An 'interactionist' perspective on barriers and bridges to work for disabled people

By Marilyn Howard

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Disabled people can be caught in a catch-22. If they need to claim incapacity benefit, they have to demonstrate their incapacity for work, but if they want a job, they have to demonstrate the opposite, their capacity for work. Whilst income distribution has been informed by assumptions based on a medical model of disability (emphasising inability), employment policies (including civil rights) imply that many impairments can be accommodated in the workplace (closer to the social model of disability).

The medical model can be seen as has dominated disability policy although the social model has become more prominent in recent years, advocated by organisations of disabled people particularly concerned with civil rights. However, some commentators have noted that both miss some key aspects of the others' concern.[1]

This paper aims to make the case for an 'interactionist' perspective to transcend the limitations of more rigid interpretations of both medical and social models. The paper offers a framework to inform policy and practice by focusing on the interactions between individual and social.

One advantage of adopting this perspective would be more coherent policies instead of the current tensions between income and employment policy for disabled people. A more integrated approach is now timely. Pilots to test out rehabilitation and job retention start in 2003, which is also the European Year of Disabled People. A new Disability Bill has been proposed, and a Single Equality Commission (incorporating disability) looks likely in the next few years.

The interactionist perspective differs from both the medical and social models in two key ways:

1. It emphasises **processes** (not just status); this allows us to analyse transitions (such as those into and out of work), and to assess when to intervene to prevent negative consequences (like avoidable job loss), or to reduce their effects;

2. It emphasises that **barriers to work arise at different levels - individual, systems and environmental -** rather than just individual or societal levels. These barriers include the perceptions of 'actors' at each level (from individual

through to employer). This means that policies can be designed to tackle the barriers at the level at which they occur, and to ensure cohesion between the different layers (for example, so that policies to help the individual are consistent with those to help employers).

This paper outlines different perspectives on disability (section 2) and then examines processes (section 3). This is followed by an examination of barriers to work occurring at an individual, system and environmental level, including how these might vary according to someone's distance from work (section 4). Next, the effectiveness of existing bridges back to work is outlined (section 5) and finally some implications for policy (section 6) and practice (section 7) are suggested.

1. Introduction

Recent attempts to encourage people on incapacity-related benefits to work underline the tension between income and employment policies, highlighted in a recent report by the Organisation for Economic Co-operation and Development (OECD).[2] People have to prove **incapacity** for benefit purposes but **capacity** when trying to get a job; the Disability Discrimination Act (DDA) implies that impairments can be accommodated. Attempts to tackle this tension have involved grafting 'active' measures (such as work-focussed interviews) onto the 'passive' Incapacity Benefit (IB), but the strains could become increasingly acute as more measures to encourage work are introduced into benefit administration.

This discussion paper is a contribution towards the Institute for Public Policy Research project looking at 'disability and work', and is intended to stimulate thinking about longer-term reforms by exploring whether an 'interactionist perspective' can provide a different and more coherent framework for policy and practice. The paper is a personal view and although it has benefited from extremely helpful comments by people from a range of perspectives, responsibility for the final version is the author's alone.

Since 1997 the Government has experimented with employment programmes affecting disabled people, notably the New Deal for Disabled People Personal Adviser Services (PAS) and innovative schemes, other New Deals, as well as pilots to bring together employment and benefit services for all people of working age (called the 'ONE' service). The paper draws heavily on Department for Work and Pensions (DWP) research and evaluation of these programmes. This evidence has limitations: successful elements cannot always be identified, and some reports tend to over-emphasise impairment to the neglect of other issues. Research into mainstream programmes has not always identified poor health or disability among participants and so knowledge of the impact on process and outcomes remains sparse. Researchers' own perspectives can also inform the findings they report. In this paper reference is made to studies from economic, geographic and social policy perspectives. They all have a role to play, but there is unlikely to be a simple or single explanation for some of the issues, and research carried out from a multi-disciplinary perspective is rare.

Before turning to discuss the different perspectives on disability in detail, two introductory points need to be made. First, discussions about disability are sensitive to the definition used.[3] Surveys often measure self-reported limitations, or constraints on work, or use the DDA definition (impairment which has a substantial and long-term adverse effect on daily activities). Different definitions apply for civil rights and social policy, so someone can be defined 'disabled' for one purpose but not for another.[4] Second, each perspective on disability defines 'disability' or 'impairment' differently, and so the same words can mean different things, depending on your point of view (see for example section 3.1). To avoid confusion, this paper defines 'impairments' as problems with the functions or structure of the body; and 'disability' as a consequence of processes that exclude people from society.

2. Perspectives on disability and incapacity

2.1 Perspectives on disability

Traditionally, the **medical model** has been dominant, locating disability within the individual, the focus being on 'cure'. Conversely, in the past two decades or so, the **social model** has become increasingly important in identifying disability as the result of society's failure to adapt to the needs of the disabled person, discrimination being institutional, environmental and attitudinal. Two approaches in disability policy broadly mirror these models; the 'ameliorative' aims for a minimum level of income (reflecting the medical model), whilst the 'corrective' aims to reduce the effect of disability by changing the environment, such as access to employment (reflecting the social model).[5] As well as policies for income transfers often being at odds with those promoting employment, there can be conflicts between 'social welfare' and 'civil rights' approaches.[6] This means that policies apparently with the same goals can have different starting points, and send out conflicting messages about disabled people.

Some commentators have identified the need for a 'dual model' to take into account both individual and social factors.[7] Perspectives that view disability as the outcome of interactions between individuals and their environment may fill this gap.[8] One such perspective is Duckworth's **empowerment model**, focussing on improving individuals' self-esteem.[9] It is intended to help service providers develop practices and procedures to enable those who have internalised the individual model to develop self-esteem and control over their lives. Another is the **biopsychosocial (BPS) model**, described by Waddell, aiming to take different elements of other models into account.[10] BPS includes:

Bio	Permanent physiological or psychological impairment: function
Psycho	Attitudes and beliefs: psychological distress: coping strategies: illness behaviour: motivation, effort, performance
Social	Occupational demands (physical and psychological): economic incentives and controls: 'cultural attitudes': behaviour

Elsewhere, we have also suggested that the **interactionist perspective** can bridge the gap between the individual and the social.[11] It encompasses both social barriers and limitations imposed by some impairments, and the relationship between them. Although similar to BPS, the interactionist perspective gives greater prominence to processes and transitions, and the 'social' (systems and institutional responses). As the interaction between the individual and their environment is a **social process**, this implies that disability is 'dynamic', occurring over time and within a particular social context. The problem is not **located** either in the individual or the social alone, so dynamics could be altered through elements of both individual and social change, and targeted where they occur. Problems can arise at a systems level; hence the solutions concern changes that need to be made to the functioning of a system as a whole.[12] This 'systems' perspective is picked up in later sections on policy and practice. Finally, the concept of **mutuality,** emphasises common experiences, as some of the barriers encountered by disabled people can also be experienced by others who are socially excluded.[13]

2.2 Perspectives on barriers and bridges to work

The medical model assumes that disabled people need to be helped to adapt to society's demands, but this favours medical or technical solutions that emphasise **difference** rather than promoting inclusion.[14] Giving 'special' help outside of the mainstream allows society to exclude disabled people with a clear conscience. The social model, on the other hand, emphasises the need for equal treatment through adapting social structures. Waddell suggests that both models imply that the disabled person is the passive victim (either of their condition or their social situation), whilst the BPS model contains scope for some individual control through their own effort, behaviour and motivation, though there are aspects of their interaction with health care, employers, and the benefits system over which they have little control. The empowerment model appears to share this view, and offers ways in which individual motivation can change through a structured approach. The interactionist perspective concerns the perceptions of individuals and institutionalised attitudes within systems. It includes scope for individual change, though this may often only be achieved with assistance (and so needing system level changes). The different perspectives are compared in Table One.

