Title of consultation
Closing the Disability Employment Gap

Name of the consulting body
House of Commons Select Committee: Work and Pensions Committee

Link to consultation:

Why did the MRC/CSO Social and Public Health Sciences Unit contribute to this consultation?
Welfare reform and employability interventions which affect those unable to work due to sickness or disability are important social determinants of health which impact most strongly on groups who experience health inequalities. The Unit has expertise in this area which should be leveraged to inform policy if possible.

Our consultation response
The MRC/CSO Social and Public Health Sciences Unit, University of Glasgow is responding to the following questions outlined by the Committee for this Inquiry’s written evidence:

Effective employment support for disabled people:
1) What should support for people with health conditions and disabilities in the proposed Work and Health programme look like?
2) How should providers be incentivised to succeed?

Likely effects of proposed ESA reform:
3) What are the likely impacts on disability employment of the abolition of the Employment and Support Allowance Work Related Activity component?
4) What evidence is there that it will promote positive behavioural change? What evidence is there that it will have unintended consequences, and how could these be mitigated?

Our response:

Executive Summary
Research evidence indicates that current DWP programmes have not delivered the employment outcomes anticipated for those with long term health conditions. A focus on sanctions has done little to reduce the disability employment gap. More joined-up working between health services and DWP employability providers is recommended.

One approach worthy of consideration is the Individual Placement Support Model (IPS),
an approach already offered in some UK health services. Further research on the IPS model and its impact on employability within a UK context are recommended. Its applicability not only to mental health but also to other long term health conditions is worthy of consideration.

There is no evidence to support the government’s contention that the Work Related Activity (WRA) component of Employment and Support Allowance (ESA) disincentivises employment among disabled people. Disabled people and representative organisations argue strongly that removal of the WRA component will increase distance from the labour market as it will negatively impact health and reduce resources available for engaging in work preparation activities. Individuals assigned to the WRA group have been deemed unfit for work due to their health condition, and as such incentivising work amongst this group may not be an appropriate strategy. There is evidence that sudden and large decreases in income due to benefit changes may trigger serious health consequences, with knock-on effects on health and social services. Given the apparent risks of potential harm, it is essential that this policy is properly evaluated, ideally by piloting at a small scale prior to full-scale implementation.

Background

The MRC/CSO Social and Public Health Sciences Unit, University of Glasgow conducts world-leading research to understand the determinants of population health and health inequalities, and to develop and test interventions to improve health and reduce inequalities. The Unit’s research uses a wide variety of methods including qualitative research, the collection, linkage and analysis of social survey and routinely collected data, evidence synthesis, randomised controlled trials and natural experimental studies. The Informing Healthy Public Policy programme has a particular focus on, and expertise in, evaluating the impacts of welfare to work interventions. The Unit receives core funding from the Medical Research Council and the Scottish Government Chief Scientist Office, as well as grant funding for specific projects from a range of sources. Further information about the Unit is available at http://www.gla.ac.uk/sphsu

1. What should support for people with health conditions and disabilities in the proposed Work and Health programme look like?

1.1 Current employment support for people within the ESA WRAG (Work Related Activity Group) is provided via the Work Programme. There has been little rigorous evaluation of this Programme and the principal source of publicly available data to assess its implementation and effects arises from small scale observational studies. Research conducted by the mental health charity Mind found that disabled participants received virtually no specialist employability support via the Programme and were, in the main, directed into generic work preparation programmes which focused on basic tasks such as preparing a CV (Hale 2015). Respondents to the Impact of Welfare Reform Tracking Study (2015) reported increased pressure to find work but no improvement in the support available to help them move into employment, with their skills, interests and constraints given little consideration (Graham et al 2015). Employment outcomes for disabled people and those further from the job market in the Work Programme have been poor; only 11% of participants found sustainable employment up to March 2014 (NAO 2014). Within a ‘payment by results’ system, there has been evidence of private providers ‘creaming’ and ‘parking’ disabled participants (Rees et al 2014). Contractors are awarded with incentive payments for performance, evidence suggests that those in harder to help groups, such as those with disabilities, receive very little support (NAO 2014). Participants with long term health conditions report being pushed into unsuitable jobs, this can result in unintended consequences such as increased anxiety, worsening mental health, more usage of health resources such as GP
appointments, increased risk of self-harm and suicide, cycling in and out of work (Graham et al 2015, McQueen 2014).

1.2 An approach worthy of consideration, and for which good evidence is available, is the Individual Placement Support Model (IPS). Individual Placement and Support (IPS) is an employability intervention aimed at people with severe mental health conditions which has been tested extensively in a number of countries. Contrary to the Work Programme model, IPS offers ongoing, intensive support tailored to the individual’s career aspirations, skills and health condition. The support is delivered by highly skilled advisors working within statutory health services. Whilst most research evidence is focused on those with long term mental health conditions the approach may be transferable to other long term conditions.

