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Understanding mental health in the UK welfare system: insights from a secondary analysis of qualitative longitudinal research

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Introduction

Understanding mental health in the UK welfare system: insights from a secondary analysis of qualitative longitudinal research

The rising number of people claiming out-of-work benefits due to long-term health conditions is generating significant cross-party political concern in the UK at the current time. Within this trend, over two-thirds of claimants cite mental health problems among the reasons for their claim[1]. This situation has been building over more than a decade[2]. Successive governments have struggled to find effective ways to support people with experience of mental health problems to move off benefits and into fulfilling and sustainable work.

This study sought to better understand the experience of benefit claimants who are affected by mental health problems. We drew on a large archive of qualitative longitudinal data generated by an earlier academic study, the Welfare Conditionality Project[3], selecting a sample of 70 cases from a larger subset of participants who described experience of mental health problems. We conducted a Qualitative Secondary Analysis using narrative and thematic methods to explore in detail the relationships between mental health, benefits and employment.

01.

Main findings and policy messages

Capacity for work is about more than mental health

- All participants included in this secondary analysis had experience of mental health problems. Their distress was genuine, significant and at times severe. However, our in-depth narrative analysis revealed that the functional impacts of psychological distress were rarely the only thing constraining people's capacity for work.
- A complex range of social, structural, economic and interpersonal factors also limited participants' capacity for work. Considering employment experiences over time, it was evident that people's ability to sustain work had been shaped by factors including unstable housing and homelessness, relationship breakdown, violence and abuse, bereavement, lone parenthood, supporting children with additional needs, informal caring, debt and financial instability. It was often these same social, structural, economic and interpersonal factors that had led to the emergence of mental distress in people's lives.
- When seeking to return to work, participants' opportunities continued to be shaped by many factors beyond the direct emotional and physical symptoms of mental distress. Local labour markets, employer flexibility, financial viability of work, transport availability, suitable childcare, aspirations and preferences, training opportunities, fit with prior skills and qualifications, citizenship status, digital exclusion, amongst many other things, also shaped and constrained people's capacity to return to work.

- These experiences were lived out within the context of a welfare system that takes a predominantly medicalised approach to conceptualising people's capacity for work. For participants whose capacity for work was constrained by a multitude of social, structural, economic and interpersonal factors – including but not limited to mental distress – it was generally only their mental health symptoms that were taken into account by the welfare system when assessing their benefit eligibility and the conditionality that would apply. Our analysis starkly reflected the absence of opportunities within the current system for claimants to describe and receive mitigations for the wider range of work-related constraints that they faced.
- The consequence of this narrowly medicalised approach to understanding capacity for work is that claimants facing complex barriers *necessarily* have to utilise a medicalised framing through which to convey what is often a much more multifaceted set of circumstances preventing their return to employment. It is essential to acknowledge that people's distress is real, genuine and at times severe. But our analysis shows that it is rarely the whole story of what is shaping their capacity for work.

Why we need a more holistic approach to understanding capacity for work

- The problem of economic inactivity is currently being framed in UK welfare policy as primarily an individualised and medicalised problem of mental illness, rather than as the outcome of a complex range of social and structural factors that operate at multiple and compounding levels, often across the lifecourse. These factors include but, for many people, go beyond mental ill health. Yet, for most claimants, the only current alternative to a 'fit for work' status is one of medically-defined incapacity.

- This narrowly medicalised approach to understanding and assessing capacity for work means that claimants are rarely offered an opportunity to express the full range of diverse challenges that are constraining their ability find appropriate, sustainable and fulfilling employment. The resulting rise in mental health related claims may thus be seen, at least in part, as a self-fulfilling prophecy: of all the numerous and interrelated barriers and constraints people face, ill health is the only one that 'counts', thus it is the one that gets counted.
- This study concludes that we need a more holistic approach to understanding and assessing capacity for work. Where people are facing a complex combination of social, economic, structural and interpersonal challenges which pose significant barriers to work, the welfare system should acknowledge and make allowances for these factors *on their own terms*, not only via a medicalised framework that is limited to assessing the functional impact of manifest psychological distress.
- A more holistic understanding of work-related barriers and contingencies could offer a more comprehensive, meaningful and compassionate approach to support for people who are facing numerous interrelated constraints on their capacity for work, which include but go beyond mental distress.