Table One: Perspectives on barriers and bridges to work

	Medical	Social	BPS	Interactionist
Barriers / problem focus	Disability results from impairment	Disability results from society's failure to adapt	Impairment, but also depends on psychosocial / social factors	Disability is the outcome of a social process, individuals interacting with social & environmental systems
Bridges / solutions	Medical treatment & rehabilitation	Society has to remove barriers	Combination of health care, rehabilitation, personal effort and modification of social situation Interactions	Removal of barriers at appropriate levels, e.g. socially-created barriers, changes to systems and individual attributes where possible
Assumptions about work	Disabled people can't work	Disabled people are excluded from work	More could work if individual, psychosocial and systems barriers removed	More could work if different levels of barriers were tackled & under the right conditions
Focus of intervention	Individual / supply side	Employer/ demand side	Individuals, health care professionals and employers	Individuals, employers and systems

The Government's 2002 Green Paper (Pathways to Employment), seems to have been influenced by the BPS model in promoting rehabilitation pilots to help people manage their condition, and acknowledging obstacles arising from a range of factors, not just impairment.[15] Its weakness lies in the limited emphasis on systems and environmental barriers, including employer attitudes/practice, indicating that the

approach suggested may not tackle all aspects of the tension between incomes and employment policy.

2.3 Legacy of the medical model

Disability as a status

The medical model emphasises disability as a status, which is permanent. This creates artificial distinctions between people.[16] Often disability has also been equated to incapacity (see below). 'Disability' has also been viewed as a category used to determine distribution of resources and exemption from the obligations of citizenship.[17] Once labelled, the process of returning to society has been relatively neglected, with neither the individual, nor society regarded as having a responsibility to fulfil them.[18]

Incapacity as a status

Similarly, income maintenance benefits based on 'incapacity' exempt people from obligations applied to other groups (looking for work as a condition of receiving benefit) but is in turn less likely to enable them to return to work since this entails jeopardising their entitlement. Surveys indicate that, once labelled as 'incapable', people may come to believe that they are incapable of all work, compounded by a continual pressure to prove incapacity in order to retain financial support.[19] The general rule is that recipients have to show they are incapable of work, so that activities that call into question the reason for incapacity can result in someone being treated as capable of work and so lose Incapacity Benefit (IB); though some voluntary and 'permitted' work is allowed.[20] The Personal Capability Assessment (PCA) is the mechanism used to identify people who should not be expected to seek work in order to receive state benefits (i.e., to determine whether they should be receiving either IB or Jobseekers Allowance). It does not reflect someone's actual prospects of work, instead applying an abstract scale of functional limitations to determine which benefit someone should receive. The 2002 Green Paper now acknowledges that there cannot be an objective dividing line between those who can or cannot work, as this is a continuum.

As well as emphasising benefits over work, the medical model has:

- Reinforced the assumption that disabled people in work are 'less disabled' than people out of work;[21]

- Influenced previous benefit policy (e.g., changes to the incapacity test in 1995);

- Influenced some of the alternatives put forward, like 'partial capacity benefits'. This largely retains the concept of incapacity, and there is little evidence from other countries that partial benefits help people combine work and benefit;[22]

- Associated impairment with dependency, affecting how employment and support services respond. The gap between policy and delivery can be filled by 'practice assumptions' shaped by the medical model.

An emphasis on **benefit status**, rather than transitions, can reinforce this legacy. Benefit status determines access to the New Deals; so losing or changing benefit can affect eligibility. 'Status' also implies a focus on consequences rather than

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processes, running the risk of perpetuating 'disabling' environments, and creating discontinuities when people move from one status to another (working can threaten both benefit status and disability status). Being in one status long-term may affect the self-perception of an individual.

The two main aspects of the interactionist perspective are examined in the following sections, starting with social processes (section 3) and then analysing barriers at different levels (section 4).

3. The interactionist perspective: social processes and transitions

The interactionist perspective views disability as a social process, rather than just a characteristic of individuals. This is consistent with the revised World Health Organisation (WHO) approach to disability, which moved from a medical perspective to one considering the person within their social and environmental context. Whilst complex, this allows scope for changes at a variety of levels and at different stages of a process, with the aim of altering some of the consequences of being disabled in our society. A 'dynamic' view of the processes of transition (such as the routes onto benefit or the transition back to work) might help understand the impact of disability and impairment and identify processes of exclusion.

3.1 Dynamics rather than status

Social policy thinking now involves a dynamic analysis; rather than simply looking at characteristics of people on low incomes, academics have studied patterns of flows onto benefit and time spent on a low income.[23] Interest in 'disability and transitions' is beginning to emerge; life cycle transitions (childhood into adulthood, setting up home, becoming a parent), may pose difficulties, either because of the impairment itself or disabling responses to it.

A study of self-reported activity limitations from seven years of the British Household Panel Survey shows different patterns over time. [24] It also highlights the impact of language and perspectives: the study analysed responses to questions about limitations on activities, which could be described as 'disability' (medical model); or 'impairment' (social model); or 'self-reported limitations' (BPS model). Whatever the perspective, however, the study revealed a different picture over time compared with a single snapshot, showing that:

- At any one time, about 11 per cent of the working age population reported limitations in activities of daily living ('ADL limited'), whilst 26 per cent reported some mental distress (according to the 'GHQ' scale of 12 standard questions usually taken as indicators of mental health);

- Over seven years, one in ten of those ADL limited were only affected once, but one in four people experienced some limitation, of whom only ten per cent were limited throughout.

Older people tended to have longer spells of restricted activity, women were more likely to have a physical limitation and more than one spell of mental distress than men. Intermittent patterns of limitation were particularly evident across measures of mental distress.

3.2 Transitions in and out of work

Exclusion from work has been seen as a significant cause of some of the other exclusions faced by disabled people. Employers and co-workers have tended to make assumptions about someone's ability, often reinforced by inaccessible

workplaces.[25] Such factors can affect job loss or difficulties obtaining a job after a period out of work.

Job loss

Whilst it is important that people are not harmed by work, evidence from longitudinal analysis suggests that many people leave work when they would rather remain in their job. One study found that within a year of becoming impaired, one in six workers lost their jobs.[26] About three per cent of workers become impaired every year, people in manual jobs having three times the risk of losing jobs than those in non-manual occupations. A survey of disabled people also found that fewer than four out of ten left their job willingly; the rest were dismissed or advised by a health or other professional to leave, 28 per cent saying they could have stayed in their job had adjustments been made, though only 12 per cent were offered any.[27]

Journeys out of work could range from sudden injury or trauma (perhaps requiring long periods of rehabilitation); gradual sensory loss (requiring a series of adjustments); fluctuating and deteriorating conditions (some leading to absence from work); changes in working conditions (changes in the job revealing a previously hidden impairment) changes in personal assistance arrangements.[28]

Return to work

Evidence has shown that once out of work, disabled people were six times less likely to get employment than non-disabled people.[29] Having lost a job, people could go through a process of detachment from the labour market, ranging from looking for work through rejection and giving up.[30] The 2002 Green Paper suggests that people making a claim for benefit are already partly detached from work; in the two years before their ONE claim, a third had not worked at all. A study of workless men (including those on IB) found that fewer of those described as long-term sick or early retired were looking for work at the time of the survey than when their last job ended.[31] Another survey reported similar findings, non-disabled people being more likely than disabled people to be still looking for a job even after five years.[32] The reasons why disabled people are less likely to look for work over time are unclear, but could relate to the range of barriers described in the next section.

Certainly people on IB tend to spend long periods on benefit; half have been receiving benefit for more than five years, and after a year, the average duration will be eight years.[33] Longer-term claimants (over three years) were less likely to say they need training or rehabilitation, and more likely to describe themselves as sick/disabled than unemployed or caring.[34] However it is not clear whether this results from changes in human capital resources and health, declining confidence following a period of fruitless job search, or the stress of longer periods on a low income. The 2002 Green Paper concludes that the longer out of work, the more a person's health is likely to decline, and so suggests that engaging with people at an early stage could help prevent further deterioration. However, we may need to go further back to examine the journey onto IB.

