which aimed to increase the number of IB/IS recipients who moved towards and into employment.[135] Pathways comprised a package of measures which included:

- specialist advisers
- mandatory WFIs
- a variety of interventions (the 'Choices' package) including Condition Management Programmes, to support return to work
- a Return to Work Credit of £40 per week, for a maximum of 52 weeks, for certain people returning to work and earning less than £15,000 a year.[136]

The programme was eventually rolled out nationally, applying to all IB/IS claimants, except those with the most severe disabilities, and formed the basis for ESA conditionality. Following the recommendation made in the Freud Report,[137] much of the Pathways programme became subject to competitive tender and contract, with private and voluntary organisations accepting responsibility for those claimants with the greatest barriers to employment. The various models of provision and the relationships between Jobcentre

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134 Department for Work and Pensions *Pathways to Work: Helping People into Employment* (DWP, TSO Norwich 2002).

135 A Corden and K Nice, *Pathways to Work: Findings from the Final Cohort in a Qualitative Longitudinal Panel of Incapacity Benefits Recipients* (DWP Research Report No 398 CDS, Leeds 2006) 9.

136 ibid 10.

137 D Freud, *Reducing Dependency, Increasing Opportunity: Options for the Future of Welfare-to-work* (CDS, Leeds 2007).

Plus and its contractors have been extensively evaluated and are the subject of numerous DWP research reports.

All researchers reported that the longer the claimant had been in receipt of IfW benefits, the less likely were they to be looking for or actually in work,[138] mainly because long-term claimants have more serious health conditions. Lack of confidence is also a major factor, particularly for claimants with MH problems, 63 per cent of whom cited this as a barrier to employment.[139] This suggests that early intervention may be advantageous. Claimants with MH conditions cited other people's attitudes towards mental illness, personal troubles, lack of motivation or a lack of skills or experience as barriers to work.[140] The persistent stigma of mental illness in wider society was also seen by IBPAs as a constraint on support for this group of claimants.[141]

A qualitative study, undertaken between January 2008 and February 2009 explored the reasons why Pathways has yielded mixed results for claimants with MH conditions and which factors contributed to good outcomes. The research established that positive outcomes were facilitated by:

- appropriate intervention timing
- long-term support and case management
- right combination of support

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138 see eg T Sejersen, O Hayllar and M Wood, *Pathways to Work: The Experiences of Longer Term Existing Customers* (DWP Research Report No 586 HMSO, Norwich 2009) [6.2].

139 ibid [6.2].

140 ibid.

141 M Hudson and others, *People with Mental Health Conditions and Pathways to Work* (DWP Research Report No 593 CDS, Leeds 2009) 21.

- help outside Pathways, including counselling and talk therapies
- opportunities for group interaction
- GPs embracing the Pathways ethos
- informal social networks of friends, and particularly family, contributing to health improvements, practical and emotional support.[142]

Not all these factors are within the control of welfare-to-work providers.

The most recent research data available confirmed that, 14 months after the start of their claim, people with MH conditions were less likely to be in paid work than those without this type of problem (24 per cent compared to 15 per cent), and were also more likely not to be looking for work (56 per cent compared to 47 per cent).[143] Researchers also found that the proportion of former Pathways participants undertaking employment was 30 per cent in Jobcentre Plus areas but only 21 per cent in Provider-Led schemes, which were working with the hardest-to-help groups.[144]

For a Government programme which cost £798m there has been a remarkable lack of evidence which demonstrates that this money has been well-spent. Reporting on the Pathways to Work scheme, 18 months after the introduction of ESA, the National Audit Office commends the DWP strategy for tackling the 'intractable' problem of incapacity benefits but states

> Pathways has turned out to provide poor value for money and it is therefore important that the Department learns from this experience. In the future it should base its programme

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142 ibid [7.5].

143 O Hayllar and M Wood, *Provider-led Pathways to Work: The Experiences of New and Repeat Customers in Phase One Areas* (DWP Research Report No 723 CDS, Leeds 2011) Table 7.16.

144 ibid Table 7.6.

> decisions on a robust and clear evidence base, follow best contracting practice and establish a measurement regime which allows it to understand better what happens to those whom they may have helped.[145]

Although Pathways reduced the length of claims by about five per cent, 80 per cent of that reduction is due to medical assessments being brought forward, so that those failing assessment leave benefit at an earlier stage.[146]

Conclusion

Continued entitlement to ESA requires claimants to submit to a WFHRA, participate in a series of WFIs, engage in work-related activity and draw up an action plan. There is as yet, little evidence to demonstrate that these activities are assisting claimants, particularly those with MH problems, to secure employment. Neither has there been a proper evaluation as to whether incentives to enter work might be better than a penalty system of sanctions.

Mentally ill claimants have difficulties meeting the conditions placed on them and are at risk of being sanctioned for non-compliance. A decision to sanction a claimant carries a right of appeal, and appeals form the subject of the next chapter.

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[145] Comptroller and Auditor General, *Support to Incapacity Benefits Claimants through Pathways to Work* NAO HC 21 (2010–11) Summary [31].

[146] ibid [2.8].

CHAPTER SEVEN

APPEALS

Introduction and overview

People who are refused benefits that they have claimed, generally have the right to appeal the refusing decision to an independent appeal tribunal. Most incapacity benefits appeals related to a decision that the person was not incapable of work, either following a PCA medical or because they failed to attend for medical examination. Similarly, most ESA appeals concern failure of a LCWA, although the introduction of income-related ESA opens up 'ESA appeals' relating to other issues eg income, capital, housing costs and partner's employment, with the consequence that the Tribunals Service occasionally erroneously lists these matters for hearing by a panel including a doctor rather than by a Judge sitting alone. The greater conditionality of ESA was also expected to produce an increase of 1,500 appeals annually.[1]

This chapter outlines the various dispute procedures,[2] including appeals, which are available to disappointed benefit claimants, and the particular problems that those with MH difficulties have with the processes. It analyses the published appeal statistics and explains why large numbers of appellants succeed in overturning the original decision.

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1 DWP, *Explanatory Memorandum and Impact Assessment of the Employment and Support Allowance Regulations 2008* (DWP 2008) 3.

2 since TCEA 2007 and new Tribunal Procedure Rules.

Approximately 15 per cent of new IB/IS claimants,[3] and a total of around 140,000 claimants a year were disallowed benefits following a PCA,[4] of whom roughly 40 per cent proceeded to appeal.[5] Statistics published in August 2010 on the outcome of LCWA medicals for the period from ESA inception to February 2009[6] showed that 66 per cent of those examined were assessed as being fit for work.[7] If roughly the same proportion of unsuccessful claimants appeals as under IB/IS, there will be a huge increase in the number of appeals, a situation which is likely to be exacerbated by migration of IB/IS recipients to ESA.

The chapter demonstrates that although the success rate of WCA appeals is slightly lower than that for the PCA, the appeal success rate indicates serious concern about the standard of the medical assessment and of decision-making.

Dispute procedures

Decisions about entitlement to social security benefits are made by civil servants known as decision-makers, who act on behalf of the Secretary of State for Work and Pensions. Written decisions are issued to the person making a claim.[8] The recipient of a decision is entitled to request an explanation of it, which may be provided orally, and to receive written reasons for the decision. A request for a written statement of

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3 Merits of Statutory Instruments Committee, *Drawing Special Attention to: Employment and Support Allowance (Transitional Provisions, Housing Benefit and Council Tax Benefit) (Existing Awards) Regulations 2010 etc* HL 7 (2010-11) Government response A1.

4 Stephen Timms, Evidence to Work and Pensions Select Committee, Q48 2 July 2008.

5 Merits of Statutory Instruments Committee, HL 7 (n 3) Government response A16.

6 DWP Quarterly Statistics <http://research.dwp.gov.uk/asd/workingage/esa_wca/esa_wca_27072010.pdf> accessed 27 July 2010.

7 Figures are not directly comparable because the LCWA takes place at an earlier stage.

8 SSCS(D&A) Regs reg 2 and 28(1)(a).

reasons must be made within one month of the date of decision[9] and a response received within 14 days of receipt.[10]

Anyone who believes that the decision made on their claim is wrong may ask for the decision to be looked at again[11] or lodge an appeal against that decision.[12] There is a general time limit of one month for requesting either a revision or appeal of the decision, which is extended by 14 days when a statement of reasons has been requested.[13]

DWP's preference is to divert claimants away from the appeals route into its own 'disputes process.' Its literature invites claimants to ask the Department to 'reconsider'[14] decisions that they feel are wrong, but may leave claimants confused. Asking for a reconsideration carries the risk of delay and provoking further correspondence should the outcome be no improvement over the original decision.[15] In oral evidence to the Work and Pensions Committee Inquiry into Decision Making and Appeals HH Judge Robert Martin described the situation as follows.

> I think it is presented as a false choice to claimants who have received a refusal of their claim. It is presented in terms of, 'Would you like us to look at our decision again or would you like to appeal?' Presented with that choice, most people unsurprisingly … opt for reconsideration. Would you look at it again? It seems to be quicker, and if you do appeal there is no suggestion that the Department will also look at the decision again. ... [I]t might be better presented if it was expressed in terms of, 'Would you like us to look at our decision again superficially or would you like us to look at our decision again

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9 SSCS(D&A) Regs regs 2 and 28(1)(b).

10 SSCS(D&A) Regs reg 28(2).

11 SSA 1998 s 9.

12 SSA 1998 s 12(2).

13 Tribunal Procedure (First-tier Tribunal) (Social Entitlement Chamber) Rules 2008 sch 1.

14 'reconsideration' is not a statutory term.

15 Work and Pensions Committee, *Decision Making and Appeals* HC 313 (2009-10) Memorandum by HH Judge Robert Martin DM27 [22, 24].

> seriously? … What is surprising to me is that if an appeal is lodged it is as though the Department then opts out of the process.[16]

Decision-makers appear to be relying entirely on the HCPs' reports and are not taking into account any other evidence, including that of the claimant themselves. Jobcentre Plus does not maintain statistics on the reconsideration process for IB and ESA claims.[17] There is anecdotal evidence from welfare rights advisers that the DWP rarely revises a decision made on such claims,[18] and such is the suspicion that requesting reconsideration is a waste of time, that some advisers recommend not bothering with the process and moving straight to an appeal.[19] For comparison, in 2008/09 51 per cent of DLA decisions and 60 per cent of Attendance Allowance decisions were revised in the claimants' favour.[20] In any case, legislation provides that, once an appeal has been made, a decision can be revised at anytime,[21] and should a fresh decision be advantageous to the claimant their appeal lapses automatically without the need for the claimant to withdraw it.[22]

The new provision, unique to LCWA determinations, which allows appellants to receive ESA at the assessment rate until a First-tier tribunal has made a decision,[23] may well encourage more people to submit appeals, particularly since benefit is not repayable even if the appeal is lost. However NI credits are paid only if the appellant's appeal is allowed. There is no provision for payment when a claimant simply requests

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16 ibid Q72 (9 November 2009).