Applying easements and rebuilding trust through person-centred support

- Statutory and discretionary powers already exist, to allow Work Coaches to make tailored adjustments to work-related conditionality[4]. More widespread awareness and application of these existing provisions for conditionality 'easements' could reduce the additional distress that is generated when mandatory jobsearch requirements are imposed on people who are facing significant *non-medical* constraints on their capacity for work.

- Expanding Work Coaches' use of discretionary conditionality easements would significantly improve the experience of claimants whose circumstances prevent an immediate move into 'any job' but who are willing and able to consider some forms of work, if appropriate support and flexibilities can be put in place.
- However, claimants' readiness to discuss personal and work-related challenges more holistically will rest on a much-improved level of trust between themselves and DWP staff. This means overcoming barriers that have been built up through many years of punitive conditionality perceived as forcing people to return to work, with the threat of sanctions for non-compliance.
- Fundamentally, our findings add to the call for a more person-centred and less punitive approach in the benefits system, where the emphasis shifts away from conditionality and surveillance to a system designed around compassionate and collaborative support to help people find appropriate employment at the appropriate time. Discussions and negotiations about what is appropriate need to include, but go beyond, considerations of mental health alone.

02.

Research method

This research project was a Qualitative Secondary Analysis drawing on archived data from the Welfare Conditionality Project 2013-2018[5].

Qualitative Secondary Analysis (QSA) involves drawing upon an existing data set to answer new research questions that were not necessarily core to the focus or aims of the original study. Secondary analysis may be carried out by members of the original research team and/or by researchers not connected with the original study. In the present case, none of our research team had been involved in the original project in which the data were generated[6].

The Welfare Conditionality Project archive contains over 1000 transcripts from interviews with 481 claimants of UK benefits, conducted over the period 2014-2017. Each participant was interviewed up to three times at approximately annual intervals. The original study aims were focused on understanding claimants' experiences and perceptions of sanctions and support in the welfare system. Our QSA project was specifically focused on the longitudinal narrative accounts of individuals who had experience of mental distress. We constructed a subsample of 70 claimant cases (182 interviews in total), selected from those participants who spoke in one or more of their Welfare Conditionality Project interviews about experiences of mental health difficulties.

Our central aim was to identify differing ways in which benefit claimants described, made sense of, and acted upon their experiences of mental distress, particularly in the social realms of welfare and employment. Through the combined use of thematic narrative analysis and a structured model of 'illness representation', we wanted to understand in greater depth the ways in which people's conceptualisations of their mental distress influenced or interacted with their experience of the benefit assessment process and of welfare-to-work obligations and supports.

Study sample

Our QSA sample was selected using a keyword approach, searching the full archive to identify the participants who used mental health related terminology most frequently. Keywords included: depression, anxiety, bipolar, schizophrenia, Post Traumatic Stress Disorder (PTSD), trauma, Obsessive Compulsive Disorder (OCD), anorexia, bulimia, and psychosis. This approach allowed us to locate the transcripts that contained the richest and most detailed accounts of mental distress. Our focus was on participants' own understandings of their lived experience; hence we did not use formal diagnosis or clinically defined conditions as an inclusion/exclusion criterion.

The self-reported age and gender of participants is given in Table 1, below. The sample included 11 participants of minority ethnic identity. Benefits claimed by participants in the sample covered a wide range of those available within the UK at the time the Welfare Conditionality Project interviews were conducted (2014-2017). These included Jobseeker's Allowance (JSA), Employment and Support Allowance (ESA), Incapacity Benefit, Disability Living Allowance (DLA), and Income Support for lone parents, with a minority of participants being early claimants of Universal Credit and Personal Independence Payment (PIP). Many were also claiming housing and childcare related benefits. For several participants, benefit status changed over the course of the longitudinal study. For this reason, and also due to lack of certainty about specific benefit status in a number of participants' accounts, it is not possible to give a meaningful quantification of benefit type across the sample. Significantly, however, not all participants who described experiences of mental distress had received health-related benefits and several moved between health and non-health benefits over time.

Table 1. QSA sample overview

	20s	30s	40s	50s	60s	TOTAL
Male	8	9	8	7	1	33
Female	6	13	12	6	0	37
TOTAL	**14**	**22**	**20**	**13**	**1**	**70**

Analysis

We used the archived interview transcripts to construct detailed chronological narrative accounts of each of the 70 participants' experiences of mental distress and its interplay with work and the welfare system over time. Our analysis explored the language people used to describe their experiences of distress, what they saw as the causes of their mental health difficulties, how the manifest symptoms of distress affected their capacity for work and other daily activities, and the broader context of evolving events and circumstances in their lives both historically and in the present time.

