Social Welfare Reform: From dependency to malingering for people with mental health disabilities?

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Long-term unemployment is a key characteristic and primary economic cause of social exclusion. In the case of people with mental health disabilities, there is a growing body of evidence that their labour market experiences are characterised by long-term unemployment and marginalisation in the secondary labour market, with the majority being 'inactive' based on Labour Force Survey definitions and data (2008).

This was supported by the resent Black Review; 'Working for a Healthier Tomorrow' which, in providing a baseline analysis of the health of the UK's working age population, highlighted that of the 600,000 new claimants of incapacity benefits in the UK, approximately 40 per cent report mental health disabilities. The percentage remains consistent for the total number on incapacity benefits, over 2.5 million people of which 41 per cent report mental health 'problems' (Black 2008).

These statistics are especially striking when considered in the context of legislative and labour market policy reform during the past 15 years, which have generally expressed a commitment to addressing the exclusion of disabled people. In the UK this has largely relied on two apparently positive and related pressures. The first has been legislative change, which for the first time in the UK provides a statutory right for people with mental health disabilities not to be discriminated against on the grounds of their health (through the Disability Discrimination Act 1995). The second pressure, and focus of this article, has come via active governmental labour market policy, most notably the Welfare Reform Act 2007. This has focused on a shift from passive to active policy, and attempted to improve individual employability through various employment support programmes.

This paper presents a discussion of these changes (primarily incapacity benefit), their theoretical basis and a critique of their potential impact for those with mental health 'problems'.

Essentially, the Labour Government has tightened the gateway to incapacity benefits, and their Conservative counterparts have expressed a commitment for taking these changes even further. In both cases, the claim is that these changes will not only benefit the taxpayer by reducing the 'spiralling' incapacity benefits bill, but also reduce social exclusion by promoting employment for those who can work. Yet the impact of these changes to incapacity benefit provision has, to date, received very little attention particularly in relation to the largest recipient group.

The theoretical basis for incapacity benefit and its reform in the UK

Goodwin's (1997) view of welfare regimes in relation to mental health policy suggests that, despite some limitations of the approach, the clustering of European welfare states provides a useful framework for distinguishing national types and levels of mental health care, which are fundamentally ideal-types: liberal, conservative and social democratic.

Liberal regimes are identifiable by the emphasis placed on the maintenance of market relationships in the economic and social spheres. The state acts as a safety net when the market fails to provide for basic needs; thresholds for entitlement to services will be set at a level that is perceived not to reduce motivation for individuals to provide for themselves. Benefits will normally be means-tested and consequently are often stigmatising. The dominant approach in the UK has been liberal, yet a number of significant issues have been highlighted. These limitations and tensions are now outlined.

The 'benefits trap'

Previous research has suggested that the loss of benefits was seen as a major reason not to return to work (Rinaldi and Hill 2007) and the financial disincentive to work is large. It is simply not economically viable to work for many people with disabilities, in particular those with severe mental health disabilities, as minimum wage employment is unlikely to provide the same disposable income as current benefits.

This is particularly the case in relation to part-time employment. Turton (2001) suggested that for people wishing to do part-time work, as they found the majority of people with disabilities did, might be the biggest deterrent when considering the move from unemployment. The fear of having difficulty in getting benefits reinstated if an attempt to start work is unsuccessful may be a further limiting factor. Understandably, people seem unlikely to work if their wage is lower than their benefits entitlement (Turton 2001). This was highlighted as a major driving force of welfare reform, as the system was believed to be 'perversely' rewarding people for not working and promoting socially inappropriate behaviours (Waddell and Ayward 2005).

In essence it fails to provide positive support and may actually have a negative impact, becoming a somewhere to 'hide' those who have been failed by the Department for Work and Pensions (DWP) and other agencies in obtaining employment.

The positive relationship between work and health

In addition to the 'benefits' trap, the second key driver for change has been the growing recognition of the positive impact that work can have on an individual's health and wellbeing and the detrimental impact of worklessness. It is clear that the relationship between sickness or disability and capability to work is complex, but broadly speaking there is a growing recognition that work may well be the best form of welfare. Of course, this must be balanced with appropriate support for those who are unable to work. Historically, benefits have failed to recognise that this is the case and those who have found themselves on Incapacity Benefits (IB) have had to prove that they are ill (Hadler 1996). On doing so, IB may well reinforce incapacity and become a barrier to employment in itself. This is particularly the case as if a recipient indicates recovery or improvement in 'capacity' they jeopardise their own financial stability.