17 ibid [124].

18 ibid [123].

19 see eg Rightsnet discussion forum <http://www.rightsnet.org.uk/dc/dcboard.php?az=show_topic&forum=106&topic_id=2352&mesg_id=2352&listing_type=&page=> accessed 1 October 2007.

20 Work and Pensions Committee, HC 313 (n 15) [117].

21 SSCS(D&A) Regs reg 3(4A).

22 SSA 1998 s 9(6); SSCS(D&A) Regs reg 30(1) and (2).

23 ESA Regs reg 30(3).

a reconsideration. As an alternative, an IfW appellant may claim JSA pending their appeal. The advantage of so doing is that NI credits are paid, but the person will be required to meet the labour-market conditions for JSA and be available for[24] and actively seeking work.[25] This, again, illustrates the importance for claimants to seek authoritative advice.

Disputes and claimants with mental health problems

Claimants with MH problems who disagree with a benefit decision are disadvantaged in several ways. Many of the issues discussed in Chapters One and Three regarding obtaining information and making a benefit claim will be relevant, also, to the appeal process.

There is widespread confusion over the processes of requesting an explanation, requesting that a decision be looked at again and appealing, which affects many claimants, and not only those with MH difficulties. This complexity is aggravated by the tight time limits. People who are depressed or apathetic may find that, by the time they have decided to appeal, the time for appealing has expired.

There is provision to appeal outside the one-month time limit, with an absolute limit of one year from the date that the general time limit for appealing expired.[26] A decision-maker has authority to accept a late appeal if they are satisfied that to do so is 'in the interests of justice'.[27] The legislation adopts a peculiar construction by specifying that it is not in the interests of justice unless it was not practicable for the

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24 JSA 1995 s 6(1); JSA Regs 6, 10

25 JSA 1995 s 7(1); JSA Regs reg 18.

26 TP(FT) Rules r 23(5).

27 SSCS(D&A) Regs reg 32(4).

person to appeal in time owing to a very limited set of circumstances. These include that the appellant or a partner suffered serious illness.[28] It is possible that suffering from a mental illness could fall within this definition, but this is not guaranteed. If the Department does not admit a late appeal the matter must be referred to a First-tier Tribunal[29] which has the power to extend the time limit.[30]

The decision notice which claimants receive always states that the decision carries a right of appeal[31] and briefly points out the next step in the process. An appeal must be in writing and needs to include certain important information. Although the approved form (GL24) is not essential,[32] using that form provides a checklist of required information. Appeal forms are available from decision-makers, Jobcentres and advice agencies or they may be downloaded from the internet.[33] The next hurdle is the actual completion of an appeal form.

An appellant is required to state why they believe the decision is wrong. Without advice from an experienced welfare rights worker, many people have difficulty identifying the key issue(s) on which an appeal will turn. It is fairly common for appeals made by mentally ill claimants to be returned by the Department with a note stating that the appeal has not been admitted, and a request that the appellant should clearly identify grounds for appeal.[34] For an appeal against a decision that the person is not incapable of work because they failed to reach the points threshold, what is

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28 SSCS(D&A) Regs reg 32(6)(a).

29 SSCS(D&A) Regs reg 32(1).

30 TP(FT) Rules r 5(3)(a).

31 SSCS(D&A) Regs reg 28(1)(c).

32 SSCS(D&A) Regs reg 33(2) and (5).

33 *If You Think Our Decision Is Wrong (GL24)* <http://www.dwp.gov.uk/docs/gl24dwp.pdf> accessed 8 June 2010.

34 several clients of CBWR&CAB.

required is a clear statement that certain descriptors apply to them, together with a brief account of their problems.

The appeal form also provides an opportunity for the appellant to appoint a representative. Statistics show that the likelihood of winning an appeal is significantly improved when a representative acts on the appellant's behalf.[35]

When the Department has received an appeal it prepares an appeal submission which contains the legal basis of their decision and a copy of all relevant documents, and sends this to the appellant, their representative and the Tribunals Service.[36] The Tribunals Service then issues an enquiry form which asks whether the person wishes to withdraw their appeal, and elicits administrative information. It is at this stage that many people panic. They are faced with a sheaf of paper couched in legal language and containing numerous references to statute and caselaw, which appears authoritative. It is easy to reach the conclusion that an appeal would be hopeless. The prospect of continuing with an appeal may be daunting and frightening to someone with MH problems. Withdrawing the appeal is a simple matter of ticking a box and signing and dating the form. Without sound advice, appellants may be induced to discontinue their appeal. The case study, below, is an extract from a posting on Rightsnet, a discussion forum for welfare rights advisers. It illustrates some of the frustrations advisers face when working with claimants with MH problems and the ethical problems that can arise.

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35 see later.

36 Tribunal Procedure (First-tier Tribunal) (Social Entitlement Chamber) Rules 2008 r 24.

Case Study A[37]

I became a representative for a client in relation to his Incapacity Benefit appeal about a month ago. He now wants to withdraw his appeal because he says he wants to look for work. I spent a long time trying to persuade him against this course of action including saying that he could still look for work whilst receiving Incapacity Benefit. I tried every argument I could think of to get him to change his mind. However, he was adamant that he did not want to continue.

The client received six mental health points in his PCA and both myself and a colleague who have spoken to him feel that he clearly meets the criteria for Incapacity Benefit. We also feel that he is not mentally competent to make this decision.

Is there anything we can do to make him carry on with the appeal against his wishes?

In responses to this enquiry, the consensus view was that freewill includes the freedom to make the wrong choices, and that it was dangerous to prevent someone from exercising their rights by interfering. Some also questioned whether the adviser had any expertise in assessing mental competence and pointed out the statutory principles that a person is assumed to be capable of making their own decisions unless it is proved otherwise, and is not to be treated as unable to make decisions merely because he makes an unwise choice.[38] Three weeks after his original posting to the website the adviser submitted an update. He had given his client time to cool off, had confirmed his advice in writing and asked his client to sign a disclaimer absolving his organisation from any responsibility for their client's actions. Consequently, the client had changed his mind and decided to proceed with his appeal.[39]

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37 Rightsnet discussion forum <www.rightsnet.org.uk/dc/dcboard.php?az=show_topic&forum=106&topic_id=3033&mesg_id=3033&page=> accessed 1 November 2008.

38 Mental Capacity Act 2005 s 1.

39 Rightsnet discussion forum (n 37).

Appeal hearings

Appeals relating to capacity for work and good cause for failing to attend a medical examination are heard by a tribunal consisting of a Judge and a doctor.[40] When completing the enquiry form, the appellant is asked to choose whether they want the panel to decide on the basis of documentary evidence alone, or whether they want an oral hearing. The statistics show that the chance of success increases enormously when there is an oral hearing. Typically, 57 per cent of oral hearings relating to the PCA were decided in the appellant's favour, whereas only 19 per cent of paper hearings were so decided.[41] However, it should be borne in mind that there may be some bias in the choice of hearing type, because appellants with weak cases may decide that it is not worthwhile attending in person.

The thought of attending an appeal tribunal can be frightening for anybody, let alone a person with mental health problems. Many believe, mistakenly, that they will be on trial in a court. The change of nomenclature from 'Chair' to 'Judge' brought in by TCEA 2007 may contribute to this misconception.

> *Will there be two big chairs with judges in them?* [42]

Hazel Genn, who conducted research into representation of appellants at tribunals, noted:

> There was a common belief that the process would be dominated by the presence of solicitors and legal representation. In fact, because participants had limited knowledge

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40 TCEA 2007 sch 4 para 15(4); First-tier Tribunal and Upper Tribunal (Composition of Tribunal) Order 2008; Practice Statement para 5(a) and (b).

41 DWP Quarterly Statistics, www.dwp.gov.uk/asd/asd1/appeals/Appeals_Mar06.xls and other quarters.

42 Appeals Service user in the waiting room. Quoted in H Genn, *Tribunals for Diverse Users* DCA Research Series 1/06 (2006) 134.

of tribunals they extrapolated from the knowledge they had of the criminal justice system (often based on images and reports presented by the media) to tribunals.[43]

Observations undertaken by Fry indicate that poor communication is an issue at tribunals.[44] In one case she observed that a client, who had no representative, 'was literally trembling before the tribunal' and another unrepresented appellant, who had mental health problems, was 'very hesitant in replying to even straightforward questions'.[45]

Those suffering from anxiety, agoraphobia, panic attacks communication problems or paranoia may find the prospect of appearing before a tribunal particularly upsetting.

> *Having to go to an appeal is just too much for me – I couldn't explain things to them. I would just go to pieces.* [46]

One of the advantages of having a representative is that the appellant can be prepared for the hearing. The procedure will be explained and they can be advised as to the type of questions they will be expected to answer.

However, even when thoroughly prepared, the actual hearing can be intimidating. Although some Judges will accept evidence from a community psychiatric nurse, mental health worker etc, others insist on verbal evidence from the appellant alone. The appellant faces the panel directly and may have to answer numerous personal

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43 H Genn, *Tribunals for Diverse Users* DCA Research Series 1/06 (2006) 101.

44 EA Fry, *Patterns of Advice and Representation at Social Security Tribunals* (PhD thesis, Polytechnic of Newcastle upon Tyne 1990).

45 ibid 297.

46 Client of Neath Mind, quoted in J Stenger, *The Big Book of Benefits and Mental Health 2006/07* (Neath Mind 2006) 8.

questions and give an account of their MH difficulties that they might not even acknowledge.

> *There's no way I'm going to put myself under that sort of pressure.* [47]

Interviews with unsuccessful appellants, who suffered from MH problems, elicited that they felt disadvantaged. One complained that 'there was too much emphasis on the physical aspects of my situation and not enough on the mental aspects' and another that his depression caused him to have a poor memory so that some things he wished to say during the hearing were forgotten.[48]

There are particular problems for appellants with poor language skills who require an interpreter. It is difficult for the tribunal to be sure that the subject or, worse, concept that they wish to discuss is translated in such a way that it has meaning for the appellant. In response to a research survey one tribunal Judge mentioned the difficulty of asking about feelings of depression through an interpreter:

> Sometimes, particularly on medical issues - and I feel strongly about this with regards to mental health problems - I have to be sure that what I ask an interpreter has been fully interpreted. So if I ask a person if they feel depressed, I really have to be sure that the interpreter knows what I am asking. And sometimes I've actually said to the interpreter 'Do you have a word for so and so, and do you understand what I mean by so and so?' And if they say 'Yes' I say 'Well will you please ask this question using that word' ... I need to know that there is a word that conveys what I mean.[49]

Even when questioning is sensitive, the prolonged probing frequently ends in tears. It is little wonder that many claimants, who may have strong cases, opt not to face a tribunal.