Use of verbatim quotes

Throughout the research findings chapter we include a number of verbatim quotes drawn from the research interviews. These include participants' descriptions of distress which some readers may find upsetting. Each quote is followed by a unique identifier indicating participant gender and the case number assigned within this secondary analysis study. Some quotes have been edited for brevity, indicated with ellipsis '…' and we have made some minor edits for clarity, indicated with square brackets [ ]

03.

Research findings

Claimants' conceptualisations of mental distress

To support our analysis of how people made sense of their mental health problems in relation to work and welfare, we applied a theoretical framework called the Illness Representational Model (IRM).[7] The IRM is a five-dimensional framework which considers how an individual perceives the **identity, cause, timeline, cure/control and consequences** of their illness. Table 2 provides a description of these dimensions with example quotes from the participant narratives.

Table 2. Overview of the Illness Representational Model dimensions (with data examples)

Dimension	Description[8]	Examples from the data
Identity	Ideas about the label and nature of illness and its associated symptoms	*"I also suffer mental health issues, like paranoia, anxiety. Mood issues. Thinking bipolar, I'm on* [medication name] *and things for that. I can wake up in the morning and feel I don't want to, I'm disappointed that I've woken up"* (M17)
Cause	Beliefs about why they developed their illness	*"Basically, eight years ago I became homeless, got a drug problem and just found myself on the streets for the first time. Managed to get myself off the streets and into somewhere pretty quick, but then my marriage breakdown happened and my mum's death and my other brother's death in the same year, bang, wallop, everything there crashed and I lost everything just like that."* (M20)
Timeline	Beliefs about how long an illness may last; whether it is a long or short term condition; whether there is potential of recovery	*"I've had it for years. I had a son that died, that was a long time ago, and I've had depression on and off since then."* (F20)
Cure/control	Perceptions regarding available treatment and how one's own behaviour can influence the course of the illness	*"I attend an art therapy group once a week. And that's something that helps me as well, you know, to manage my stress and my anxiety and my depression. So it makes you feel part of something, you know? Attending a group. And it's something I enjoy, as well."* (F22)
Consequences	The perceived effect of the illness on the individual's life	*"I'm not working. I'd love to work but I need that right support first. I want to work, I'm doing quite a lot of volunteer work which they're happy about that. But then in the next breath, you know, they're trying to get everybody to work. But there's a lot of responsibility and I'm not ready for that."* (F15)

As a secondary analysis, we were conscious of the likelihood of 'missing data'. An acknowledged risk of QSA is that depth and breadth of data on the focal topic of the secondary analysis cannot be guaranteed[9]. The original Welfare Conditionality study did not set out to gather detailed accounts of mental distress. Although participants were asked in the interviews whether they experienced any mental health problems, these experiences were not systematically probed in detail as this was not a primary focus of the original study. Our secondary analysis therefore relied on the extent to which research participants volunteered detailed information and reflections on their mental health experiences, and the degree to which interviewers in the original project chose to elicit further details of these experiences[10].

Despite these potential limitations, for most participants, we were able to extract at least some data – and sometimes a substantial amount – pertaining to the five IRM domains. In particular, we found that many participants spoke in some detail about identity (diagnostic labels and symptoms experienced). Perceived cause was mentioned by a majority of participants, as was cure/control (clinical interventions, other psychosocial supports and their perceived effectiveness). The most limited information was obtained regarding timeline (how long participants had experienced mental health problems and their perceptions of likely ongoing duration). Regarding consequences, we focused particularly on aspects pertaining to work/employment and were able to extract informative details for a majority of participants, forming a main theme of our analysis and findings, as we discuss later in this chapter.

Regarding **identity**, a wide range of diagnostic labels, terminology and description were used across the QSA sample. These included: depression, bipolar disorder, anxiety, panic attacks or anxiety attacks, paranoia, psychosis, psychotic episodes, schizophrenia, breakdown or nervous breakdown, OCD, stress, PTSD, disordered eating, body dysmorphia, personality disorder or 'BPD', emotional disorder, suicide attempts, suicidal thoughts, self-harm or thoughts of self-harm. Quantification of these diagnostic categories and terminology is not meaningful to our narrative methodology. Nevertheless, we can note that participants' experiences broadly reflected the greater prevalence of 'common mental health problems', with depression and anxiety by far the most frequently mentioned, and fewer instances of rarer diagnostic labels such as bipolar disorder, PTSD and schizophrenia.