Increasing 'out of control' costs

The third and most controversial driver for change has been the apparently 'out of control' costs that incapacity benefits have placed on the government. Yet here is one of the major paradoxes. Despite this expenditure, economic inequalities between disabled people and their non-disabled counterparts have increased. In terms of mental health disabilities, the majority face social disadvantage, exclusion and poverty. This can predominantly be explained by their exclusion from the Labour Market and reliance on benefits as a source of income.

Because of these theoretical and empirical issues, reform appears to be driven by two broad policy goals (OECD 2003):

- Social protection: to provide adequate income support for people whose capacity for work is limited by sickness or disability.
- Social integration; to provide realistic opportunities and support for sick and disabled people who are able to work; to enable disabled people to participate as fully as possible in society.

Yet simultaneously, it must be recognised that there are administrative and sometime competing 'agendas', namely, controlling costs.

The government policy response manifested in the Welfare Reform Act (2007). Therefore, it is important to outline the key components of these reforms in relation to incapacity benefit. The real problem identified by Waddell et al. 2002, is that historically, the UK social security system for sickness and disability has been about passively providing financial support rather than actively supporting rehabilitation resulting in their dependency on the state rather than supporting their attempts to achieve independence.

Social Reform Act 2007: Components of reform to Incapacity Benefit - An anti-fraud focus

The political reaction to the benefits trap appears to have been translated into a belief that a large proportion of claimants are in fact well enough to work and therefore, do not require financial support. Thus, the first focus of reform has been an anti-fraud focus. This has been enforced not only through active investigation, but also through a reform of assessment of those receiving or applying for IB;

Tightening of the gateway to benefits

The major change to IB has been the introduction of new 'work capability assessments' which are far more rigorous than previous assessments. Those who are deemed capable of returning to work by 'health professionals' rather than GPs, as had previously been the case, are then required to engage in a 'work-focused interview' and activities aimed at supporting individuals off IB and into employment. These include, in part, condition management, including group therapy and cognitive behavioural therapy (CBT) aimed at improving the symptoms of those experiencing mental health disabilities. This is accompanied by a short term increase of benefits, which equally may be cut if an individual fails to engage in the process.

Time limiting benefits

A further change is that previously an individual could remain on IB indefinitely if it was deemed the individual continued to meet the criteria. In contrast, reform of IB has introduced time limitations on IB for those deemed as capable of employment at some point in the future, during which time they receive a higher rate of IB. After this period of time if an individual has yet to find employment they are moved onto Job Seekers Allowance (JSA), which brings with it far less generous financial support in an effort to reduce the so called 'benefits trap'. Those who are deemed unable to work are placed on a lower rate of IB but are not required to engage in work related activities.

Overall, it is claimed that these changes successfully meet the following ideals (Field 1998):

- prevent abuse but ensure that those for whom they are intended are not disadvantaged as a result of reforms
- principles that are clear, fair and just from the perspective of all stakeholders
- decision making should be transparent, understandable and justifiable
- do not disadvantage those recipients who are already most disadvantaged
- avoid perverse incentives

While there is broad political agreement that the previous system of IB benefits was complex and lacked both fairness and focus on promoting equality, this must not mean that reform is not exposed to rigorous critique and analysis in terms of the extent to which it impacts on those currently in receipt of benefits.

An assessment of reforms to incapacity benefits

Despite these seemingly positive aspirations, the question remains, what is the likely impact of these changes for people with mental health disabilities? At the very least, these reforms, represent a shift from liberalism to conservatism in their approach to mental health policy. The dominant trait of conservative welfare regimes is the maintenance of the status quo in relation to the economic and social order. Where state intervention occurs it will avoid providing levels of service or benefit that do not improve the position of the recipient beyond their previous status. The impact of such policy and ideological change needs careful consideration. It would appear that, at least theoretically, there might be a number of serious side effects.

Focusing on fraudulent claimants

The first issue is related to the government's interpretation of these drivers for change. This 'benefit trap' appears to have been translated into a belief that a large proportion of claimants are, in fact, well enough to work and hence do not require financial support. Yet it would appear that these changes potentially condemn individuals – both those capable of working but at minimum wage, and those unable to work of facing real poverty based largely on a public image of those with mental health disabilities as fraudulent claimants. Popular press suggests that incapacity benefit is a growing burden, supporting huge numbers of people should not be on the benefit at all based on the fact that medical evidence suggests that they 'could' work (Waddell and Aylward 2005); hence, the response has largely been an attempt to address 'fraudulent' cases. However, this caricature of the typical IB claimant is dubious, not least because the DWP's own estimation of IB fraud is significantly lower than many other forms of benefit.