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47 Client AN of CBWR&CAB.

48 H Genn (n 43) 206.

49 ibid 305.

Appeal statistics

The DWP publishes benefit appeal statistics on a quarterly basis. The table below shows figures for PCA appeals for the quarter to March 2006, but those for other quarters are similar.

Table 1: Percentage of successful appeals by type of attendance[50]

Attendance type	Successful appeals, %
All attendances	47.6
Appellant only	61.1
Representative only	44.1
Appellant + representative	73.9
Not attended	17.2

This demonstrates that the majority of PCA appeals which are attended by the appellant are successful, and that the chances of success are improved even further when the appellant is accompanied by a representative. Hazel Genn's research concluded, on the basis of regression analysis, that representation was the only factor which clearly influenced tribunal outcomes.[51] There are no national statistics available which analyse appeal outcomes for claimants with physical disabilities compared to those with MH problems.

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[50] DWP Quarterly Statistics <http://www.dwp.gov.uk/asd/asd1/appeals/Appeals_Mar06.xls> accessed 3 May 2006.

[51] H Genn and Y Genn, *The Effectiveness of Representation at Tribunals* Report to the Lord Chancellor (1989).

This high proportion of successful PCA appeals throws into question the quality of decision-making on claims. The President of the Tribunals Service is required to produce an annual report on the standard of decision-making by the Department. The report is compiled from a sample questionnaire to tribunal judges, who give reasons for overturning the original decision, and analyses data for a number of social security benefits. Table 2 shows the reasons why incapacity benefit decisions, including those involving the PCA, were changed.

Table 2: Reasons for overturning the decision[52]

Reason	%
The tribunal was given additional evidence not available to the decision-maker.	59
The tribunal accepted evidence that the decision-maker had available but was not willing to accept.	27
The decision-maker did not give relevant facts/evidence due weight.	22
The tribunal formed a different view of the same evidence.	33
The tribunal formed a different view based on the same medical evidence.	29
The medical report underestimated the severity of the disability.	35

Judges also maintained that in nine per cent of cases which reached the tribunal, an appeal could have been avoided. The data does not analyse the nature of the additional evidence which was available to the tribunal but not the decision-maker, but it is reasonable to assume that this consists mainly of oral evidence given by the appellant. Any documentary evidence supplied in advance to the tribunal would have

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[52] R Martin, *Report by the President of Appeal Tribunals on the Standards of Decision-making by the Secretary of State, 2007–2008* (The Tribunals Service 2008).

been automatically copied to the Department, who then had an opportunity to revise or supersede their decision.

Despite an appellant's misgivings, it is clearly in their interests both to attend an oral hearing of their appeal and to obtain the services of a representative. When the appellant has MH problems, personal attendance can make a difference to the outcome. The tribunal is able to observe the appellant's behaviour, question them closely, note their reaction to stress and witness any problems they may have in understanding what is being asked of them or in responding to enquiries.

The following case study illustrates how giving evidence in person at a tribunal can affect the outcome favourably.

Case Study B

Andrea suffered a nervous breakdown after ending her relationship with a long-term partner. She had previously been in a high-powered executive position, and on first meeting gave an impression of being supremely confident. However, as a result of her illness she was confused, had memory problems and found it difficult to concentrate on anything.

An examining doctor had awarded her eight points on the PCA, for descriptors 15(f)[53] and (g),[54] 16(c)[55] and 17(a),[56] (b)[57] and (f).[58] During questioning by the tribunal, Andrea talked volubly, but forgot what she was trying to say mid-sentence, veered off the subject on several occasions and spoke at length about irrelevant matters. The tribunal awarded her two additional points for descriptor 18(c): Mental problems impair ability to communicate with other people. She was held to be incapable of work.[59]

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53 Overlooks or forgets the risk posed by domestic appliances or other common hazards due to poor concentration, 1 point.

54 Agitation, confusion or forgetfulness has resulted in potentially dangerous accidents … , 1 point.

55 Is frequently distressed at some time of day due to fluctuation of mood, 1 point.

56 Mental stress was a factor in making her stop work, 2 points.

57 Frequently feels scared or panicky for no obvious reason, 2 points.

58 Is scared or anxious that work would bring back or worsen illness, 1 point.

59 Client AP of CBWR&CAB.

ESA appeals

Emerging data on ESA appeals shows a slightly different picture to incapacity appeals. For ESA claims made up until March 2009, 97,800 'fit for work' decisions had been made. Of these, 28,000 appeals had been heard by the end of February 2010 ie more than a quarter of disappointed claimants actually proceeded to an appeal hearing. 39 per cent of these appeals were decided in favour of the appellant,[60] with a similar success rate in the first quarter of 2010/11.[61] Interestingly, success rates for ESA appeals are identical to those for DLA/attendance allowance appeals.[62] That proportion is somewhat lower than the success rate for PCA appeals (47.6 per cent), but nonetheless represents a considerable number of successful appellants. Figures show that 20 per cent of claimants in the WRAG were so assigned after an appeal.[63]

The reason for the poorer appeal success rate for WCA appeals is not yet clear. It seems improbable that this is due either to better Departmental decision-making or to improvement in claimants' functional ability. The most likely explanation is that the LCWA descriptors have been more tightly written with less scope for alternative interpretation by tribunals, and this is particularly true for the MH descriptors.

ESA is now the most appealed benefit, with more than double the number of appellants of DLA, the second most appealed benefit.[64] In June 2010, 29,700 of the

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60 R Willis, *Employment and Support Allowance: Work Capability Assessment: Official Statistics* (DWP April 2010) [1.6].

61 Tribunals Service Quarterly statistics <http://www.justice.gov.uk/publications/docs/tribunals-stats-quarter1-2010-11.pdf> Table 1.2d, accessed 2 November 2010.

62 ibid.

63 DWP Quarterly Statistics <http://research.dwp.gov.uk/asd/workingage/esa_wca/WCA_by_Health_Condition_and_Functional_Impairment.pdf> accessed 1 September 2010.

64 Willis (n 60) and Tribunal Service Quarterly Statistics <http://www.justice.gov.uk/publications/docs/tribunals-stats-quarter1-2010-11.pdf> Table 1.1c, accessed 1 October 2010.

59,050 outstanding appeals awaiting referral to the Tribunals Service related to ESA, with a further 4,700 IB/IS appeals also waiting for referral.[65] Before ESA inception the DWP predicted that in a full year there would be an additional 26,500 appeals compared to IB appeals,[66] with 21,000 of these proceeding to hearing (14,500 WCA appeals, 6,000 appeals against placement in the WRAG rather than the SG and a further 1,500 appeals against sanctions).[67]

No statistics on the outcomes of placement and sanctions appeals are yet available, however the number of LCWA appeals far exceeds expectations. This is borne out by evidence from welfare rights advisers and jobcentre staff who report staff overload and long delays in the preparation of DWP submissions.[68] In May 2010, a Freedom of Information request by BBC Scotland elicited that 8,000 ESA appeals were being heard every month across the UK.[69]

Pressure on the Tribunals Service also became apparent, with a reported 128 per cent increase in appeals relating to ESA for the first quarter of 2010/11, compared to IB/IS appeals in 2009/10.[70] This is illustrated in Figure 1 which shows the steady increase in IfW appeals received by the Tribunals Service between April 2009 and June 2010.

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65 *Hansard* HC Deb vol 516 col 343W (13 October 2010).

66 approximately 45,000 incapacity benefits appeals annually. DWP Quarterly Statistics.

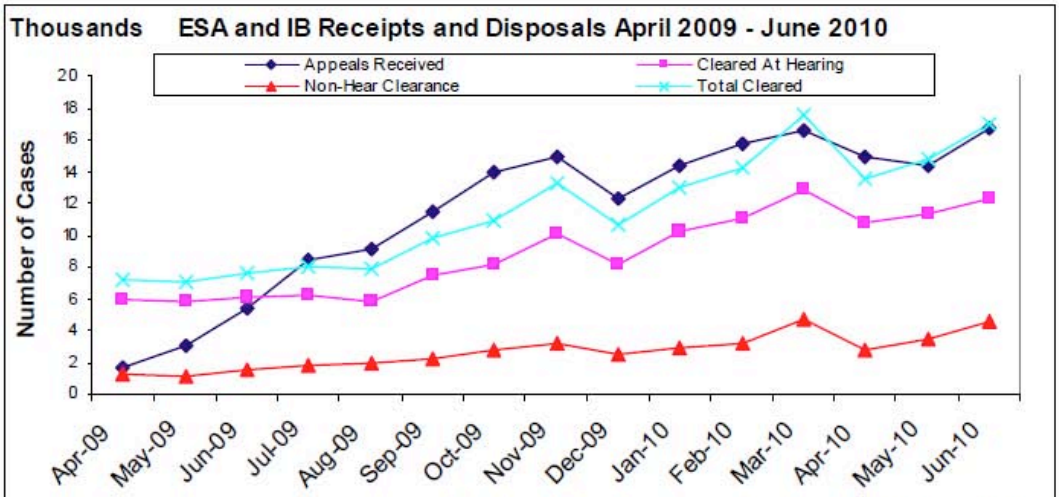
67 Department for Work and Pensions, *Impact Assessment of the Employment and Support Allowance Regulations 2008* (DWP March 2008) Table 1.

68 Statement by Ann Abraham, Appeals Officer Wellingborough BDC (Personal communication 6 May 2010).

69 *Who's Cheating Who?* BBC One Scotland, 26 May 2010.

70 Tribunals Service Quarterly Statistics <http://www.justice.gov.uk/publications/docs/tribunals-stats-quarter1-2010-11.pdf> p 3, accessed 2 November 2010.

Figure 1: IfW appeal receipts and disposals, April 2009 – June 2010[71]



One advice agency reported that clients receiving Tribunals Service enquiry forms in early August 2010 were being informed that their appeals would not be heard until February 2011.[72] Such a long wait for a hearing is stressful for appellants, particularly those with MH problems. The situation is likely to deteriorate even further as existing claimants of incapacity benefits are migrated to ESA and become subject to the LCWA.[73]

Conclusion

Many decisions that a person is not incapable of work are wrong, and claimants with MH problems appear to be particularly disadvantaged by a poor standard of decision-making. The existence of appeal rights provides dissatisfied claimants with an opportunity to explain their problems to an independent tribunal and to have erroneous decisions corrected. Although prospective appellants may have qualms

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71 ibid p 8.