Participants' explanations of the **cause** of their distress were multifaceted and often complex, with perceptions rarely centred on a single cause. Although some participants connected the trigger of their mental distress to a specific incident or episode in their lives (for example, a traumatic bereavement or violent attack), people tended to describe a combined, and often compounding, set of circumstances that brought about their mental health difficulties. Significantly, participants almost invariably cited broadly 'social' causes rather than biomedical factors. Causal explanations typically had a socio-relational and/or socioeconomic basis, for example, violence, abuse, caring, relationship breakdown, bereavement, financial strain, housing problems, homelessness, job loss, legal proceedings, and encounters with the conditional welfare system. The compounding effect of enduring multiple of these issues concurrently might also be conceived of as an additional causal factor in itself.

Reflecting the mind-body connection, some participants described their mental health difficulties as an upshot of managing and coming to terms with long-term physical health conditions or disabilities, and a few felt there may be underlying physical causes to the anxiety-like symptoms they were experiencing (e.g. thyroid or cardiovascular problems). However, only a very small minority of participants perceived their distress to have a directly biological causal origin, such as a 'chemical change' in their brain or inherited genetics. A thematic categorisation of participants' perceptions of the causes of their mental health problems is shown in Table 3.

The intertwined nature of causal factors is also important to highlight. For example, loneliness and social isolation were sometimes an upshot of intensive caring responsibilities for an ill or disabled relative; homelessness or insecure/unsuitable housing could be a result of domestic abuse, relationship or family breakdown; and financial hardship could be a result of welfare conditionality and sanctions. For many participants, recent and ongoing encounters with the welfare system were exacerbating factors in their more longstanding mental health problems, although for some, welfare conditionality – in particular the imposition of unfeasible or unsuitable work-related activity requirements under threat of sanctions – was perceived as the sole cause of their distress.

Table 3. Participant perceptions of the causes of their mental distress

Bereavement Traumatic bereavement (e.g. sudden death of partner, witnessing a murder, suicide of close friend, losing parent(s) during childhood/teens, multiple bereavements in succession, stillbirth or pregnancy loss, loss of a child); normative but emotional bereavement e.g. loss of an elderly parent, death of a pet
Adverse childhood experiences Childhood psychological or sexual abuse, neglect, family of origin involved in criminal activity, orphaned, care experienced, bullying
Caring responsibilities Caring for ill or dying relative (parent, sibling, child), caring for child or sibling with severe mental illness or disability, supporting ageing parents
Relationship and family breakdown Marital/partnership breakdown, associated financial and property issues, estrangement from children, child custody proceedings, child protection proceedings, children taken into foster care, strained relations with family members
Victim of crime Violent physical attack, victim of torture, kidnap, disability hate crime, mate crime[11]
Domestic abuse Psychological, physical, sexual or financial abuse; rape, date rape
Financial stressors Debt, severe financial hardship, managing household finances on low or insecure income, worries about meeting children's needs, associated material deprivation (e.g. hunger), unaffordable Child Support payments, benefit administration errors leading to reduction, delay or cease in payments
Housing issues and homelessness Insecure housing, unsuitable housing, poor housing conditions affecting physical health, victim of or accused of antisocial behaviour, rent arrears causing risk of homelessness, hostel accommodation, home repossession, having to move back in with parents, rough sleeping, sofa surfing
Work-related issues Work-related stress/distress, bullying at work, wrongful dismissal, job insecurity

Job loss and unemployment	Redundancy or dismissal, difficulty finding a suitable/attractive job, not getting a job that was anticipated/promised
The conditional welfare system	Experiences of Work-Focused Interviews and mandatory Work Programme engagement, encounters with/attitudes of DWP and Jobcentre staff, experience of WCA and/or PIP assessments, sanctions, Housing Benefit issues, being found ineligible for benefits
Long-term physical illness or disability	Managing conditions and impact on day-to-day living, adjusting to changed capacity and identity, awaiting diagnoses and treatment, trauma of botched medical procedures
Loneliness, social isolation, lack of social support	
Other	Armed forces service, interactions with the police and criminal justice system, neurodivergence (particularly whilst undiagnosed/unsupported), specific anxieties (e.g. driving), falling through of plans for further education, delays or hiatus in psychological treatment

Timeline was the dimension on which we were able to gather least detailed information, perhaps reflecting that gathering a full history of participants' mental health was not a key methodological aim for the primary research project. Drawing on the details that participants did recount, we can observe that some participants located the origins of their difficulties in childhood, whilst others cited events in early or later adulthood. Referring back to cause, what is notable overall is the number of participants for whom there had been multiple compounding difficulties over many years.