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Focusing on individual impairment

The second critique of these changes has been driven by the re-conceptualisation of disability, which recognises the important societal barriers, which may 'disable' an individual. This social model presents these barriers, primarily discrimination, as the most potent cause of unemployment and underemployment for people with disabilities. However, where mental health sits within this conceptual framework has, as yet, been poorly developed. Legislation and IB reform have bracketed mental 'illness' alongside other physical disabilities. This presents a problem, as those with disabilities can be extremely fit, whereas the able-bodied can be extremely ill, and this becomes even more complex with common conditions such as 'stress' and 'anxiety' which may have no obvious external symptoms. The impact of this may be to both demedicalise and depoliticise mental health, in which individuals are seen as frauds, benefit cheats or malingerers, whose unemployment can be explained as a matter of motivation or choice. This is a view that needs challenging. It is clear that the incapacity benefits caseload has increased significantly since 1979 – during which time it has trebled. There has been strong medical evidence that many IB recipients are physically capable of some work (DWP 2002). Yet in the case of common mental health 'problems', this may be considerably more difficult to judge. More fundamentally, it presumes that physical or mental capability is inextricably linked to an individual's ability to obtain employment. This is underpinned by an assumption that social exclusion is a matter of individual 'capital', failing to recognise the institutional barriers that people may face when attempting to obtain and maintain employment, in particular the process of discrimination and stigmatisation.

The discouraged worker

A further issue that becomes apparent is highlighted by the work of Waddell and Aylward (2005). They present data apparently highlighting that while people express a desire for employment, this is immediately qualified with the belief that 'of course I can't because I am too ill/sick/disabled' (p.18). They further support this lack of motivation by stating that only 3–6 per cent of long-term IB recipients are actually taking any steps to seek work. The logical conclusion made and highlighted by government reform is that inactivity is an issue of individual desire or motivation for employment. Yet this issue is more complicated than individual choice. The constant exposure to social barriers that tend to exclude disabled people, particularly those with mental health disabilities, are likely to discourage people from attempting to gain employment. If this is not recognised or addressed reforms to incapacity benefit may further discourage those previously on IB, when, having received training, work-focused interviews and CBT, are moved onto JSA yet continue to face discrimination and exclusion from the Labour Market. Hence, these changes may well do more harm than good, in essence creating a false hope of the prospect of employment.

Can't Work, Won't Work

The government's approach to welfare reform illustrates a number of potentially problematic assumptions regarding workers and potential workers with mental health disabilities. The first is that the focus on fraudulent claimants and tightening the gateway to incapacity benefit assumes that people with mental health 'problems' are claiming benefits while not wanting to work. Yet what does the empirical evidence suggest as regards their employment aspirations? Past research (see Grove et al. 2005) consistently establishes that the majority describe the lack of opportunity, support and incentive to obtain paid employment. In addition LFS (2008) data would suggest that those with mental health 'problems' who are 'inactive' are the most likely of any group (both disabled and non-disabled) to express a desire for paid employment. As a result, the tightening of the gateway to benefits is unlikely to address the needs of people with mental health disabilities or have real impact on the numbers of people on IB. This is practically supported by international evidence. For example, OECD research (2003) highlights that the US have one the toughest gateway have in relative terms more people on IB than the UK, and for those who do successfully gain benefits this may result in even more risk averse behaviour in relation to seeking employment (Aylward and Waddell 2005). Hence, any associated work programmes are unlikely to be successful (Bruyere et al. 2003). Therefore, while many programmes (i.e. Pathways to Work, New Deal for disabled people, Job Centre Plus) have been introduced in the UK when taking in the context of associated changes to IB, there success may well be limited, particularly for those with mental health disabilities.

The second assumption made is that people with mental health disabilities cannot work, not because of any medical impairment but because they are unemployable. Thus, the focus of changes has been on supporting individual employability, keeping people on JSA if necessary, time-limiting IB for those deemed potentially fit and forcing people to engage in training, including CBT aimed at addressing this issue of low employability. While it is certainly the case that people with mental health disabilities tend to also have lower educational attainment and poor work histories, this approach endorses the assumption that there is something about mental 'illness' that makes unemployment inevitable and hence employer discrimination justifiable. By making the issue one of employability, the implication is that sensible employers will screen out people with a history of mental health disabilities and therefore the only possible reason for them to be employed is charitable (Grove et al. 2005). However, a growing body of research has demonstrated that this assumption is unsupportable demonstrating that there is little empirical evidence for equating poor mental health with either capability or a desire for employment.

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As a result, the tightening of the gateway to benefits without suitable consideration of the significant social barriers faced by people with mental health disabilities in obtaining suitable, meaningful employment may well have positively harmful effects. Simply forcing people off IB through time-limitations would not mean they entered the labour market, nor would restricting access to IB. Instead, it is likely that the flow of people onto JSA would increase, or people forced into inappropriate employment will rapidly fall back onto IB. This is because such work is unlikely to provide the positive mental outcomes espoused by the government. This may well achieve the governments cost saving goals in the short term, and be publically popular but at considerable cost for individuals experiencing serious mental distress.