3.3 Transitions onto benefit

The 2002 Green Paper indicates that reasons for growth in numbers on IB include a variety of demographic and economic factors. In this respect, benefit receipt can be considered as a consequence of other social forces or as a consequence of other policies. For example, people may need to claim benefits following changes in the labour market or employment policy (half of incapacity-related benefit recipients are unemployed when they first claim). Or they may lack of information and advice about adjustments and support that might help them remain in work (such as Access to Work). However, relatively little is known about the experiences and transitions in the years before a claim. In the US, research suggests that five years before a claim, some people had health problems and periods out of work; many were living on incomes below the poverty line in each year; a quarter lost other household earners, and half experienced a decline in family size.[35] UK data suggests that men on low incomes were more likely to develop a work-limiting health condition than those better off, though the processes leading to this are unknown.[36]

A qualitative study of IB's predecessor in the early 1990s identified different routes onto benefit, which in turn affected routes off:

1. Condition-led entrants, influenced by the nature of their condition or its treatment, and the availability of employment opportunities or services;

2. Employment-led entrants, concerning the impact of age and work, experiencing more barriers including employers' attitudes and employment opportunities, the availability of employment rehabilitation or training;

3. Self-directed entrants, with some interaction between the person's condition, employment opportunities and motivation, often supported by their General Practitioner. Triggers to leaving benefit were external (benefit administration or GP), barriers to leaving included age, motivation, work opportunities.[37]

Conclusion

Little is known about the relative importance of the pathways out of work, or whether there is a process of detachment from work. More longitudinal and qualitative research is needed to establish the factors influencing, and trajectories of, job loss. Whilst intervening in the early stages of a claim has merits, the barriers facing people who have been out of work for long periods are little understood, and further work is needed to understand these barriers.

The next section looks at some of these barriers to work from an interactionist perspective, i.e., where the particular barriers are located (at an individual, systems or environmental level), and what is known about their relative importance.

4.   The interactionist perspective: Barriers to work

Perspectives on disability can involve implicit assumptions about particular barriers to work (and so the methods of overcoming them). The medical model emphasises impairment as the main barrier; the social model, society's need to adjust. The interactionist perspective considers barriers at different levels, and the interactions between them, indicating that changes may be needed at each level to tackle the barriers at source.

4.1 Assumptions about impairment

Often people are grouped according to the severity or type of impairment (such as learning difficulty, physical impairment, mental distress); this categorisation does not always indicate whether someone could work, or the barriers affecting them.[38]

Surveys often include 'severity' measures, tending to show economic activity decreasing as severity increases (especially for men). This has often led to the assumption that people who are more 'severely disabled' are less likely to want work or to be in a job. However, the association is not always uniform and studies have shown:

- People with medium-high severity scores were more likely to want work than those with lower scores;

- People with high severity scores were equally likely to report constraints on the kind of work they could do, whether or not they were in work;[39]

- Age increases the risk of impairment but is not associated with severity;[40]

- The chances of moving into work did not decline steadily with increasing severity, the main difference being between low scores and the rest.[41]

The New Deal for Disabled People Personal Adviser Service (PAS) evaluation suggested that recurrent or unpredictable health problems could be a barrier, sometimes related to concern that health would be worsened in certain work conditions.[42] Less is known about the effect of multiple impairments, though they appear to be common.[43] Whether impairment was acquired during childhood or adulthood does not seem to have a significant impact on work prospects.[44]

A survey of disabled people found that a third did not want work, but this was for family reasons; only a quarter said this was because of health problems.[45] This research also shows that people with learning difficulties and those in mental distress have the highest unemployment rates, and those with mobility problems and visual impairments are also less likely to be in work. Overall, 53 per cent of disabled people reported constraints on the **kind** of work they could so, and 32 per cent on the **amount**. People with learning difficulties or visual impairment were more likely to report effects on the **kind** of work, whilst people with progressive conditions or mental health problems reported constraints on the **amount**. Common effects were inability to do heavy physical work (34 per cent) and difficulty working in certain buildings (22 per cent), suggesting that the work environment could have as much

impact as the impairment itself. The 2002 Green Paper also analysed obstacles to work, concluding that not all are impairment-related.

The relative importance of barriers was also explored in a study of people receiving qualifying benefits for in-work help.[46] The level of unemployment was the most common barrier (mentioned by 60 per cent), then impairment (46 per cent), followed closely by employers' perceptions of their impairment (43 per cent). Other barriers (transport, access to buildings) were less important, only 7 per cent considering them the main problem. Loss of benefit as a barrier was mentioned by one in ten (31 per cent of those receiving Severe Disablement Allowance and 11 per cent of those on IB).

A recent analysis of the Labour Force Survey has attempted to understand the effects of different disadvantages on disabled people.[47] The factors of most significance in lowering the chances of employment for disabled men were age (being over 50) and having low education and skills (being single and living in areas of high unemployment were less important factors). Not only are disabled men more likely to be over 50 and low-skilled, both of these characteristics seemed to have more serious consequences for disabled men than for non-disabled. This suggests that the effects of each disadvantage can be 'additive': i.e., a disabled man aged over 50 also lacking qualifications can have a three-fold reduction in employment prospects (compared to a non-disabled man with neither disadvantage). Employment rates for disabled men could range from 65 per cent (with no other disadvantages) to five per cent (with five disadvantages).

4.2 Barriers at different levels

The interactionist perspective highlights barriers at different levels, from individual attributes, to how organisations dealing with disabled people respond as well as the local environment (see Table Two below for an overview). Barriers can also be 'perceived' and held at different levels (by claimants, advisers and employers).[48]

Table Two: Potential barriers for individuals at different levels

Personal	Systems	Environment
Impairment affecting work	Benefit rules and structure	Changes in the labour market and jobs
Older working age (over 50)	Employment services fragmented, low expectations of work	Local labour market
Few qualifications/skills	Health services, including advice to refrain from work	Local factors, e.g., living in social housing
Limited work experience	Support services, e.g., reducing support packages when in work	Transport and travel to work
Family composition and expectations		Employer practice and perceptions
Low confidence and self-esteem		

4.2.1 Personal characteristics

Surveys of incapacity-related benefit recipients suggest that impairment is one of many barriers to work; only half thought they were unlikely to get a job because of their condition, and 41 per cent said they were 'too sick or disabled to work'.[49] It has also been suggested that the situation of about 70 per cent of people on IB cannot be understood in purely medical terms.[50] However it may be difficult to distinguish between the impairment and other characteristics, as the impact of impairment can vary by age, education and other contexts.[51] For example, younger people may be more likely to see others' prejudice as a barrier to work than older people.[52] This section considers the interactions with other factors in order of importance as indicated by the Labour Force Survey analysis.

Older working age people are more likely to develop an impairment, be out of work, and less likely to leave IB for work.[53] Unemployment rates are higher for disabled than non-disabled people of the same age.[54] Older people were less likely to get advice about training/jobs from ONE advisers.[55]

Quantitative data shows that disabled people are more likely than non-disabled people to **lack qualifications**, at all ages.[56] Non-disabled people were twice as likely to have been in further education than disabled people, the latter often excluded from Further Education because of access issues or discrimination.[57] Four in ten people on incapacity-related benefits had no qualifications, twice as many as unemployed people, and 15 per cent had problems with literacy and numeracy.[58] Having a qualification can increase the chances of getting work by 30 per cent for men, and 48 per cent for women.[59] However, even with professional or degree qualifications, disabled people are less likely to be in a professional or management career than non-disabled people.[60] Disabled people who used personal assistance (those often considered unlikely to work) were slightly more likely to have qualifications at degree level or above than disabled people not using assistance, and were more likely to be working if they had A' levels and above, but far less likely if they had no qualifications.[61] One possible interpretation is that, for some people, qualifications can overcome the 'disability' disadvantage - but it is unclear if this is so, or to whom or in what circumstances it might apply.

Lack of recent work experience could be a barrier; a survey of incapacity-related claimants found that people with recent work history (and shorter periods on benefit) were more likely to get a job than those with longer periods out of work.[62] People were more likely to leave benefit for work in ONE areas if they had worked within the last two years.[63]

Household and family composition can also be significant. People on IB with a working partner have been more likely to find or want work, particularly women.[64] Perhaps the personal and financial risks of work are lessened by a working partner; however, of those receiving incapacity-related benefits, lone parents and people living with others (such as parents) also had better chances of work, so either the opportunities were more favourable to those groups or there were fewer financial barriers (like housing benefit).[65] Evidence about whether helping one partner to find work and the other partner following, is more speculative, as couples can be similar across a range of characteristics, including health problems (affecting about half of workless couples), which also reduce their chances of work.[66] For disabled people,

the presence of a child under five could reduce the odds of a disabled person looking for or entering work by 30 per cent, and older children (aged 5-12) by 20 per cent.[67] For people receiving IB, the impact of a dependent child seems greater for men than women.[68] Almost one in ten disabled people also have **caring** responsibilities, which can be an additional barrier to work.[69] Families of people with learning difficulties often had **low expectations** of their work ability, which could be a self-fulfilling prophecy.[70]

Half of participants in the New Deal for Disabled People had **low confidence and self-esteem**, which could be a significant barrier to work.[71] Many disabled people want work, but fear an adverse effect on self-confidence if unable to sustain it.[72]

Minority ethnic status can also be an added disadvantage but this does not seem to be as significant as lack of qualifications and age. [73]

Conclusion

Age and lack of qualifications are significant barriers to employment for disabled people. Further consideration of family circumstances could help to open up employment opportunities for both a disabled person and their carer. As with lone parents, the age of a child could be an important influence on whether a disabled person wants work, suggesting that invitations to participate in schemes could also be triggered by the age of youngest child. Further investigation of the impact of family and household composition and attitudes is needed to test out these ideas.