1.3 IPS was originally developed in the United States and is now available in many European countries. Research literature demonstrates a wider interest in IPS and suggests the intervention is effective across a range of cultures and policy environments. Randomised trials of IPS have been conducted in Canada (Latimer et al 2006), USA (Cook et al 2005), Australia (Killackey et al 2008), Hong Kong (Kin-Wong et al 2008) and throughout Europe, including in the UK (Burns et al 2007), the Netherlands (Michon et al 2011), and Switzerland (Hoffman et al 2012). The EQOLISE project (Burns, White and Catty 2008) compared IPS with other vocational rehabilitation services in six European countries and concluded: IPS clients were twice as likely to gain employment (55% v. 28%) and worked for significantly longer; the total costs for IPS were generally lower than standard services over first 6 months; clients who had worked for at least a month in the previous five years had better outcomes; individuals who gained employment had reduced hospitalisation rates.

The overall effectiveness of IPS is summarised in a Cochrane review containing 18 trials, with the results showing that those with severe and enduring mental health conditions offered IPS earned more and worked more hours overall (Crowther et al 2001). Centres of Excellence have been established through the Centre for Mental Health in England, NETWORKS in NHS Greater Glasgow and Clyde (Turkington 2013), The Works NHS Lothian (Meiklejohn 2011) and the Scottish Association for Mental Health (SAMH) in Scotland. Internationally it is used in New Zealand and the US. Despite the strong evidence, provision of IPS remains patchy. More needs to done to ensure sustainable funding of existing services and ongoing expansion and research within a UK context.

1.4 The IPS model promotes joint working between health services and employability, and in many instances the health sector provides the lead partner (Mental Health Strategy for Scotland 2012-2015, Scottish Union for Supported Employment SUSE 2015). The individualised placement support model is often offered through health care provision and charitable organisations with no cost to employers. Its principles include the goal of competitive employment, with clients expected to seek employment within four weeks. Vocational rehabilitation is integrated into mental health support by co-locating employment specialists/occupational therapists within mental health treatment teams. In contrast to the current statutory programmes, job searching is based on client’s preferences and choices and follow up support is continued indefinitely. For participants receiving IPS, benefit advice and better off calculations are available within the programme (Durie and Coutts 2010).

1.5 For employers, individuals supported by IPS programmes have a tailored recovery programme and time un-limited mental health support. Used successfully this can alleviate employers’ concerns about employment support needs such as accommodation, job adjustment and condition management within
the workplace.

Policy/Practice Implications
On the basis of supportive international evidence, proposals for future welfare to work programmes should consider the IPS model. IPS is already available in some areas of the UK for those with mental health conditions through NHS Lothian, NHS Greater Glasgow and Clyde, SAMH and Centres of Excellence in England through the Centre for Mental Health.

Further research on the IPS model and its impact on employability within a UK context is recommended. Its applicability not only in mental health but other long term health conditions is worthy of consideration. Health care providers with sustainable funding may be well placed to lead on this (Mental Health Strategy for Scotland 2012-2015, Meiklejohn 2011, Turkington 2013). Where IPS programmes are developed consideration should be given to ongoing use of fidelity reviews as high fidelity predicts better employment outcomes.

2. How should providers be incentivised to succeed?

2.1 Many of the barriers to employment are related to health issues. Support from health care providers working in collaboration with employers to dispel the myths around ill health and disability would be advantageous. If healthcare providers took the lead and employment was fully supported as a health outcome, incentivising private providers would be less of an issue. IPS would also incentivise employers as health providers would take some responsibility.

2.2 Consistency of support from employability advisors is important in supporting those with health conditions into work. The stress of work capacity assessments can have a negative impact on health, leading to relapse and unintended impacts on mental health (McQueen 2014).

3. What are the likely impacts on disability employment of the abolition of the Employment and Support Allowance Work Related Activity component?

3.1 Some indication of the employment impacts of abolishing the WRA component can be found in studies which compare employment rates for disabled people in countries with varying levels of benefit generosity. An analysis of data from five OECD (UK, Canada, Norway, Denmark and Sweden) countries found no evidence for a disincentive effect of higher benefit levels. In fact, employment rates among men with limiting health conditions were far higher in three Nordic countries with more generous benefits. For instance, the rate in Norway was 74% compared to 58.8% in the UK (Holland et al 2011).