72 several clients of CBWRCAB.

73 DWP, *Reassessment of Incapacity Benefit (Income Support) Project: Equality Impact Assessment* (DWP 2010) [26, 28].

about the process, statistics show that most incapacity appeals are successful, particularly when the appellant has a representative. However, many claimants with MH problems do not feel able to cope with the appeal process, and hence are further disadvantaged.

The more stringent assessment gateway for ESA has resulted in a lower proportion of successful claims, particularly by those with MH problems. The success rate of WCA appeals is slightly lower than that for the PCA, but at almost 40 per cent indicates serious concern about the standard of the medical assessment, the assessment report and of decision-making.

CHAPTER EIGHT

RECOMMENDATIONS FOR REFORM

Writing for The Foundation for Law, Justice and Society in its *Social Contract Revisited* series Frank Bloch expresses a view which chimes with that of the Coalition Government, concluding:

> The correct measure of disability benefit[1] reform is whether it serves to integrate persons with disability into the workforce and encourage their employment (that is, target those who might under past policy have fallen too easily into a lifetime of disability earned compensation) - yet also maintain a stigma free, community-supported safety net to catch those who are truly unable to work.[2]

This thesis has shown that the UK systems of IB/IS and its current replacement ESA, have failed to meet the need for a secure income for large numbers of people who are genuinely unable to work because of their mental health condition. This thesis has identified:

- symptoms of mental illness
- administrative procedures
- national insurance contribution conditions
- assessment
- conditionality
- appeals
- complexity of the welfare system

as interacting barriers to a successful claim for incapacity for work benefits for people with MH problems. Two years from ESA inception, it may be too early to evaluate

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1 Bloch is Professor of Law at Vanderbilt University, Tennessee. Although he uses the term 'disability benefit' it is clear from the context that this means, what in the UK are known as, incapacity benefits.

2 F Bloch, *Disability Benefit Reform and the Contract for Income Support* (Foundation for Law, Justice and Society 2007).

employment outcomes. The DWP has stated that it 'does not hold information centrally on whether people are moving from a claim for ESA via JSA and into work'.[3] However, considerable effort has been put into the programme of work-related activity for ESA recipients, and there is little evidence that this has operated to increase the numbers of claimants with MH problems securing and sustaining employment.[4]

Claimants of both IB/IS and ESA face similar problems, although these appear to have been exacerbated by the introduction of ESA. In view of the stated aim to remove one million claimants from incapacity benefits, this is no surprise, although the number of successful ESA claimants is even fewer than was predicted.

This chapter considers each of the barriers to a successful claim in turn and makes recommendations for reform.

Appreciating the symptoms and effects of mental illness

As was shown in Chapters One, Three, Six and Seven, people with MH problems face particular difficulties finding out about their entitlement to benefits, making a claim, attending appointments, meeting the conditions for work-related activity and engaging with the appeal process because of apathy, reluctance to leave their home, poor memory and concentration, poor communication skills and unwillingness to engage in social contact.

There is strong indication of a lack of expertise in social security issues by the

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3 Merits of Statutory Instruments Committee, *Drawing Special Attention to: Employment and Support Allowance (Transitional Provisions, Housing Benefit and Council Tax Benefit) (Existing Awards) Regulations 2010 etc* HL 7 (2010-11) Government response A4.

4 Comptroller and Auditor General, *Support to Incapacity Benefits Claimants through Pathways to Work* NAO HC 21 (2010–11) Summary [31].

medical personnel and social workers who treat, care for and support people with MH problems. This is evidenced by data on benefit under-claiming[5] and the levels of poverty recorded among people with MH problems.[6] One way of improving this situation would be for every mental health team to include welfare benefits advisers, funded by the relevant primary care trust. Authoritative benefits advice should also be available in GP practices and to all users of MH services.

As was stated in Chapter Three,[7] research has established that Jobcentre staff consider that they are both poorly resourced and inadequately trained to provide a high quality service to people with mental illnesses. One of the recommendations highlighted in a Report of the House of Commons Work and Pensions Committee[8] was the need for better training to improve the service offered to claimants with MH difficulties. A pilot project in North East London, in which Mental Health staff made training available to Specialist Incapacity Benefit Personal Advisors (SIBPAs), showed that training enhanced the service provided and

> Whilst the customers were unified in their positive experiences of the SIBPA service, they were equally as unified in their negative experiences elsewhere. There were some Jobcentre Plus training providers who were cited as lacking the understanding and supportive approach of the SIBPAs.[9]

In order to improve customer service and bring provision to claimants up to the standard achieved by the SIBPA service, the DWP should invest both in staff numbers

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5 see eg M Frost-Gaskin and others, 'A Welfare Benefits Outreach Project' (2003) 49 International Journal of Social Psychiatry 251.

6 see eg R Pacitti and J Dimmick, 'Poverty and Mental Health: Underclaiming of Welfare Benefits' (1996) 6 Journal of Community and Applied Social Psychology 395.

7 pages 103-104.

8 Work and Pensions Committee, *Incapacity Benefits and Pathways to Work* HC 616-I (2005–06) [216].

9 F Lawson and A Lawrence, *Evaluation of the Impact of Additional Mental Health Training for Specialist Incapacity Benefit Personal Advisor (SIBPA) Service in North East London for Jobseekers with Mental Health Problems* (North East London Mental Health NHS Trust London 2006).

and in the training of employees at all levels, particularly training in mental illness. Specific mental health training should be extended to everyone who has contact with claimants of incapacity for work benefits, including security personnel, reception staff, healthcare professionals and those conducting work-focused interviews.

Contact via the telephone, which is the method preferred by the DWP, poses problems for many people with MH problems. Arrangements should be put in place to permit benefit claims and other communication with the DWP to be made in a variety of ways. These should include by letter, telephone, text messaging, personal visit to a Jobcentre, paper claim form, email, online and through an authorised intermediary. Domiciliary visits should be more readily available, particularly for claimants whose MH condition makes it hard for them to leave their home.

Administrative procedures

Administrative procedures are too inflexible to enable staff to deal with vulnerable people with the necessary sensitivity and understanding. Implementation of the recommendations, above, would be helpful to claimants with MH problems, however further measures are also required. The DWP should develop systems which ensure that claimants with MH difficulties are identified at an early stage so they can be given appropriate additional support. In addition, every claimant should be allocated an adviser who is based at their nearest Jobcentre and who will manage the administrative processes and be the first point of contact in the event of a problem occurring.

Claimants are required to provide a considerable amount of information and to produce a number of documents in support of their claim. Many people with MH problems have difficulty filling in forms, organising themselves to supply the required

information and documentation and meeting deadlines. It is therefore suggested that claimants with MH difficulties should be given some latitude when they cannot provide all required information or meet the time limits.

Letters to claimants are not always clear and may be confusing. Improvements could be made if the DWP overhauled its stock letters so that all of them meet the Plain English Campaign's Crystal Mark standard, which has been achieved by several of the Department's letters and publications.

National insurance contribution conditions

Beveridge's vision of a social security system which was

> first and foremost a plan of insurance - of giving in return for contributions of benefits up to subsistence levels, as of right and without means test, so that individuals may build freely upon it[10]

has been undermined by reducing CESA for some claimants who have made private pension provision.[11] The proposal to limit CESA to one year[12] will erode it further.

The proportion of benefit expenditure going on contributory benefits has declined almost constantly since 1979/80 when it was over 63 per cent, to the current level of 41.2 per cent. Even this figure is considered an overestimate of spending on benefits for which NI contributions have been made, because people can qualify for them by virtue of credits.[13]

NI contributions are, nowadays, significant only for the purposes of qualifying for

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10 W Beveridge, *Social Insurance and Allied Services* (Cmd 6404, 1942) para 10.

11 WRA 2007 ss 2(1)9c) and 4; ESA Regs reg 74.

12 Chancellor of the Exchequer, *Spending Review* 2010 (Cm 7942, 2010) 69.

13 S Adam and J Browne, *A Survey of the UK Tax System* (Institute of Fiscal Studies December 2009) 72.

State Retirement Pensions, which account for 89.9 per cent of spending from the National Insurance Fund, whereas IfW benefits represent only 7.6 per cent of such spending.[14] In 1995, the director of the Institute of Fiscal Studies commented that 'it would be hard to find much evidence of any persisting actuarial link between contributions paid and benefits received',[15] and any link has since weakened.

The authors of a standard text on social security describe the popularity of the contributory principle as resting on its 'psychological appeal' which leads people to believe 'that because of their contributions to the scheme they are participating in its administration and may thus exercise political control over its development'.[16] However, a qualitative study into perceptions of the NI system found that although people generally maintained that contributions 'legitimised' a claim to benefit,[17] they saw NI contributions as part of Government's wider tax collection.[18]

A review of the tax system for the Institute of Fiscal Studies stated:

> National Insurance is not a true social insurance scheme; it is just another tax on earnings, and the current system invites politicians to play games with NICs[19] without acknowledging that these are essentially part of the taxation of labour income. The two systems need to be merged.[20]

Although complete integration of NI with the tax system is favoured by several employers' organisations it would significantly increase income tax and would

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14 Government Actuary's Department, *Report ... on the Draft of the Benefits Up-rating Order 2011 …* (TSO, London 2011) 23.

15 A Dilnot, *Integrating Income Tax and Social Security* in C Sandford (ed), *More Key Issues in Tax Reform* (Fiscal Publications, Bath 1995) 26.

16 NJ Wikeley, *The Law of Social Security* (5th edn Butterworths, London 2002) 39.

17 B Stafford, *National Insurance and the Contributory Principle* (DSS In-house Report No 39 HMSO, London 1999) [2.4].

18 ibid [2.5].

19 National Insurance contributions.

20 J Mirrlees and others, *Tax by Design* (OUP, Oxford 2010) [20.2.1.] (online draft).

disproportionately affect pensioners.[21]

Only a minority of claimants qualify for ESA solely on the basis of their NI contributions. Most ESA recipients have an income-related component, while a significant proportion of claimants receive only NI credits. Thus, the effect of the NI contribution conditions is to exclude from payment many people who are manifestly incapable of work.[22] The fluctuating nature of many mental illnesses, leading to periods of intermittent employment, results in people with MH difficulties being disproportionately represented among those who fail the NI contribution tests.[23]

There is a wealth of evidence, discussed in Chapter One, that long-term unemployment contributes to ill-health and, in particular, to mental illness. The current NI contribution conditions deny ESA not only to those who might more appropriately be classed as 'unemployed' but also to those who genuinely become sick or disabled during or following a period of unemployment.