4.2.2 Systems barriers

Some of the systems set up to help disabled people can also present barriers to work, through institutional practices or staff attitudes based on medical model assumptions. The attitudes and practice of employers are considered below under 'environmental' barriers, rather than within systems that have an impact on the lives of disabled people.

The rules and structure of incapacity benefits can create disincentives to work, stemming largely from the need to maintain 'incapacity' as the basis for entitlement, generating considerable fear of losing benefit. Hence people can be deterred from attending work-focused interviews for fear of putting their benefit at risk.[74] Incapacity status often conflicts with the potentially more helpful concessions (like permitted work); in practice, some people have not been allowed to do such permitted work, even when an adviser had helped them find it, whilst others have been referred for a PCA (to review their entitlement) shortly after starting their job.[75] Benefit recipients in an 'expert patient' role (helping others to manage their condition) might be putting their benefit at risk. People could also lose IB or the extra costs benefit, Disability Living Allowance (DLA) if engaging in rehabilitation.

Earnings limits can be low, especially for means-tested benefits (£20 a week disregarded) or relative to previous earnings. People can fear they will be worse off in work, younger people being more worried about the financial implications of working and managing until payday than older people.[76] Financial incentives may differ depending on the combination of benefits and family circumstances. Overall,

one in ten people cited loss of benefits as a barrier; the extra costs associated with work could also be a worry.[77]

People can also be concerned that if the job does not work out, they would be unable to re-qualify for benefit.[78] Linking rules can reduce the risk of working by allowing people to reclaim benefit at the original rate; however in practice this may not happen if people are unaware of these rules or encounter problems in using them, which could be a disincentive to try work again.[79] Lack of information about in-work benefits and tax credits means they cannot be an incentive, compounded by limited information amongst advisers.

Employment services can be fragmented and lack cohesion.[80] Perhaps as a result, many disabled people have lacked knowledge about adaptations or financial support available.[81] People on IB can sometimes face difficulty gaining access to programmes for the long-term unemployed because of their benefit status (see section five). Research from the ONE pilots and Jobcentre Plus Pathfinders shows that, even with a 'work-first' service, there have been obstacles to success, including:

- Advisers have not always raised work issues, often lacking confidence in dealing with disabled people and uncertain of their ability to cater for the full range of needs presented by such a diverse group;

- Advisers lacked knowledge of services to help disabled people move into work or closer to it;

- Few disabled people had discussed with advisers how health problems affected work; people with both physical and mental impairments reported that that meetings with advisers had failed to provide them with the information they needed, in particular benefits advice.[82]

Helping disabled people into work will be a huge challenge to Jobcentre Plus.

In the past, professionals and organisations set up to help disabled people have had low expectations of their work prospects.[83] Consistent with the medical model, ONE advisers assumed that benefit receipt determined closeness to the labour market, and so people on IB were considered unable to work.

Health and support services have also been influenced by the medical model. GPs are often uncertain about assessing fitness to work or encouraging rehabilitation.[84] Advice from a health professional not to work has been a factor in losing a job, as well as a disincentive to try to return to work.[85] Social services staff can assume that disabled people do not work, so the capacity to hold down a job can sometimes be seen as demonstration that people are no longer, severely disabled.[86] As a result, individuals can risk losing their support package.[87] Work aspirations have not been routinely included in assessments, and it unclear whether welfare to work plans have had an impact in practice.

Conclusion

At a systems level, a short-term response would be to change the benefits system so as to reduce negative consequences of claiming benefits (longer term changes are outlined in section 6). Employment advisers and health professionals need to have

higher expectations of what disabled people could do, and assumptions and procedures about impairment need to move from a medical approach (sickness) to include a greater emphasis on adjustment (disability).

4.2.3 Environmental barriers

The environment in which people live can also present barriers to work, including the availability and suitability of jobs in the labour market, the perceptions and practices of employers, as well as transport and housing.

Where people live can have an impact on work prospects. **Social housing** has become increasingly associated with reduced chances of work; disabled people were less likely to be in work if they were social or private tenants rather than homeowners, though this is likely to reflect broader disadvantage (and so becoming home owners may not necessarily improve job prospects).[88] Difficulty travelling to work or using public **transport** can be additional barriers; one in ten people in poor areas turned down a job in the past year because of transport problems.[89] 12 per cent of disabled people in work had difficulties travelling to their job, including getting to and from bus stops and getting on or off buses and trains; lack of reliable local public transport was a particular problem in rural areas.[90] Having a driving licence or access to a car was associated with getting a job.

Disabled people have also been affected by **changes in the types of jobs available**, including the decline in demand for low-skilled labour.[91] Some jobs may no longer exist, or there is a 'mismatch' between skills gained in older industries and those required by newer jobs; people moving from welfare to work could also be more at risk of redundancy, particularly if older and with less training in the new job.[92] ONE participants lacked awareness of transferable skills, so many were unable to consider their options fully, and even considered returning to previous jobs despite possible health risks.[93] Half felt that the opportunities locally for the type of work they wanted were poor (as this perception did not vary by pilot or control area, personal advisers had not altered this view).

The **local labour market** is an obvious barrier to work, particularly in areas with high concentrations of people claiming disability and unemployment benefits. People on IB have been described as 'hidden unemployed', implying that under different labour market conditions they might work.[94] This is consistent with the view that disadvantage is primarily about local labour markets and only secondly about individual characteristics, more disabled people being employed in high employment areas.[95] However, even in areas of high unemployment, disabled people still want and get work: in one study, 15 per cent in the weakest labour market position were keen to work; and significant proportions of PAS participants found work in such areas.[96] This indicates that locality is not always a barrier, though why some people move into work in these areas is unclear.

The labour market can also influence leaving work in the first place. Health was a more common factor in rural or higher employment areas (like Northampton), less likely in slacker labour markets (like Barnsley) where most people lost their jobs through redundancy; once out of work, twice as many in Northampton wanted work than in Barnsley.[97] However, Barnsley IB claimants were more likely to have a

pension, redundancy money, own their home outright and not claim means-tested benefits, which may have influenced their desire for work.

Employer practice and perceptions can be important, as most people are in work when their impairment begins. Not all leave for reasons related to their condition: three out of ten working disabled people changed their job completely or partly because of disability, though only one in five felt their current job was worse; a quarter experienced discrimination.[98] Employer attitudes were often perceived as a barrier, even by people with invisible impairments; so it is not surprising that some disabled people do not want prospective employers to know about their health or disability.[99] Non-disclosure might be a factor in sustaining the perception of some employers that disabled people do not apply for their vacancies: more than half of small firms said they had never knowingly employed a disabled person, mainly because none applied.[100] Many employers also seem unaware of the kinds of impairments their workers might have.[101]

Awareness of the DDA by employers and service providers remains low; many did not know or understand the potential needs of disabled customers and were being reactive rather than anticipating what may be required.[102] Employers also seem more willing to recruit lone parents and jobseekers rather than people with physical or mental health problems, the latter raising most concerns in the workplace and in interaction with colleagues or customers.[103]

Conclusion

At an environmental level, confidence building when learning new skills, good advice about alternative occupations, and initiatives to support a return to work in a new field are important. Significant numbers appear to want work even in areas of high unemployment, so employment opportunities in those localities need to be developed (see section six).