3.2 As this policy has not been implemented, there is little academic evidence on the likely impacts on the ability of disabled people to access employment. However, many groups which represent disabled people have gathered data and conducted research on the potential impacts. For example, in responses to a consultation conducted by Mencap which received submissions from 33 organisations and 178 disabled people (Low et al 2015), a majority of respondents believed that removing the WRA component of ESA would increase barriers to employment for WRAG members. Sick and disabled people frequently have extra living costs associated with their health conditions, such as a need for increased heating, higher transport costs or adaptive aids. Equivalised income scales which take account of the extra costs of disability find that the income required to sustain a given standard of living is substantially higher than that required by non-disabled people, a shortfall which is not covered by current benefit levels (Zaidi and Burchardt 2005). Given that existing benefits do not cover the extra costs of
disability, it seems likely that loss of the WRA component will reduce still further the resources available for job searching among those recipients who are in a position to seek employment, as well as for expenditures which might assist with recuperation or maintaining independence, both of which are prerequisites for a timely return to work (Low et al 2015).

3.3 Given that there is uncertainty around the likely impacts of abolition, and a clear risk of potential harm, we would argue that it is essential to evaluate this policy prior to full-scale implementation. There have been calls for evaluation from a number of stakeholders, including a majority of those in the House of Lords, but these have been rejected on the grounds that this would delay implementation (HL 2016). Small-scale piloting and testing would be the most appropriate approach to ensure that a potentially harmful policy is not implemented across the board.

4. What evidence is there that it will promote positive behavioural change? What evidence is there that it will have unintended consequences, and how could these be mitigated?

4.1 The government’s 2015 Impact Assessment (IA) of the removal of the Work-Related Activity Component justifies the removal in terms of the financial incentive not to work created by the payment of £30 per week. There is no evidence to support the contention that generous benefits disincentivise employment. There is evidence that employment is higher among disabled people in countries with more generous benefits (Holland et al 2011), although causal relationships cannot be inferred from such studies. Similar cross-national comparative studies of employment rates among both single mothers (Destro & Brady 2011) and the general population (Howell & Rehm 2009) found no relationship with benefit levels.

4.2 In support of reducing the ESA WRA component, the IA (2015) cites the statistic that 61% of WRAG group members say they would like to return to employment. This is taken from the DWP report A Survey of Working Age Benefit Claimants (DWP 2013). However, respondents to this survey were also asked whether they were able to work at the present time, and whether having a job would be beneficial to their health. Responses indicated that only 15% of recipients of disability related benefits were able to work, and only 23% thought that working would be beneficial to their health. Expressing an aspiration to return to work does not necessarily equate to ability to do so at the present time. People assigned to the ESA WRAG are judged to be incapable of work due to ill health, and as such they are not required to be available for work. This would suggest that seeking to incentivise work among this group may not be an appropriate strategy.

4.3 The often cited argument that employment is health promoting originates in Waddell and Burton’s review of evidence on work and health (2006). The IA states that work is good for health and well-being and should be encouraged in those whose health condition permits. However, people receive the WRA component of ESA because their health condition does not permit them to work and Waddell and Burton’s review also states that those deemed eligible for disability benefits should not be required to seek work.

4.4 While there is no direct evidence on the impacts of this policy because it has not as yet been implemented, some data relevant to potential unintended consequences have been collected by representative groups. These include both the views of disabled people on how the policy is likely to affect them, and their experiences of rapid income reductions caused by existing reforms to the welfare
system. In keeping with research evidence on the negative impacts of continuing to attend work while unwell (on health, productivity and higher future levels of sickness absence; Gustafsson & Marklund 2011, Bergström et al 2009), many disabled people attest that returning to work prematurely will worsen their existing health conditions, leading to greater distance from the labour market (Low et al 2015). Available evidence also suggests that increased financial hardship will cause physical and mental health to deteriorate, again militating against return to employment. Existing cuts to benefits through sanctions and reforms such as the removal of the Shared Room Subsidy have been shown to trigger instances of self-harm and suicide attempts (Barnes et al 2016). Health effects such as these may increase pressure on health and social services, with significant cost implications.

References


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Latimer, Eric A.; Lecomte, Tiana; Becker, Deborah R.; Drake, Robert E.; Duclos, Isabelle; Piat, Myra; Lahaye, Nicole; St-Pierre, Marie-Sylvie; Therrien, Claude; Xie, Haiyi (2006). "Generalisability of the individual placement and support model of supported employment: results of a Canadian randomised controlled trial". The British Journal of Psychiatry 189: 65–73.


Turkington S (2013) SNAPSHOT Health Works Information Report


**When was the response submitted?**

9 May 2016

**Find out more about our research in this area**

Welfare reform and health:

http://www.gla.ac.uk/sphsu/research-programmes/po/

Employability services for disabled people:

http://www.gla.ac.uk/sphsu/research-programmes/co/

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