It is, therefore, suggested that consideration should be given to the removal of national insurance contribution conditions for ESA. Social security for people who are unable to work could become a universal benefit, similar to the disability benefits DLA and attendance allowance, and thus be paid to all those who meet the 'incapable of work' criteria. Were such a benefit to be taxable this would have the effect of paying most to those in greatest financial need, without the additional complications of means-testing. The greater cost of a universal benefit would, to some extent, be offset by an

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21 A Seely, *National Insurance Contributions: an Introduction* (House of Commons Briefing Paper 2011) 16.

22 Circumstances in which people are more likely to fail the contribution tests are discussed in Chapter Four pages 138ff.

23 DWP Statistics February 2008 at <http://83.244.183.180/100pc/ibsda/icdgp/ccbencod/a_carate_r_icdgp_c_ccbencod_feb08.html> accessed 22 March 2008.

administratively simpler system.

Methods of assessing work capability etc

The assessment of incapacity for work is the biggest barrier to a successful claim for both incapacity benefits and ESA, but a greater proportion of ESA claimants fails the LCWA.

ESA is an 'all or nothing' benefit in that claimants either satisfy the assessment criteria and hence receive benefit, or they fail the test and lose entitlement.[24] A more stringent gateway assessment operates to increase the number of people who fail to qualify for IfW benefits but who still have reduced working capacity. Some people may be able to work but only with limitations on their hours, working normal hours with reduced productivity, or with periods of incapacity due to a fluctuating condition. The OECD suggests that failure to recognise partial capacity leads to premature exit from the labour market by many people with substantial work capacity. It also states that it is better to focus on what people **can do** and to provide support accordingly.[25] However, the experience in some jurisdictions of paying a benefit for 'partial capacity' has been that it led to lower amounts of benefit being received by people who were unable to work but who had lesser impairments.[26] The alternative, of subsidising employers who take on workers with reduced capability, has been introduced in Poland, with limited success.[27]

The UK has previously operated two wage top-up schemes designed to encourage

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24 page 195.

25 — *New Ways of Addressing Partial Work Capacity* (OECD, Geneva 2007) 3.

26 D Pozzo and others, *Assessing Disability in Europe: Similarities and Differences* (Council of Europe, Strasbourg 2002).

27 — *New Ways of Addressing Partial Work Capacity* (OECD, Geneva 2007) [3.1].

into employment, people who had an illness or disability which put them at a disadvantage in getting a job: disability working allowance[28] and disabled persons tax credit.[29] The latter scheme was effectively just a renaming, the main difference being that tax credits were paid by Inland Revenue via wages, rather than as a DSS benefit. Both schemes applied to people who were mentally ill and were receiving treatment,[30] were relatively short-lived and had very few claimants. Although the Government predicted 50,000 recipients of disability working allowance,[31] there were never more than 18,000 at any one time, and fewer than 41,000 recipients of disabled persons tax credit, 65 per cent of whom were single.[32] There are several reasons for the low uptake of these benefits:

- they required work for at least 16 hours per week[33]
- they were means-tested and a couple's income and capital aggregated[34]
- awareness of their availability was poor[35]
- people underestimated their potential payment[36]
- claimants must have been receiving a disability benefit at the point of claim, or a sickness benefit in the preceding eight weeks.[37] This was

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28 Disability Living Allowance and Disability Working Allowance Act 1991 s 6. Disability Working Allowance (General) Regulations 1991, SI 1991/2887. In force 10 March 1992 – 4 October 1999.

29 Tax Credits Act 1999 s 1(1). In force 5 October 1999 – 7 April 2003.

30 DWA Regs reg 3 and sch 1 para 16.

31 HC Debs 21 May 1991, vol 191, col 825.

32 Analysis and Research, *Disabled Persons Tax Credit Summary Statistics January 2003* (Inland Revenue 2003).

33 DWA Regs reg 6(1)(a).

34 DWA Regs reg 12(1).

35 G Zarb, N Jackson and P Taylor, *Helping Disabled Workers: Disability Working Allowance and Supported Employment* (DSS Research Report No 57 HMSO, Norwich 1996) [5.3.1.].

36 K Rowlingson and R Berthoud, *Disability, Benefits and Employment* (DSS Research Report No 54 HMSO, Norwich 1996) [2.5]

37 DWA Regs sch 1 paras 21, 22.

extended to 26 weeks in 1999.

Research into the low uptake of these benefits pointed out that aggregation of family income leads to the conclusion that the 'corollary of helping disabled people back to work may mean a disincentive for their partners to take paid jobs'.[38]

When working tax credit was introduced in April 2003, disabled persons tax credit was subsumed into the new system as a 'disability element',[39] forming only one component of any award, which also includes lone parent, 50-plus, 30-hour and childcare elements. Greater awareness of the new tax credits and inclusion of the disability element in a 'family' award appear to have had a positive effect, and there are currently 119,500 workers benefiting from a disability element in working tax credit, 60 per cent of whom are single people, mostly without children.[40]

An evaluation of disability working allowance concluded:

> Benefit recipients may feel discouraged from looking for work in case their incapacity is questioned and their benefit is taken away from them. … [An] irony of the introduction of IB is that those people who are found fit to work following the new medical test will probably be those most likely to be helped by DWA[41] into work but they will have to find a job within eight weeks of leaving IB otherwise they will lose all possible entitlement to DWA. Removing these people from IBs means that DWA might have an even smaller pool of potential recipients. More people on disability benefits might be encouraged to look for work if the system made greater allowance for partial incapacity.[42]

It is therefore proposed that consideration should be given to payment of a benefit for people with partial capacity. This should be in the form of a top-up to earned income for those in employment but who are not fully productive, and paid regardless of any spouse's income. Given that people leaving IfW benefits, particularly those

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38 Rowlingson and Berthoud (n 36) [3.3].

39 Tax Credits Act 2002 ss 11(3) and 11(4).

40 Child and Working Tax Credit Statistics Dec 2010 <http://www.hmrc.gov.uk/stats/personal-tax-credits/cwtc-dec2010.pdf> accessed 11 April 2011.

41 disability working allowance.

42 Rowlingson and Berthoud (n 36) [12.4].

with MH conditions, will be at a disadvantage in securing employment, they may need time to do so, and should have a minimum of a year from leaving benefit in which to claim partial capacity benefit.

On 15 November 2010 *The Guardian* reported that welfare ministers were examining changes to benefit rules to allow people to sign up for work for as little as two hours a week under a 'slivers of time' initiative. Slivers of time is a social enterprise which is designed to tap into the pool of people who cannot work the usual hours expected even of the average part-time employee. The report suggested that it was hoped to pilot the system for disabled people and lone parents at Jobcentres across Britain from next April, with a view to incorporating it into universal credit from 2013.[43] Providing that any such scheme included an appropriate disregard of any earned income, this would be a welcome innovation.

Only 38 per cent of those who are medically assessed are found to have limited capability for work, and only 9 per cent are placed in the SG. Large numbers of ESA claimants with mild to moderate MH problems, who might have been found incapable of work under incapacity benefits, are held to be fit for work. This suggests that huge problems will occur when migration to ESA from IB/IS begins. Very few claimants with MH problems are placed in the SG. One improvement would be for claimants with high levels of care needs, those on Community Treatment Orders and in intensive MH support to be automatically exempt from assessment and placed in the SG. Exemption from assessment should also apply to those who are only temporarily unfit for work, and to people who require time to adjust to traumatic experiences or to a drastic change in circumstances such as bereavement.

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[43] N Watt 'Welfare Reform: Government Backs System of Working in "slivers of time"' *The Guardian* (London 15 November 2010) 1.

The existence of a group of people who are paid more than other ESA claimants reinforces a public perception that only a small proportion of claimants is 'genuinely' incapable of work. Almost all claimants who are placed in the SG will meet the criteria for DLA, a benefit which is intended to meet the 'extra costs' of disability. ESA, like its predecessor benefits, is an earnings-replacement benefit, hence the rationale of paying a lower amount to claimants who are not in the SG is questionable. For these reasons, it is proposed that all claimants who are found to have limited capability for work should be paid at the same rate. Any additional payment to the most severely disabled claimants should be met by increasing DLA.

The LCWA, like its predecessor the PCA, is a test of functional capacity based on the 'medical model' of disability. These assessments, while purporting to determine a person's incapacity for work, actually only measure their ability to perform certain prescribed activities, which may not correlate to work-readiness. As discussed in Chapter Five,[44] the assessments ignore the fact that incapacity for work is a complex concept in which physical disability, mental health and social and environmental factors inter-relate. It would be advantageous to claimants for decision-makers to give greater weight to evidence supplied by claimants' doctors and carers eg community psychiatric nurses, who are well-placed to provide an opinion as to whether their patient is fit for work. Improvements could be made in the assessment process by increasing the role played by occupational therapists, who are experts in this field.

At the absolute minimum, there are two changes which are required to improve the assessment process, particularly for claimants with MH problems, while retaining a formal assessment of functional capacity. Firstly, the ESA50 questionnaire should be

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[44] page 153.

redesigned so that it correlates better with the statutory wording of descriptors. Secondly, there should be a thorough review of the limited capability for work assessment, with rewriting of descriptors, particularly the MH descriptors, so that assessment scores result in a distribution of scores which more accurately reflect claimant capacity than the current assessment.[45]

The PCA was supposed to assess functional abilities relevant to daily living rather than in a workplace context.[46] During the first year of operation of the LWCA the DWP conducted a review. Reporting on that review,[47] the Department signalled a change in approach. The review panel included an employers' representative whose rôle was to ensure that people identified as fit for work 'would meet the requirements of an employer in the modern workplace'.[48]

Employment generally requires a person to arrive, not only at a specified place, but at a particular time, appropriately dressed and in a state that does not offend colleagues. Whereas the PCA awards points to claimants who need encouragement to get up and dress,[49] and who do not care about their appearance[50] there are no analogous descriptors in the LCWA. It is suggested that the capability assessment should include not only questions regarding getting to an appointment on time and maintaining appearance and hygiene without help/prompting, but also about the difficulty of understanding and carrying out instructions (which is distinct from the activities of

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45 The Harrington review of the LCWA is not due to report until after the submission date of this thesis.

46 Corporate Medical Services, *Incapacity Benefit Handbook for Approved Doctors* (DWP 2004) [3.1.8.] See further, Chapter Five page 176ff.

47 J Bolton, *Work Capability Assessment Internal Review* (DWP Health and Wellbeing Directorate 2009).

48 ibid [3.1].