4.3 Barriers at different stages of distance from work

So far, this section has discussed different 'layers' of barriers to work at individual, systems and environmental levels. Cutting across these layers is the concept of 'distance' from the labour market. The medical model assumes that impairment alone places someone far away from work; the interactionist perspective, however, suggests that other factors are important at different stages of distance from work, and so the task is address those factors so as to help people move closer to work. Employers can also be seen as being at varying stages of 'readiness' to employ disabled people.

The relative importance of different barriers could change depending on how distant someone is from work. For instance, evidence suggests that benefit recipients who were considered most likely to find a job thought the main obstacle to work was 'external', i.e., not their personal attributes, whilst those least likely to work thought their impairment was the main barrier (Table Three). Those who moved into work were more likely to have said that their main barriers were unemployment and employers attitudes.

Table Three: Main barriers to work by likelihood of finding employment

	Most likely	Fairly likely	Less likely	Least likely
Too many unemployed	37	15	11	10
I'm too impaired	14	25	36	39
Employers think I'm too impaired	26	22	12	12

Source: Rowlingson K and Berthoud R, 1996, 'Disability, benefits and employment', DSS Research Report 54

Similar results were obtained in the more recent study of incapacity-related benefit recipients, where those **looking for work** perceived the main barriers as absence of jobs, rather than health problems; they were half as likely to cite their health condition as a barrier than those wanting work in the future or needing rehabilitation.[104] ONE clients looking for work were more likely to say that barriers were lack of jobs locally (50 per cent), the kind of jobs available, low confidence (49 per cent) and age (45 per cent); those not looking for work were more concerned about health (59 per cent).[105] People closer to work were more likely to see finances as a barrier.

Those **not expecting to work** tend to have been on benefit longer, and they are less likely to consider that the jobs available locally and lack of skills/experience were barriers.[106] People who move from IB to Jobseekers Allowance (and therefore expected to actively seek a job) were less likely to feel ready for work; a quarter had both physical and mental health problems, they were unlikely to report improved health, were more pessimistic about their chances of work, and most faced multiple disadvantage and barriers to work.[107] This is one of the consequences of the current benefits structure separating people into capable (jobseekers) or incapable, discussed in section two above (for long term solutions see also section six). In contrast, one study also found that people receiving DLA, which is payable to people considered to be severely disabled, but irrespective of work status or other income, were more keen to work than people on other qualifying benefits, though reasons why are not clear.[108]

Disabled people may be less likely to see themselves as disadvantaged once they have a job. However, even when in work, barriers remain, including continuing impairments.[109] Of people who started work after seeing a Personal Adviser, one in five subsequently left their job; those who had not disclosed their condition to their employer could experience recurrence of symptoms, which could be difficult to manage, or had financial problems.[110] US evidence suggests that pre-existing barriers may emerge, or new problems may arise.[111] Co-operation from employers was needed to help people with physical problems retain employment, and additionally for people with mental health problems, support from co-workers. This suggests that barriers do not invariably melt away as people go into work, but need to be anticipated and overcome.

4.4 What triggers movements towards or away from work?

Relatively little is known about what helps disabled people move closer to work. Some possible triggers from the evidence to date are outlined below.

Improvements in health condition can prompt job search or work.[112] Over a period of about 20 weeks the health of more than a quarter of disabled ONE participants improved.[113] Others (including those who regarded work as an immediate prospect as well as those seeing it as a long term prospect) had **learned to manage their condition** and moved into work.[114] There may be scope to explore 'health'-based interventions in the early stages of a claim, as proposed in the 2002 Green Paper. However, this will not be a solution for everyone; some people (such as with learning difficulties) have conditions that will not improve, often with other barriers like poor literacy and numeracy, inability to use public transport alone.[115]

People may move closer to work if **helped to identify and tackle some of the barriers** (such as gaining new skills or confidence).[116] Evaluation of small-scale projects indicates that people's perceptions of barriers may change if helped to identify them, concerns shifting from internal to external barriers, and with help to overcome them.[117] Confidence levels might also increase by upgrading skills.

Generalised fears about **finances** may become prominent at particular stages of distance from work, or under certain family circumstances (disabled people with young families or younger disabled people living at home). The appeals process also has an impact (perhaps reinforcing the need to maintain incapacity status), as those challenging an IB disallowance were less likely to get work.[118] The 2002 Green Paper proposals that people in the pilot areas will receive employment help may make some difference to this.

One partner getting work could be associated with the other partner moving closer to work.[119] Conversely if one moves further away, the other may be drawn in the same direction. Factors pushing people further away from work also include a **poor relationship with advisers**, and lack of follow-up.[120] **Advice from health or other professionals not to work**, a factor in job loss, has also been a disincentive to return. A **negative experience** of working, returning too early, or a job interview before feeling ready, could reinforce low self-esteem.[121] Delays in obtaining assessments or programmes can also sap motivation.[122]

Other circumstances changing might make a difference; for example, **transport** to and from work might make it easier to take up paid work.[123] Finding a **sympathetic employer**, or **not disclosing impairment**, or having **a trial period at work** to prove what they could do, could overcome employer attitudes. **Access to Work** help (especially travel to work and support workers) could be crucial to take up work, though most applicants are already in a job.[124]

A mechanism is needed to identify actual prospects of work and what can move people closer to work (see section 6).

4.5 Employers' readiness to employ disabled people

This section has focussed on barriers at different levels faced by individuals and it may be possible to construct a similar approach for employers. As a first step, the interactionist perspective could help to develop a similar approach to analyse the barriers facing employers. An attempt to outline some barriers appears in Table Four, based on existing research into employer perceptions (though this is speculative as more information would be needed to develop an adequate analysis).

Table Four: Potential barriers facing employers at different levels

Employer	Systems	Environment
Lack of experience of disability/DDA awareness	Limited information about support, adaptations	Sector and type of work
Perceptions at all levels (e.g., costs/hassle)	Poor job matching	Economy/business case may not be clear
Size		Locality?

Similarly, employers can be grouped according to their readiness to employ disabled people. Employers can be seen as engaged, prepared or active.[125] Survey evidence suggests that employers who are active in their encouragement of disabled people are more likely to:

- Already have disabled employees;

- Make adjustments, if needed, to recruit and retain disabled staff;

- Have a written policy on employing disabled people.[126]

Around one in five employers (but six per cent of small firms) actively encouraged recruits. DDA awareness was higher among those with disabled employees. There has been an increase in the proportion of employers giving active encouragement to disabled employees, and more have written policies, though they remain a minority. Larger and public sector companies are more likely to have a written policy and to be disability symbol users.

As with disabled people, employers are diverse in their size, sector, locality and willingness to encourage disabled applicants. But far less is known about the triggers to becoming more active in encouraging disabled employees. However evidence from the PAS and NDDP to date suggests that:

- **Positive experiences** of disabled employees could encourage future engagement (which indicates increasing the number of employers using JobCentre Plus and Job Broker services);

- In some cases, **financial incentives** could make a difference for smaller firms if offered at the right time;

- A Personal Adviser with **knowledge of the employers' business** (and adapting the business case for employing disabled people), being easily contactable can help make a 'good match' between individual and employer.

More research is needed to develop a similar conceptual framework for employers by readiness and levels of barriers to that developed in this paper for individuals. Far more also needs to be done to engage with employers on a policy and practical level.

Conclusion

Viewing the different levels of barriers to work for individuals by distance from work implies that by systematically removing them, people stand a better chance of moving towards work. However even when in work, further follow-through is needed to ensure that employment is sustained. Better knowledge of the triggers to changing distance could help to identify appropriate times and levels of intervention. Ways of measuring and identifying who wants work is needed so as to distinguish expectations from vague aspiration. More research is needed to develop a conceptual framework of readiness of employers to engage by levels of barriers and triggers to becoming more active.

The next section considers the success of existing 'bridges' back to work.