Condemning individuals to poverty and worsening symptoms?

As has been suggested previously, forcing people off incapacity benefit and onto JSA, or into inappropriate employment may have two very significant implications. Firstly, the belief that the majority of those claiming incapacity benefits are well enough to work may well condemn those with mental health disabilities to the risk of poverty based largely on a misleading public image that they are fraudulent claimants. At present JSA is time limited, in contrast to IB. As those with mental health disabilities are also the least likely to be in employment, and may well face significant barriers to employment which are largely outside their control, they are amongst a group highly likely to be pushed into poverty. These changes essentially replace financial support as a right with support contingent on its potential to improve an individual's social status, yet at the same time this removes the safety net for people with disabilities, exposing them to risk of social and economic exclusion.

As discussed previously the theoretical underpinning of these changes is the fundamental assumption that employment is 'good for your health'. Not only does it provide a sense of identity and promote individual independence, but may also aid recovery (Grove et al. 2005). Clearly promoting the employment opportunities of people with mental health disabilities should be a political priority, however the risk, as highlighted by these changes is that this is translated into any work, with little or no thought placed on the aspirations, skills and abilities, potentially forcing people into inappropriate employment. Indeed, the government's mantra has been 'work for those who can, security for those who can't'. Dividing people in this way is underpinned yet again by a medicalised view of mental health, with no consideration of the circumstances of employment. As Ford (2000) states;

> "While it is probably true that in the right circumstances almost everyone can work, it can equally be said that in the wrong circumstances nobody will."

Perhaps it should be added that in the wrong circumstances nobody should. As Waddell and Aylward (2005) point out, while work is generally good for physical and mental health, there are major provisos, namely:

- physical and psychosocial conditions are satisfactory and provide a decent 'human' quality of work.
- work provides adequate financial reward and security.

These reforms of IB place people with mental health disabilities in an extremely vulnerable position. Not only is the experience of 'worklessness' put at risk by removal of the benefits safety net, but work is increasingly seen as a

requirement rather than a choice. While some argue that this should indeed be the case for people who are 'capable' of employment, it ignores the apparent risk of forcing people into 'any' employment. Of course, the government may well argue that in conjunction with the DDA and active labour market policy such as Pathways to Work, the barriers faced by disabled people in obtaining and maintaining employment have been addressed. However, the required provision of accommodation required for free access to appropriate employment is unlikely given the continued power of employers to dictate the terms of the employment relation and the labour process and the very low employment rigidity in the UK. Creating enabling workplaces requires continued pressure for legislation mandating accommodation by employers – yet the governments focus on reforming incapacity benefits fails to recognise the distinct limitations of the DDA, particularly for people with mental health disabilities.

In summary, tightening the gateway to benefits, focus on fraudulent claimants and time limiting benefits while failing to neither recognise nor fully address the social barriers faced by individuals with mental health disabilities may have a number of crucial unintended side effects, most fundamentally:

- People are forced into inappropriate or unsustainable employment.
- People are forced onto Job Seekers Allowance once they are unable to obtain employment.

In both cases, particularly the first, this undermines the driving assumption that employment is a positive force in an individual's life and may even be therapeutic or aid individual recovery.

Conclusions

Of both existing and new claimants of Incapacity Benefit over 40 per cent report mental health conditions. This is not only a damning illustration of the impact of contemporary work on individual health, but an indication of serious discrimination faced by people with disabilities in gaining and maintaining employment. For those on IB, the experience can be extremely distressing in itself, accompanied by shame, guilt and loss of identity and continuation of poor mental health. Yet the government's response to the problem of inactivity amongst people with mental health disabilities has the potential to further stigmatise this group as unemployable. In addition it may in fact expose them to the very economic and social exclusion the government claims it is intended to protect them from. Removal of support as a right without proper consideration of the social barriers to obtaining and maintaining employment places individuals in a position of vulnerability, neither 'employed' nor 'unemployed', yet not supported by the welfare state. The inevitable result is, in fact, a worsening of the labour market division between disabled and non-disabled people. As Grove et al. (2005) points out, these reforms are underpinned by a number of unsupportable assumptions about the functioning of the labour market:

- **motivated, capable people have free and equal access to the labour market.**
- **people with mental health problems are in fact to blame for their reliance on welfare as they are currently 'unemployable' and represent a risk to employers.**

This rational view of labour markets fails to recognise that the primary cause of labour market exclusion lies not in the individual, but at the heart of our organisations and institutions.

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