49 SS(IFW) Regs sch para 16(a).

50 SS(IFW) Regs sch para 16(d).

learning and remembering) and engaging in normal activities without panic attacks. These issues, all of which reflect on a person's capacity for work, were included in the initial recommendations of the Technical Working Group for the forthcoming LCWA[51] but were not carried forward to the final regulations.

The regulations also demonstrated a considerable tightening of the test compared to the original proposals. For example, the suggested wording of the 15-point descriptor for the activity of memory and concentration 'Forgets or loses concentration daily, to a degree that cannot be self managed' was changed by introducing a new test that the forgetfulness or loss of concentration should be to 'such an extent that overall day to day life cannot be managed', and by adding the necessity for on-the-spot verbal prompting.[52] 'Moderate difficulty' in sustaining personal action … 'on three or more days a week' became 'cannot … for the majority of the time'.[53] It is suggested that a person who, on a daily basis, forgets or loses concentration to a degree that cannot be self-managed would be a liability in any workplace. An employer would be unlikely to tolerate the reduced productivity of an individual who experienced moderate difficulty in sustaining personal action on at least three days a week. It is therefore submitted that the statutory wording of the descriptors for the activities of memory and concentration and for sustaining personal action is less effective at identifying capability for work than was that proposed in the post-evaluation Technical Working Group's first report, and that the initial proposals should be implemented.

However, it is suggested that a more radical rethink should be undertaken. Given

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51 Technical Working Group, *Transformation of the Revised Personal Capability Assessment: Phase 1 Evaluation Report* (DWP 2007).

52 ESA Regs sch 2 para 14(a).

53 ESA Regs sch 2 para 16(c).

that the current Secretary of State for Work and Pensions has made far-reaching proposals for changing the social security system by the introduction of a Universal Credit, there is now an opportunity to consider alternative approaches to incapacity for work benefits and to the assessment process which acts as a gateway to entitlement. It is therefore recommended that the current functional capacity tests should be abandoned, with a return to 'informal' assessment which adopts the 'social model' of disability, as happened under the IVB regime.

The advantages of informal assessment are that it is simple to implement, easily understood by claimants and tends to produce a commonsense outcome. In the face of complex barriers to employment, neither the PCA nor the LCWA has worked well in identifying those who are unable to work, especially for people with MH difficulties. An informal approach to assessment is also favoured by the independent think-tank, Demos, which states:

> A holistic and personalised test is needed, which identifies the physical, psychological, social and practical barriers to employment that a person may have. Such an assessment would improve the effectiveness of welfare to work programmes and allow for more targeted support.[54]

There may be concerns that informal assessment could result in a massive increase in claimant numbers and prove to be too expensive, but this need not be the case. Informal assessment combined with the concept of 'partial capacity' could lead to large numbers of claimants becoming engaged in some form of employment and who might eventually leave benefit altogether.

As of February 2010, Atos Origin employed 539 contracted (sessional) doctors, 242 full-time-equivalent doctors and 265 full-time-equivalent nurses to undertake

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[54] C Wood and E Grant, *Destination Unknown* (Demos 2010) 19 recommendation 2.

assessments of claimants' functional capacity for PCA/LCWAs.[55] It is suggested that doctors (whose main function is to diagnose and treat their patients) and nurses (who mainly care for patients and provide treatment) are not necessarily best-placed to take on this rôle. Assessment, including functional assessment of mental health, is however, a core skill of the occupational therapy process.[56] Occupational therapists have specific training in identifying the medical, environmental, social, psychological and other factors which act as barriers to occupation.[57] The Policy Manual of the US Medicare system emphasises that 'Only a qualified occupational therapist has the knowledge, training, and experience required to evaluate and, as necessary, reevaluate a patient's level of function'.[58] However, a thorough holistic assessment conducted by an occupational therapist may take longer to perform than one conducted by a nurse or doctor using a 'medical' model of functionality.

It is submitted that informal assessment undertaken by occupational therapists and informed by evidence from the patients' medical team would be better able to identify claimants' capacity for work than the current assessment process. It would also free up numbers of qualified staff to return to community medicine to undertake the core activities of diagnosis and treatment, which should have a positive impact on health.

The All Work Test/PCA was introduced deliberately to minimise the role of the claimant's GP from that of principle gateway to IfW benefits. It is submitted that,

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55 *Hansard* HC Deb vol 508 col 731W (29 March 2010).

56 N Phillips and L Renton, 'Is Assessment of Function the Core of Occupational Therapy?' (1995) 58 British Journal of Occupational Therapy 72; College of Occupational Therapy, *Definitions and Core Skills for Occupational Therapy* (COT/BAOT Briefing Paper 23 COT, London 2006).

57 J Creek, *The Knowledge Base of Occupational Therapy* in J Creek and L Lougher (eds), *Occupational Therapy and Mental Health* (Elsevier 2008) 26.

58 Centers for Medicare & Medicaid Services, *Medicare Benefit Policy Manual* (CMS Publication No 100-02, 2011) *Practice of Occupational Therapy,* ch 15 [230.2.A.].

especially in the case of people with MH conditions, the GP has knowledge of their patients' medical history and social conditions and is in a good position to form a holistic opinion as to their ability to sustain employment. Recent research has established that doctors make decisions on sickness certification regardless of the patient's explicit wishes and, when MH conditions were in question, certificates were not issued in order to maintain a relationship with their patient.[59]

Conditionality

Claimants with MH problems have the highest reported 'want to work' rates of any of claimant group, however panic, anxiety and distress were common responses to the letter inviting them to a WFI.[60] Many feared that they were being pushed into work before they felt able.[61] Research into the Pathways to Work programme undertaken between January 2008 and February 2009[62] investigated the experiences of both mandatory and voluntary participants, all of whom had mental health difficulties. The research demonstrated that claimants who felt able to work, despite their illness, or who believed that they would be able to work in the near future, were willing to volunteer for welfare-to-work programmes. Many mandatory participants felt that the opportunity to participate had not come at the right time for them,[63] whereas voluntary participants experienced health improvement, then felt better able to engage with Pathways and

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59 A Campbell A and J Ogden, 'Why Do Doctors Issue Sick Notes? An Experimental Questionnaire Study in Primary Care' (2006) Family Practice 2006 23 125–130.

60 M Hudson and others, *People with Mental Health Conditions and Pathways to Work* (DWP Research Report No 593 CDS, Leeds 2009) [4.1.1.].

61 ibid.

62 The scheme was then mandatory only for new claimants.

63 M Hudson and others (n 60) [7.4.1.]

make the transition into employment.[64] The research also found that those who actually moved into work were, invariably, voluntary participants.[65] Several participants reported being pressurised to apply for unsuitable posts,[66] and there is some evidence that people with MH difficulties who are encouraged to apply for jobs which they do not secure lose confidence in themselves and become increasingly depressed.[67] Since research evidence demonstrates better outcomes for voluntary participants, it is proposed that mandatory participation in the WFHRA, WFIs and work-related activity for claimants with MH problems should be discontinued. Instead, these claimants should be informed about the value of these pursuits to their well-being, and should be given every encouragement to participate voluntarily.

People with MH problems find WFIs stressful and have difficulty complying with conditionality, so are at risk of being sanctioned. There is also minimal evidence that the conditions which are imposed on claimants increase the numbers of those who leave benefit for sustainable employment. The purpose of the WFHRA is unclear,[68] while its value as an assessment tool is questionable.[69] The fact that the WFHRA has been suspended for two years, pending a review of its usefulness, supports these views. It is recommended that the DWP should commission research into the effectiveness of sanctions as a means of increasing engagement with welfare to work programmes, and should consider alternative inducements to achieve this aim. The best inducement to

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64 ibid 5, [6.2].

65 ibid [7.3.3.]

66 ibid [5.3.1.]

67 ibid [5.4.2.]

68 H Barnes, J Aston and C Williams, *Employment and Support Allowance: Customer and Staff Experiences of the Face-to-face Work Capability Assessment and Work-Focused Health-Related Assessment* (DWP Research Report No 719, 2010) s 3.3.

69 ibid [3.5.2.], [5.8.4.]

involved participation in work-related activity would be to have a scheme which is perceived by claimants as non-judgemental, supportive and worthwhile, and which provides a range of tailored opportunities for enhancing their confidence and pre-employment skills. Consideration should be given to the payment of a bonus to claimants who complete the work-related activity programme.[70] There appears to be little point in requiring claimants to engage in work-related activity, when they have jobs which are being kept open for them, and to which they can return when they are well enough.

Current welfare policy which views employment as the only successful outcome creates a perverse incentive for welfare to work providers to assist only those who are closest to attaining employment. It is important for the Government to recognise that people can contribute to society in ways other than through paid employment. Other markers of success should include 'soft' outcomes such as improved confidence and new skills.

Appeals

Claimants are often confused by the reconsideration and appeals processes, however, this could be overcome by the implementation of relatively simple measures. To begin with, the current process of reconsideration should be eliminated altogether. Instead a thorough review of all the evidence should take place automatically during the appeal process. Additionally, advice on pursuing an appeal, and provision of support and representation should be made much more readily available to claimants with MH problems. The earlier recommendation, that welfare rights advisers should form part of

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[70] A figure in the region of £100 (£20 for each WFI after the first interview) is suggested. This is a little over one week's payment of CESA.

every mental health team, would meet this proposal.

Many claimants with MH problems find the appeals process daunting and may delay making their appeal until after the one-month time limit. It is recommended that the 'normal' time limit for appeals should be extended to at least two months to allow claimants to obtain appropriate advice and representation.

Many claimants who have entitlement to benefit discontinued after a medical assessment proceed to a successful appeal. This, then, raises questions over the standard of decision-making in PCA/LCWA decisions. One method of improving decision-making would be for tribunals which overturn a decision refusing IB/ESA to be more ready to comment on the medical assessment in question and on the standard of decision-making. Consideration should also be given to a return to a reporting mechanism such as existed prior to the Social Security Act 1998, which abolished the rôles of Chief Adjudication Officer and Adjudication Officer.[71] Further suggestions are that appellants' entitlement to ESA should continue automatically pending the appeal hearing, and that appellants should not be required to engage in work-related activity during this time.

Complexity of the welfare system

In 1980, a DHSS document on industrial injuries compensation stated that 'the present benefit structure presents the disabled with a labyrinthine world of social security'.[72] Since then, benefits have become even more complex so that today's system of social security represents a patchwork of provision which attempts to meet

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71 The reporting role, has in part, been taken up by the President of the Social Entitlement Chamber of the First-tier Tribunal, however a mechanism for taking note of comments is still lacking.