5. Bridges to work

The medical model emphasises the difference between disabled people and others, leading to specialist provision to meet 'special' needs. Traditionally, this has been aimed at those assessed as having lower productivity, leading to subsidies for employers (as compensation for reduced productivity) and segregated provision, with little opportunity to progress to open employment.[127] Specialist disability teams and advisers also administered help with adaptations, equipment and support workers. The emphasis is now more on placements by a sponsoring organisation in open employment. Disabled people have been assumed to go through specialist schemes, though this can reinforce the 'disability' rather than ability as potential employees.[128] These schemes have tended to assist unemployed disabled people or those already in work, rather than those on IB. Even so, most unemployed disabled people have been dealt with by mainstream advisers; fewer than one in ten used specialist Disability Employment Advisers.[129]

5.1 Participation in New Deal and ONE

Participation in the PAS pilot tended to be low, at about six per cent of the eligible group. Whether PAS participants were closer to the labour market is not completely clear; only slightly more participants than survey respondents said they actually expected to be working in the future.[130] Advisers' perceptions were that PAS participants ranged across a spectrum of 'work-readiness', from the most ready (1) to the least (6), who:

1. Identified a specific job, saw no major barriers, wanted financial advice;

2. Identified a specific job but were concerned about fluctuating health problems (including mental health), perhaps wanting a gradual return to work. Some were influenced by financial pressures;

3. Were seeking work, felt there were few suitable jobs and employers' attitudes were against them (including young people who had never worked);

4. Were seeking training, the largest barrier being lack of qualifications;

5. Were a long way from the labour market, anxious about their ability to work, perceiving high barriers, including lack of qualifications and financial insecurity, but had no clear idea of how to overcome them (perhaps emerging from a traumatic life event e.g., relationship breakdown, which distracted them from thinking about work);

6. Were a long way from the labour market, with considerable health concerns, mainly engaged in domestic activities and unsure how to move closer to work. They may be dealing with onset of impairment, or older people with deteriorating health.

Picking up the different levels of barriers as outlined in section four, and the different effect they may have on people at different stages of distance from work, the six groups of PAS participants are placed into categories in Table Five below. Some groups may appear at more than one level.

Table Five: PAS participants by barrier and distance

DISTANCE	LEVEL OF BARRIERS		
	Individual	**Systems**	**Local environment**
Not want work	6 – health/domestic concerns 5 – anxious about ability, lack of qualifications	5 – finances, need help to identify how to overcome barriers	
Want work	2 – fluctuating health	2 – fluctuating health/finances	
Looking for work	4 – qualifications	4 –training offered 1 – financial advice	3 – suitable jobs/ employer attitudes

Source: Developed from Loumidis J et al, 2001, 'Evaluation of the New Deal for Disabled People Personal Adviser Service pilot', DSS research report 144. The numbers here correspond with the stages of work readiness as identified by Loumidis.

The trigger to participate in the PAS seemed to be circumstances, rather than a set point in time; the invitation came at the right time, e.g., when trying to get a job on their own or asking about training/qualifications; others wanted more specific help e.g., benefits, self employment.[131]   Conversely, poor health, not knowing enough about it, being too old and not considering themselves as disabled were reasons for not participating. Anxiety about previous contact could put off later entrants. There have also been concerns about using the PCA as the forum for inviting participation in the New Deal for Disabled People, when the PCA is the gateway to benefits based on incapacity.[132]

Reasons for not participating in ONE included the belief that it was not relevant, inappropriate timing, or the claiming experience (past and present) was off-putting. In addition, for sick/disabled people, either the work focus was not considered appropriate (having left work because of illness or disability), or their claim was likely to be short term. People were unlikely to see an adviser more than once, as caseloading for sick and disabled clients was rare, with work centring on chasing benefit claims.[133]

5.2 Effectiveness of programmes

The specialist schemes remain significant in assisting disabled people; during 2001-02, 23,000 people attended Workstep programmes (supported employment), 32,500 were helped by Access to Work, 7,500 went on Work Preparation (formerly rehabilitation) and 2,100 received a wage subsidy.[134]

The PAS pilot may have helped some people with work activities but there is little evidence that significant numbers moved into work.[135] 24 per cent said they got work and 60 per cent said they started looking for work or increased job search after seeing a personal adviser. 8,200 people obtained employment as a result of the two-year pilots. However, it is possible that only 100 extra people left benefit as a direct result.[136] The New Deal for Disabled People (NDDP) innovative schemes

were likely to be less successful if dealing with people more distant from work, and with more complex needs.[137] Since the begnning of the NDDP National Extension (July 2001), almost 28,000 people have registered and over 6,000 found a job. One broker organisation went into liquidation, apparently due to low take-up and outcome-based funding.[138]

The ONE pilots also found that people getting jobs had fewer of the barriers to work identified above. Over a period of five to six months, one-fifth of disabled ONE participants found work of 16 hours or more (nearly two-thirds returning to a previous employer), and were mainly white, home owners, with qualifications, recent work experience and no work-limiting impairments.[139] Also important was having a driving licence, car or telephone; and, for a small group of people, receiving child support payments. However, ONE did not increase the probability that disabled participants would leave benefits for work.[140]

Schemes without a disability label

The 2002 Green Paper acknowledges that many people on IB do not perceive themselves as disabled and so have not necessarily seen 'disability' programmes as relevant to them. However, there remains little information to indicate what works, and for whom, nor how or why disabled people go through one programme in preference to another. For instance, a third of New Deal 50Plus participants had a health problem or disability, but 5,113 people previously receiving IB moved into work.[141] The New Deal 50Plus broad eligibility, simple approach and financial incentive might attract people in preference to the New Deal for Disabled People.

There may be scope for more specialist skills, as proposed by the 2002 Green Paper, as disabled people may need support and guidance from people who understand disability and their needs in relation to employers.[142] However experience suggests that the most effective approach to 'mainstreaming' is generalist provision, taking into account the needs of disadvantaged groups in the services provided, combined with specialist co-ordinating structures offering advice and techniques for mainstreaming and policy development, and monitoring how mainstreaming operates in practice.[143]

In the longer term there may be advantages in having a single New Deal, with different components, rather than separate ones based on benefit status.

Conclusion

Little is known about the effectiveness of employment programmes. Evaluation of mainstream projects needs to include more detail about health problems/disability, to identify which features work best and to enable comparison between programmes.

The next section considers what might be needed to help develop policy in this area.

6.   A policy framework

The tension between income and employment policies described above suggests that there may be a need for a new policy framework to integrate different policies into a more coherent direction. Policy-makers can be heavily influenced by medical models of disability.[144]   Viewing disability as an individual problem can lead to dealing with the consequences of the failure of other structures, and responses to one problem can create another.[145]   Solutions based on a 'static' view of the problem can also result in a disparate group of people being treated the same way, rather than understanding any different patterns involved.[146]

6.1 Policy-making for processes and transitions

As noted above, there is growing interest in a 'dynamic' approach to social policy, which can change the kinds of intervention, the risks of adverse events and mitigating their effects.[147] This can include:

- Prevention of an event or reduction of risks (e.g., job retention);

- Promotion of exit or escape (e.g., welfare to work);

- Protection from impact of the event (e.g., cash benefits);

- Propulsion away from adverse circumstances (e.g., in-work benefits).

The first two concern risk reduction, the others, consequences. Achieving one of these is certainly progress but addressing all four of these categories in a **cohesive** way would be the ultimate aim.

Focus of intervention	Risk of event	Effects of event
Entry to adverse state	Prevention	Protection
Exit from adverse state	Promotion	Propulsion

Identifying which factors increase the risk of adverse events later on can be difficult, as higher odds do not always predict actual outcomes. Less is known about people who have successfully made transitions into work and progressed, or moved off benefit than those who have not.

In relation to disability policy, the policy emphasis has traditionally been on protection (benefits) and propulsion (in-work tax credits) with only recent attempts to deal with entry and exit in relation to work. The 2002 Green Paper addresses some of these, for example, promoting exit from an adverse state (rehabilitation pilots for those out of work) and propulsion (the return to work credit). Additional objectives for disability policy could include:

- Reducing risks of transitions (e.g., interventions for job retention);

- Reducing costs of transitions (e.g., Access to Work/benefit run-ons);

- Reducing negative transitions (e.g., avoidable job loss) or negative consequences of transitions (e.g., help with job search and financial support that allows the flexibility to try out work).

It is also important to distinguish between impairment and disability: there is a case for policies to promote occupational health (including health and safety) to **prevent impairments** developing in the workplace, in tandem with policies to promote adjustments to the environment to **prevent the impact of impairment becoming disabling** (by exclusion from work).

A focus on transitions can include considering policies to promote welfare to work and reduce the incidence and negative consequences of job loss.