72 DHSS, *Industrial Injuries Compensation: a Discussion Document* (HMSO 1980) [2.22].

the needs of groups of people rather than the requirements of individual claimants. Thus a claimant's specific needs may not be addressed or they may have a number of benefit options available. Furthermore, the legislation is constantly changing. The editor of a textbook on social security law describes writing a new edition of the book as 'like painting the Forth Road Bridge whilst the bridge is simultaneously being dismantled and rebuilt around you.'[73] Proposals for a Universal Credit are still at an early stage, and it is not yet clear how the scheme will achieve benefit simplification while at the same time the system meets the needs of individual claimants. One commentator has already suggested that the proposals are regressive and reminiscent of the 'one benefit' supplementary benefit regime.[74]

The suggestion, made earlier, that information about benefits should be more readily available from mental health teams, would assist claimants to understand their available options and supply them with impartial advice. Another measure should be that benefit award notices should automatically be accompanied by the Department's Information Leaflet *INF2 Other Help You May Be Entitled To*.

The necessity for change

Everyone who is incapable of work needs income security, but people with MH difficulties face problems which may be different to those faced by physically disabled people. Some recommendations towards resolving this issue were made on pages 294-295 of this chapter. Designated advisers would assist mentally ill claimants to negotiate the system, and should be able to give accurate information and advise them

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73 NJ Wikeley, *The Law of Social Security* (5th edn Butterworths London 2002) preface vii.

74 'Steve_h', Rightsnet discussion forum at <http://www.rightsnet.org.uk/forums/viewthread/567/> accessed 21 October 2010.

of all their benefit options.

Employment, which may be the ultimate goal for claimants, is a field in which market forces operate; social security is the safety net for those who are withdrawn from that market. Welfare-to-work programmes and conditionality conflate these two situations. Claimants of the old incapacity benefits are furthest from the labour market and are thus least likely to find sustainable employment. For this reason it is recommended that despite the added complexity of maintaining claimants on benefits that are no longer available to new claimants, the DWP should abandon migration of all incapacity benefits claimants to ESA, which involves a more stringent medical assessment.

It is submitted that it is not appropriate to use the social security system as a means of coercing people with MH problems into employment. The DWP should consider adopting a more encouraging approach such as payment of a benefit for partial capacity to those who enter employment from incapacity for work benefits. Furthermore, the centre of attention of welfare-to-work programmes should be shifted away from claimants and directed towards changing the attitudes of employers towards people with MH difficulties. Employers should also be encouraged to offer employment to people with previous MH problems who are ready and willing to work. An even more effective solution would be for the Government to focus on preventing the slide from employment to benefit by persuading employers to adopt measures to reduce workplace stress and to assist employees with emergent MH problems, rather than on a return to work from welfare. At the same time, this would assist returnees with MH problems to sustain employment and reduce 'revolving door' incapacity.

This thesis has established that claimants with MH problems face numerous barriers to a successful claim for IB/ESA. However, there are a number of changes

which could be made to the system which would be advantageous to claimants, especially those with MH difficulties. Some of the suggested improvements, eg inclusion of an information leaflet with decision notices, could be achieved at minimal cost, while others would actually save money. The proposals to discontinue WFHRAs and to exempt from conditionality claimants who have a job to which they can return are cost-saving. Were the recommendations made above to be implemented, people would find claiming ESA less stressful, and claimants would find it easier to pursue a successful claim and to retain their entitlement to benefit for as long as they are unfit for work.

CONCLUSION

This thesis came to be written as the result of the author's work as an adviser for a Citizens Advice Bureau, where week after week, she came across clients with mental health difficulties who were struggling to achieve secure entitlement to incapacity for work benefits. Employment and support allowance was introduced, for all new claimants, during the period of research and writing, thus providing an opportunity to compare the two regimes.

The thesis set out to answer three research questions:

1. Do people who cannot work because of their mental health problems face particular difficulties when claiming earnings-replacement benefits which underwrite incapacity?
2. If so, what are the difficulties, and why?
3. How have claimants with mental health problems been affected by welfare reform and the introduction of employment and support allowance?

The thesis has considered the particular problems that are posed for people who are unable to work because they have MH difficulties, when they seek to establish and maintain entitlement to social security benefits. It has identified the barriers to incapacity for work benefits which mentally ill people face, considered the effects of recent welfare reform, and made recommendations for change to remove or ameliorate some of those difficulties.

The research concludes that people with MH problems experience significant difficulties, over and above those that all claimants might encounter, when claiming

incapacity for work benefits. Particularly problematic areas for mentally ill claimants are obtaining advice,[1] finding out about entitlement,[2] making a claim,[3] communicating with the DWP[4] and completing forms.[5] Many of those with MH problems fail to meet the national insurance contribution conditions[6] and to establish entitlement via medical assessment.[7] They also find it difficult to challenge adverse decisions on entitlement,[8] maintain their entitlement,[9] gain exemption from conditionality[10] and comply with the conditions.[11]

The thesis identifies the symptoms of mental illness,[12] administrative procedures,[13] national insurance contribution conditions,[14] assessment,[15] conditionality,[16] appeals[17] and complexity of the welfare system as inter-relating barriers to a successful claim for incapacity for work benefits for this group of vulnerable people.

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1 pages 96-99.

2 pages 99-105.

3 pages 106-114.

4 pages 102-105.

5 page 113.

6 pages 136-142.

7 pages 150-236.

8 pages 273-289.

9 pages 133, 171, 173ff.

10 pages 201-205, 232.

11 pages 238-272.

12 Chapter One.

13 Chapter Three.

14 Chapter Four.

15 Chapter Five.

16 Chapter Six.

17 Chapter Seven.

The problems which have been noted, above, are apparent with both incapacity benefits and ESA. However, problems with ESA for claimants have been shown to be even worse than before, in relation to administrative procedures, NI contribution conditions, assessment, conditionality, appeals and complexity.

A recent DWP internal review, which took place under the previous Government, made proposals for tightening the assessment criteria even further.[18] At the time of writing, an independent review into the work capability assessment is taking place, and a report is due in December 2010.[19] The process of assessment remains the biggest barrier to a successful benefit claim on MH grounds and this problem will be solved only by wholesale re-writing of the assessment descriptors, or preferably, by a return to informal assessment based on the 'social model' of disability. Consideration should also be given to the introduction of payment for partial capacity.

The ESA scheme and ongoing reforms appear to have worked well for people who are at the most severe end of the spectrum of mental illness, who qualify for placement in the support group. Not only are they relieved of conditionality, but they also receive enhanced payment. For claimants with lesser MH problems the situation has worsened. Large numbers of people with mild to moderate MH problems, whose GPs have certified that they are unfit for work, are finding that they fail the limited capability for work assessment. Those who are held to have limited capability for work, but are not placed in the support group, are required to engage in work-related activity. Claimants with MH problems have difficulty complying with these conditions and are at risk of receiving a

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18 J Bolton, *Work Capability Assessment Internal Review* (DWP Health and Wellbeing Directorate 2009).

19 M Harrington, *The Work Capability Assessment – a Call for Evidence* (DWP 2010).

benefit sanction. In order to deal with these problems, it is recommended that, for claimants with MH problems, work-related activity should not be mandatory. There should also be an end to sanctions as a means of achieving desirable claimant behaviour, with movement towards a system of incentives.

The Government's proposals for a universal credit are still at an early stage, but there is presently an opportunity to conduct a thorough review into social security provision. The issue of incapacity for work has long been seen as a 'problem' for the social security system, to which no satisfactory solution has yet been found. It is possible that the 'solution' to the perceived problem lies with the medical profession, by way of better diagnosis and treatment, rather than in attempting to find better ways to decide whether people are too sick to work or not. Hopefully, future welfare reform will endeavour to safeguard vulnerable people, such as those with MH problems, who will find their situation improved by any new scheme. The author submits that the proposals which are recommended in this thesis would bring such a system closer.

APPENDIX I

THE PERSONAL CAPABILITY ASSESSMENT

The Social Security (Incapacity for Work) (General) Regulations 1995

SI 1995/311

SCHEDULE Disabilities which may make a person incapable of work

Part II: Mental Disabilities

(1)		*(2)*	*(3)*
Activity		***Descriptor***	***Points***
15. Completion of tasks.	15(a)	Cannot answer the telephone and reliably take a message.	2
	(b)	Often sits for hours doing nothing.	2
	(c)	Cannot concentrate to read a magazine article or follow a radio programme.	1
	(d)	Cannot use a telephone book or other directory to find a number.	1
	(e)	Mental condition prevents him from undertaking leisure activities previously enjoyed.	1
	(f)	Overlooks or forgets the risk posed by domestic appliances or other common hazards due to poor concentration.	1
	(g)	Agitation, confusion or forgetfulness has resulted in mishaps or accidents in the 3 months before the day in respect to which it falls to be determined whether he is in incapable of work for the purposes of entitlement to any benefit, allowance or advantage.	1
	(h)	Concentration can only be sustained by prompting.	1

(1)		*(2)*	*(3)*
Activity		***Descriptor***	***Points***
16. Daily living.	16(a)	Needs encouragement to get up and dress.	2
	(b)	Needs alcohol before midday.	2
	(c)	Is frequently distressed at some time of the day due to fluctuation of mood.	1
	(d)	Does not care about his appearance and living conditions.	1
	(e)	Sleep problems interfere with his daytime activities.	1
17. Coping with pressure.	17(a)	Mental stress was a factor in making him stop work.	2
	(b)	Frequently feels scared or panicky for no obvious reason.	2
	(c)	Avoids carrying out routine activities because he is convinced they will prove too tiring or stressful.	1
	(d)	Is unable to cope with changes in daily routine.	1
	(e)	Frequently finds there are so many things to do that he gives up because of fatigue, apathy or disinterest.	1
	(f)	Is scared or anxious that work would bring back or worsen his illness.	1
18. Interaction with other people.	18(a)	Cannot look after himself without help from others.	2
	(b)	Gets upset by ordinary events and it results in disruptive behavioural problems.	2
	(c)	Mental problems impair ability to communicate with other people.	2
	(d)	Gets irritated by things that would not have bothered him before he became ill.	1
	(e)	Prefers to be left alone for 6 hours or more each day.	1
	(f)	Is too frightened to go out alone.	1

APPENDIX II

THE LIMITED CAPABILITY FOR WORK ASSESSMENT

The Employment and Support Allowance Regulations 2008

SI 2008/794

SCHEDULE 2 Assessment of Whether a Claimant has Limited Capability for Work

Part II: Mental, Cognitive and Intellectual Function Assessment

(1)		*(2)*	*(3)*
Activity		***Descriptor***	***Points***
12. Learning or comprehension in the completion of tasks.	12(a)	Cannot learn or understand how to successfully complete a simple task, such as setting an alarm clock, at all.	15
	(b)	Needs to witness a demonstration, given more than once on the same occasion, of how to carry out a simple task before the claimant is able to learn or understand how to complete the task successfully, but would be unable to successfully complete the task the following day without receiving a further demonstration of how to complete it.	15
	(c)	Needs to witness a demonstration of how to carry out a simple task, before the claimant is able to learn or understand how to complete the task successfully, but would be unable to successfully complete the task the following day without receiving a verbal prompt from another person.	9
	(d)	Needs to witness a demonstration of how to carry out a moderately complex task, such as the steps involved in operating a washing machine to correctly clean clothes, before the claimant is able to learn or understand how to complete the task successfully, but would be unable to successfully complete the task the following day without receiving a verbal prompt from another person.	9

(1)		*(2)*	*(3)*
Activity		***Descriptor***	***Points***
	(e)	Needs verbal instructions as to how to carry out a simple task before the claimant is able to learn or understand how to complete the task successfully, but would be unable, within a period of less than one week, to successfully complete the task without receiving a verbal prompt from another person.	6
	(f)	None of the above apply.	0
13. Awareness of hazard	13(a)	Reduced awareness of the risks of everyday hazards (such as boiling water or sharp objects) would lead to daily instances of or to near-avoidance of: (i) injury to self or others; or (ii) significant damage to property or possessions, to such an extent that overall day to day life cannot be managed.	15
	(b)	Reduced awareness of the risks of everyday hazards would lead for the majority of the time to instances of or to near-avoidance of: (i) injury to self or others; or (ii) significant damage to property or possessions, to such an extent that overall day to day life cannot be managed.	9
	(c)	Reduced awareness of the risks of everyday hazards has led or would lead to frequent instances of or to near-avoidance of: (i) injury to self or others; or (ii) significant damage to property or possessions, but not to such an extent that overall day to day life cannot be managed when such incidents occur.	6
	(d)	None of the above apply.	0
14. Memory and concentration	14(a)	On a daily basis, forgets or loses concentration to such an extent that overall day to day life cannot be successfully managed without receiving verbal prompting, given by someone else in the claimant's presence.	15

(1)		*(2)*	*(3)*
Activity		***Descriptor***	***Points***
	(b)	For the majority of the time, forgets or loses concentration to such an extent that overall day to day life cannot be successfully managed without receiving verbal prompting, given by someone else in the claimant's presence.	9
	(c)	Frequently forgets or loses concentration to such an extent that overall day to day life can only be successfully managed with pre-planning, such as making a daily written list of all tasks forming part of daily life that are to be completed.	6
	(d)	None of the above apply.	0
15. Execution of tasks	15(a)	Is unable to successfully complete any everyday task.	15
	(b)	Takes more than twice the length of time it would take a person without any form of mental disablement, to successfully complete an everyday task with which the claimant is familiar.	15
	(c)	Takes more than one and a half times but no more than twice the length of time it would take a person without any form of mental disablement to successfully complete an everyday task with which the claimant is familiar.	9
	(d)	Takes one and a half times the length of time it would take a person without any form of mental disablement to successfully complete an everyday task with which the claimant is familiar.	6
	(e)	None of the above apply.	0
16. Initiating and sustaining personal action.	16(a)	Cannot, due to cognitive impairment or a severe disorder of mood or behaviour, initiate or sustain any personal action (which means planning, organisation, problem solving, prioritising or switching tasks).	15
	(b)	Cannot, due to cognitive impairment or a severe disorder of mood or behaviour, initiate or sustain personal action without requiring verbal prompting given by another person in the claimant's presence for the majority of the time.	15

	(c)	Cannot, due to cognitive impairment or a severe disorder of mood or behaviour, initiate or sustain personal action without requiring verbal prompting given by another person in the claimant's presence for the majority of the time.	9
	(d)	Cannot, due to cognitive impairment or a severe disorder of mood or behaviour, initiate or sustain personal action without requiring frequent verbal prompting given by another person in the claimant's presence.	6
	(e)	None of the above apply.	0
17. Coping with change	17(a)	Cannot cope with very minor, expected changes in routine, to the extent that overall day to day life cannot be managed.	15
	(b)	Cannot cope with expected changes in routine (such as a pre-arranged permanent change to the routine time scheduled for a lunch break), to the extent that overall day to day life is made significantly more difficult.	9
	(c)	Cannot cope with minor, unforeseen changes in routine (such as an unexpected change of the timing of an appointment on the day it is due to occur), to the extent that overall, day to day life is made significantly more difficult.	6
	(d)	None of the above apply.	0
18. Getting about	18(a)	Cannot get to any specified place with which the claimant is, or would be, familiar.	15
	(b)	Is unable to get to a specified place with which the claimant is familiar, without being accompanied by another person on each occasion.	15
	(c)	For the majority of the time is unable to get to a specified place with which the claimant is familiar without being accompanied by another person.	9
	(d)	Is frequently unable to get to a specified place with which the claimant is familiar without being accompanied by another person.	6
	(e)	None of the above apply.	0

19. Coping with social situations	19(a)	Normal activities, for example, visiting new places or engaging in social contact, are precluded because of overwhelming fear or anxiety.	15
	(b)	Normal activities, for example, visiting new places or engaging in social contact, are precluded for the majority of the time due to overwhelming fear or anxiety.	9
	(c)	Normal activities, for example, visiting new places or engaging in social contact, are frequently precluded, due to overwhelming fear or anxiety.	6
	(d)	None of the above apply.	0
20. Propriety of behaviour with other people.	(a)	Has unpredictable outbursts of aggressive, disinhibited, or bizarre behaviour, being either: (i) sufficient to cause disruption to others on a daily basis; or (ii) of such severity that although occurring less frequently than on a daily basis, no reasonable person would be expected to tolerate them.	15
	(b)	Has a completely disproportionate reaction to minor events or to criticism to the extent that the claimant has an extreme violent outburst leading to threatening behaviour or actual physical violence.	15
	(c)	Has unpredictable outbursts of aggressive, disinhibited or bizarre behaviour, sufficient in severity and frequency to cause disruption for the majority of the time.	9
	(d)	Has a strongly disproportionate reaction to minor events or to criticism, to the extent that the claimant cannot manage overall day to day life when such events or criticism occur.	9
	(e)	Has unpredictable outbursts of aggressive, disinhibited or bizarre behaviour, sufficient to cause frequent disruption.	6
	(f)	Frequently demonstrates a moderately disproportionate reaction to minor events or to criticism but not to such an extent that the claimant cannot manage overall day to day life when such events or criticism occur.	6
	(g)	None of the above apply.	0

21. Dealing with other people	21(a)	Is unaware of impact of own behaviour to the extent that: (i) has difficulty relating to others even for brief periods, such as a few hours; or (ii) causes distress to others on a daily basis.	15
	(b)	The claimant misinterprets verbal or non-verbal communication to the extent of causing himself or herself significant distress on a daily basis.	15
	(c)	Is unaware of impact of own behaviour to the extent that: (i) has difficulty relating to others for longer periods, such as a day or two; or (ii) causes distress to others for the majority of the time.	9
	(d)	The claimant misinterprets verbal or non-verbal communication to the extent of causing himself or herself significant distress for the majority of the time.	9
	(e)	Is unaware of impact of own behaviour to the extent that: (i) has difficulty relating to others for prolonged periods, such as a week; or (ii) frequently causes distress to others.	6
	(f)	The claimant misinterprets verbal or non-verbal communication to the extent of causing himself or herself significant distress on a frequent basis.	6
	(g)	None of the above apply.	0

ABBREVIATIONS

CAB	Citizens Advice Bureau
CBWR&CAB	Corby Borough Welfare Rights and Citizens Advice Bureau
CDS	Central Document Services
CESA	contribution-based employment and support allowance
CPAG	Child Poverty Action Group
DSS	Department of Social Security
DWP	Department for Work and Pensions
ESA	employment and support allowance
HCP	healthcare professional
IB	incapacity benefit
IfW	incapacity for work
IRESA	income-related employment and support allowance
IS	income support
IVB	invalidity benefit
JSA	jobseekers allowance
LCWA	limited capability for work assessment
LCWRAA	limited capability for work-related activity assessment
MH	mental health
NAO	National Audit Office
NI	national insurance
OECD	Organisation for Economic Co-operation and Development
PCA	personal capability assessment
SDA	severe disablement allowance
SG	support group
SoS	Secretary of State
SSAC	Social Security Advisory Committee
SSP	statutory sick pay
WCA	work capability assessment
WFHRA	work-focused health-related assessment
WFI	work-focused interview
WRA	work-related activity
WRAG	work-related activity group

ESA Regs	Employment and Support Allowance Regulations 2008, SI 2008/794.
IS Regs	Income Support (General) Regulations 1987, SI 1987/1967.
JSA Regs	Jobseeker's Allowance Regulations 1996, SI 1996/207.
SDA Regs	Social Security (Severe Disablement Allowance) Regulations 1984, SI 1984/1303.
SSA 1998	Social Security Act 1998.
SSCBA 1992	Social Security Contributions and Benefits Act 1992.
SS(C&P) Regs	Social Security (Claims and Payments) Regulations 1987, SI 1987/1968.
SS(Cr) Regs	Social Security (Credits) Regulations 1975, SI 1975/556.
SSCS(D&A) Regs	Social Security and Child Support (Decisions and Appeals) Regulations 1999, SI 1991/991.
SS(IB) Regs	Social Security (Incapacity Benefit) Regulations 1994, SI 1994/2946.
SS(IBWFI) Regs	Social Security (Incapacity Benefit Work-focused Interviews) Regulations 2003, SI 2003/2439.
SS(IFW) Regs	Social Security (Incapacity for Work)(General) Regulations 1995, SI 1995/311.
SS(JPI) Regs	Social Security (Jobcentre Plus Interviews) Regulations 2002, SI 2002/1703
SS(ME) Regs	Social Security (Medical Evidence) Regulations 1976, SI No 1976/615.
TCEA 2007	Tribunal Courts and Enforcement Act 2007.
TP(FT) Rules	Tribunal Procedure (First-tier Tribunal) (Social Entitlement Chamber) Rules 2008, SI 2008/2685
WRA	Welfare Reform Act

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2010/19	Social Security (Contributions Credits for Parents and Carers) Regulations
2010/1907	Employment and Support Allowance (Transitional Provisions, Housing Benefit and Council Tax Benefit) (Existing Awards) (no 2) Regulations
2010/2377	Welfare Reform Act 2009 (Commencement No 3) Order 2010

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