Preventing job loss

Key issues in intervening in job retention are identifying individuals at risk and how to help them. Evaluation of the job retention component in the PAS concluded that as it was hard to predict those at risk of job loss, we could not know what interventions were successful. International evidence suggests that combinations of interventions could be important, including job protection and financial incentives from the benefits system.[148] Strong job protection and generous benefits promote work with the former employer; where both are weak, more people returned to work with a new employer, but weak protection and strong benefits worked less well in returning people to work.

There can be four different stages in the development of a problem; preconditions, causes, effects and consequences. Intervention might occur between any of these levels (primary, secondary and tertiary intervention respectively). [149] Table Six summarises how this idea could be adapted to job retention.

Table Six: Stages and intervention levels in job retention

Stages of problem	Levels of intervention	Objectives of intervention	Actors/agencies
Precondition			
↓	Primary	To reduce risk of job loss generally	State infrastructure: broad policy level, eg legislation (health & safety, DDA)
Cause			
↓	Secondary	To ensure policies and practices promote retention	Workplace: employer, GP, rehabilitation services
Effect			
↓	Tertiary	To reduce the odds of job loss once a particular individual is at risk	Once an individual is at risk: availability of information/support, action of personal advisers etc
Consequence			

A framework could help to ensure cohesion between the different layers (so that policies for individuals are consistent with policies for employers).

6.2 Some systems-level changes

The interactionist perspective poses slightly different questions to the medical or social models. The problem may not be located at an individual level but in the functioning of a system; hence the solutions are not to 'cure' an individual but to repair flaws in a system.[150] One example of such a question is the concept of 'sustainable livelihoods', where, rather than just asking 'how many are poor' the question becomes 'what are the assets, resources (which can be influenced by policy design and delivery), capacities and activities required for someone to sustain a living'.[151] In disability terms this could mean asking what is needed across the range of systems for someone to gain and sustain work.

Section four described barriers at different levels which can identify what changes might be needed at those levels. Tackling some of the barriers strategically is within the scope of government agencies (though often in partnership with others). There is an obvious need for more policy-making to focus on cultural change, giving top priority to increasing the numbers of employers becoming active in employing disabled people. Other systems-level changes are suggested below.

1. Expanding employment opportunities

Although the local labour market may not be the prime disadvantage faced by disabled people, solutions have to lie where people live, especially in areas with high concentrations of claimants. Many claimants may want the kind of work that has disappeared in some areas; as well as barriers of age and health, magnified in local labour markets with too little diversity and demand, many claimants face a lack of appropriate retraining that might allow some of them to compete in the new jobs that are available now or in the future.[152] Sectoral strategies may be needed, as well as more tailored local and regional interventions.

Jobcentre Plus now emphasises marketing direct at and supporting employers, with a new Employer Services Directorate and Local Account Managers. As part of its role in aiming to be a major recruiting agent for employers, Jobcentre Plus could ensure that businesses are fully aware of the support available (such as Access to Work), the benefits of recruiting and retaining disabled people, and their obligations as employers and service providers under the DDA especially in the light of further implementation in 2004. Such a strategy could also highlight that most adaptations are possible at no or little cost. If the numbers looking for work increase, expansion of the employer base used by Jobcentre Plus will be needed. Jobcentre Plus could also act as a 'model employer' by recruiting more disabled people as Personal Advisers.

As well as engaging with local employers, some of the 'intermediate labour market' solutions already adopted by organisations like the Wise Group for long term unemployed people (and more recently disabled people) could be developed. This could include adapting the 'neighbourhood match' approach within Employment Zones (linking community needs with the provision of jobs), or 'Step-Up' (aiming to give the hardest to help a guarantee of a job for a year), or the other forms of transitional work often associated with disability (social firms or supported employment like Workstep). Whilst disabled people are commonly assumed not to want full time work, most do; women are more likely than disabled men to prefer part

time work, more for family reasons than impairment.[153]   Any expansion strategy could also include exploring the scope for more part time work, perhaps with a focus on disabled women and for people with progressive conditions or mental health problems, who may be more likely to want this pattern of work.

2. 'Rehabilitation'

The 2002 Green Paper proposes testing out different rehabilitation interventions to help people cope with their condition and employment-related assistance. We may also need a better understanding of what measures are effective and under what circumstances. Problems with previous rehabilitation schemes have included patchy and fragmented provision (often associated with contracting out), the limited range of skill areas on offer, and the lack of help with dealing with employer attitudes and practice.[154]   More recently, evaluation of Work Preparation (formerly called employment rehabilitation) noted that it is difficult to assess the link between vocational rehabilitation and return to work, as it can be difficult to isolate the effects of different elements of a programme.[155]   Neither does there seem to be much association between type of impairment and a successful outcome. Indeed, US studies suggest that for some people, supported employment can be as effective (in terms of employment outcomes and well-being) as traditional counselling or job clubs. Whilst there may be a role for some 'rehabilitation', it is likely that this needs to be integrated into other forms of assistance and linked closely to work experience and jobs. Provision could also be more evenly spread, and could be part of the role of English Regional Development Agencies and regional assemblies in taking a strategic view of employment. A better infrastructure of support may also be needed, including an expansion and upgrading of qualifications held by practitioners in the field of disability and employment, including a central body similar to the General Social Care Council.[156]

3. Benefits/tax credits

The 2002 Green Paper proposals imply major re-thinking of the current benefits structure. In the short term this could include more flexible combinations of work or training and benefits, including moving away from individual decision-making about permitted work towards greater use of collectively-negotiated concessions.[157] Waiving the daily incapacity condition could also be tested out, perhaps linking with the Green Paper pilots, so as to allow people to undergo rehabilitation without benefit being lost. Waivers might also be devolved to advisers or areas with high inactivity/unemployment. Linking rules could also be made easier to access and extended for longer periods of a guaranteed return to benefit, perhaps indefinitely for those exempt from the PCA.

In the longer term, more is required than changing the name of IB, as suggested in the Green Paper. The OECD recommended that disability should not be equated with inability to work, nor automatically seen as an obstacle to work (with benefit eligibility no longer based on work status). If additional payments for disabled people create disincentives to work or encourage a 'disabled identity'[158] there seems to be a case for change. In Australia, discussion about welfare reform has included a possible integrated payment for all working age adults, supplemented by extra costs payments.[159]   Similarly New Zealand merged its unemployment and sickness benefits into a 'community wage' for a period of time.[160]   This approach has

attractions as a longer-term aim for the UK, as a single income maintenance payment for people of working age (ending the distinction between JSA and IB) but with additional resources for disabled people being payable for extra costs (rather than for incapacity for work). This would be consistent with the objective of a 'level playing field' applied to personal assistance users and work.[161] It would entail some kind of profiling mechanism (see 6.3 below) so that distance from work and barriers could be realistically assessed; conditions of entitlement would also have to ensure that people were not expected to seek or take work that might be damaging to their health, or risk losing benefit as a sanction. One possible model might be the Child Tax Credit, perhaps using DLA as the foundation of a disability costs credit, combined with other payments that taper off as incomes rise (disability premiums within Income Support). This could be tested out (see below).

6.3 Identifying who needs what intervention

The current benefits system, based on an incapacity for work, also fails to provide a coherent approach to identifying which recipients want work and their distance from the labour market. According to Labour Force Survey estimates, about a third of disabled people not in a job want work; representing 480,000 people receiving IB in 2002.[162] It is unclear if this is a vague desire for work or a realistic appraisal of prospects. Of 350,000 disabled people who entered work during a year, about a third had not wanted work at the start of the year.[163] Other measures include asking people whether they expect to work (intended to be more realistic than a generalised desire for work). Over three-quarters of people on incapacity-related benefits said they did not expect to work, three per cent were looking for work, seven per cent wanted work but were not looking and almost 12 per cent said they would need rehabilitation or training first.[164] However, even with this approach, 35 per cent of those who said they could work and five per cent of those who said they could not, got a job within two years. More is needed to identify more clearly who wants work.

Given the diversity of IB recipients, some kind of 'targeting' may be needed to ensure that the right intervention is offered at the right time. Evaluation of international schemes indicates that this can be difficult to implement, raises issues of equity between groups (e.g. excluding people without recent work history); and targeting would also have to reflect characteristics that predict employment.[165] Not enough is known about these, and it would be important to avoid medical model assumptions when deciding which characteristics were important.

There are limited mechanisms to identify people who might want work; the Capability Report (CR), carried out at the same time as the PCA, is intended to identify work limitations and possible adjustments; but doctors, advisers or claimants have not found this particularly useful.[166] Assessments can be devised to either identify appropriate intervention or screen people out. 'Work Ability Assessments' are used in Australia to 'stream' clients into appropriate measures; although considered fairly successful, there has been some misclassification because of limited information – clients may not always disclose barriers and staff may be working under pressure of time.[167] Similarly Employment Zones categorise their clients by distance from work, using indicators such as age, personal barriers, benefit levels and previous experience, though these can be inaccurate in some cases.[168] It does, however, offer a model to follow, if adapted to address disability. The advantages of

Employment Zones are in the dual focus on individuals and employers; the sharp focus on getting people into sustainable employment; having the discretion to respond to individual need; and flexibility in funding and benefit arrangements through the 'Personal Job Account'. Disadvantages that would need to be overcome for this approach to be expanded include the incentive structure for contractors and frontline staff, as those who are hardest to help, including people with mental health problems, often cannot be linked up to other support services within the timeframe of the Zone. It has been suggested that job brokers could assess the work prospects and needs of people on incapacity-related benefits as a policy experiment.[169] People who could make such assessments may need to be better skilled and rewarded so as to avoid the problems with assumptions and expectations of employment staff detailed in section 4. Care would also be needed so as to avoid reverting to medical model assumptions, such as impairment determining distance (which could simply lead to a reinvention of the PCA).

The Employment Zone approach could be extended to test out key questions:

1. To what extent does the incapacity status prevent work? Different packages of Personal Job Accounts could test this out, including separating costs from income maintenance, including integration with other funds such as rehabilitation allowance. The PCA 'points' system might be modified so as to identify a 'costs' element associated with impairment (to sit with the current care and mobility components of DLA). This might also entail designing a new 'out of work' test for income maintenance benefits to replace the PCA.

2. Which groups of people on benefits have health problems/disabilities and are closer to the labour market and how can we identify them? An interactionist perspective on how to categorise might entail analysing barriers at personal, systems and environmental level, the potential triggers to and timing of transitions into work.

3. How should assessments be carried out? The OECD recommended that assessment should follow the WHO approach. An Employment Zone could also test out whether those who are expert in functional assessments (rather than doctors) could have a more extensive role

4. What are the main barriers to work for this group, their similarities and differences from other claimants, and testing out how they might be overcome? A range of general labour market experts and disability specialists could be involved in the design.

Finally in the next section, implications of the interactionist approach for practice are considered.

7. A practice framework

The interactionist approach not only offers a different policy emphasis, it can help with a new focus for practice. The discussion of barriers at different levels in section 4 noted that some of the 'systems' barriers included assumptions that can often unconsciously reflect the medical model. Attributing problems to individual deficits leads to a different response (often casework) than problems that emanate from a systems or environmental level. The interactionist approach can help practitioners identify and address the systems and environmental barriers at a local level, as well as offering individually tailored help. Some organisations providing employment or job broking support may already be practicing an 'interactionist' approach, though it may not be described as such.

7.1 Engaging employers

One major concern about the 2002 Green Paper, and other employment programmes, is that they tend to focus more on individuals than employers. This may change as the role of Local Account Manager develops, but it is already clear that the most successful projects are those where training and work experience is focussed on the immediate needs of local employers.[170] Employers are likely to need a range of assistance from practical help, through to confidence-building and ongoing support. As with individuals, employers are a diverse group, suggesting that work with employers also needs to be specifically tailored.[171] The Employers Forum on Disability has also developed an approach ('Recruitment that Works') which aims to take a more strategic and systematic approach to recruitment, involving employers and Jobcentre staff signing up to a project involving clear roles and a staged process.[172]

Employers are key partners, both on a strategic and local level, and individual employers need to be 'targeted' in order to match disabled people with suitable jobs as noted in section 4.5 above.

Employment Zones contain some important lessons for creating employment opportunities locally, aiming to help those furthest away from work. It differs from Workstep or supported employment in focusing on provision of services of value to low-income households and communities as well as helping people into sustainable (open) jobs.[173] Some other employment projects have a dual focus of providing a community services as well as employment (e.g. furniture project offering jobs to people with mental health problems).

7.2 Engaging the individual

Individually tailored support remains important, even when barriers are experienced at a systems or environmental level. Personal Advisers can be confronted with an individual but there is no inevitability about framing an understanding of their needs and responses to them in just one (medical) way. Intervention can be organised at different levels. For example, a purely 'casework' approach can limit perceptions of the problem (and solutions) to the individual, and lead to just processing individuals one by one. In social work practice, individuals and teams can hold collective myths

about their practice, unsubstantiated by factual analysis, so that broad patterns of problems in the area can be obscured.

The first stage could be to identify what the individual considers the most significant barriers; people may over- or under-estimate the impact of various barriers they face but their own views are a necessary starting point. Perceptions of other professionals and intermediaries dealing with the individual, as well as employers, are as important as 'objective' barriers. An analysis of barriers at differing levels, including the role of perceptions of players at each level, can help to identify solutions for the individual. At the same time looking at 'circles of support' (a wider network of social support such as friends, relatives, etc) can also help to identify resources that can help to tackle these barriers.[174]

Secondly, individual action plans can be compiled, allowing time to explore new options.[175] Key activities include both 'mobilising and supporting' and 'matching and mediating', taking place with both employers and clients.[176] Factors associated with success were having comprehensive pathways from the start (including intensive one to one support), seeing employment opportunities as integral to the pathway (i.e., having set up a job to go to), as well as targeting opportunities in the local labour market where there were skill gaps or labour shortages. Where people had multiple impairments, issues also included recognising the less obvious impairments, intervening early so as to prevent secondary problems (such as mental distress) developing, and recognising that motivation may be fragile.

In many cases people moving off sickness benefits need preparation and support to develop a positive mindset and confidence; support in job search and understanding of impact of impairment on certain types of jobs; and to be steered through more realistic training and job opportunities.[177] Work tasters may help with the transition back to work, especially for older people, such as knowing about the job before starting, more confidence and training.[178]

7.3 Identifying and tackling local systems barriers

Putting the concept of 'mutuality' into practice can entail identifying and tackling experiences that are common to others as well as the specific barriers concerning disabled people.

Barriers common to both disabled and other people out of work include:

- Lack of or few qualifications;
- Limited recent work experience or training;
- Lack of or outdated skills;
- Lack of confidence and motivation to find work;
- Negative attitudes of employers;
- Transport/travel difficulties;
- Living in social rented housing (though this may be a proxy for other disadvantages);

- Local labour market conditions offering few suitable jobs.[179]

It may be possible for locally-based generic projects, or Jobcentre Plus, to consider ways to bridge common barriers within their locality; e.g., group work can also tackle some of the wider problems of social exclusion; projects involving carers have found some of the most useful elements have been meeting people, raising self-esteem and confidence, help with practical skills like compiling a CV and information about jobs.[180] Group processes can also be important for raising confidence/self-esteem. Even for specialist projects, a mix of individual and group support can be valuable. Group work might also be able to address some of the common themes across impairments, including disability awareness and attitudes to work (including challenging attitudes and motivation).[181]

Area-based approaches to tackle common barriers could also include access to reliable and affordable transport as key for many groups, especially if jobs are located in out of town industrial estate, or for people in rural areas – plus employers are also increasingly wary of recruiting people without reliable independent transport.[182] As access to a car is important in securing employment for many out of work, there may be some scope for specific local schemes to enable access to private transport or low cost car loans. Adviser discretion funds could be used to assist with meeting local transport needs, as has already been tried with some New Deal schemes (e.g., mopeds in rural areas and bus projects), as well as using Access to Work resources for travel to work more strategically.

Developing skills audits locally could focus on what individuals can do rather than what they can't, with a view to matching them with needs within the locality, like a skills bank (such as former shipyard workers teaching in local secondary schools).[183]

8. Conclusion

This paper has argued that an interactionist approach can help develop policy and practice. In particular, Government has a role in tackling systems-level barriers, often in partnership with others. Government can also set a framework to reduce barriers at a local environmental level. Having regard to processes means that questions for policy and practice concern helping people to make successful transitions by ensuring that the right support is available at the right time. The interactionist perspective may be one way to help Government move policies away from a focus on 'incapacity' towards a focus on 'capacity'.

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