Linking together the cause and timeline dimensions, it is also important to highlight the *temporal dynamics* of people's distress. For example, several participants cited traumatic events in their childhood and adolescence – which (in retrospect) they identified as influential in the emergence of their later mental health difficulties. Subsequent experiences of further trauma and adversity (e.g. violence, abuse, poverty, homelessness, physical illness) re-triggered or exacerbated mental health problems later into adulthood. Numerous participants noted that the intensity of their depression or anxiety fluctuated over time, with some feeling that oscillations were unpredictable and one person noting a seasonal aspect.

Regarding perceptions of **cure/control**, the things that participants described in relation to treating, managing or otherwise ameliorating their mental distress are thematically grouped in Table 4, below. Perhaps unsurprisingly, almost all participants had at some point been offered prescribed medication to address their mental health difficulties. Many had also been referred to psychological therapies of various types. In relation to pharmaceutical and psychotherapeutic interventions, perceptions of usefulness varied. Some people found medication to be helpful whilst others did not. Likewise, some recounted very beneficial experiences of talking therapies but others found them ineffective or additionally distressing (e.g. attending group therapy or unearthing historic trauma). There were also experiences of long waiting lists, during which time mental health problems could exacerbate. Time-limited provision, or hiatuses in treatment due to staff turnover within mental health services, had also presented difficulties for some people.

Despite the prevalence of medical and psychotherapeutic input, it was notable that participants also described a wide range of more holistic cure/control strategies, including broader wellbeing enhancing activities (exercise, social engagement, volunteering, stress management) and the amelioration or alleviation, over time, of the material, financial or socio-relational circumstances that were operating as causal and maintaining factors in their distress. For some, this included the resolution of administrative problems with welfare benefits, or outcomes of Work Capability Assessments or appeals which resulted in the removal of unfeasible or inappropriate work-related obligations. Some participants described control mechanisms which, from an outside perspective, may be perceived as counterproductive (e.g. substance use) but which nonetheless helped them to endure ongoing challenges and adversities.

A number of participants had received support from specialist services (e.g. homelessness or drug rehabilitation[12]) and often cited a particular individual from within these organisations as pivotal in their recovery and/or resolution of material and economic issues. In the main, these professionals were spoken of positively, with favourable characteristics including being well-informed, compassionate, person-centred and dependable. These workers helped people to build up confidence and self-belief and facilitated practical access to services and support. However, there were instances of more difficult relationships with support workers, which had sometimes broken down or fallen away with staff turnover.

Table 4. Participant perceptions of cure/control mechanisms

Prescribed medication	Anti-depressants, anti-anxiety medication, anti-psychotic medication, opioid substitutes
Psychiatric intervention	Psychiatrist, Community Psychiatric Nurse, Crisis Teams
Psychotherapeutic intervention	Cognitive Behavioural Therapy (CBT), psychotherapy, counselling
Mindfulness and mindset	Mindfulness, mindset or gratitude practices, meditation, breathing exercises, self-help
Wellbeing and lifestyle approaches	Healthier eating, healthier sleep patterns, physical exercise (e.g. running, yoga, walking groups, gym; some via social prescribing), stress management courses, food psychologist
Creative activities and hobbies	Creative writing, art and craft, art therapy, learning a language
Engaging in social and community activities	Social groups incl. faith-based, community groups, peer support groups, volunteering
Organisation and future focus	Planning and structuring time, keeping occupied, having things to look forward to
Long-term support of a key professional	Social workers, housing support officers, drug and alcohol workers, care coordinators, vocational support worker, clinical therapists
Stabilisation of housing circumstances	Moving into more appropriate and better-quality housing, attaining a more stable housing situation
Financial stability	Resolving/stabilising benefit issues
Stabilisation or treatment for physical health issues	Physical health conditions being diagnosed, treated, medicated, brought under control
Social supports	Support from family, family as motivator to get/stay well, comfort and companionship of pets
Improved understanding of mental health experiences	Formal mental health diagnosis, psychoeducation and peer contact can bring relief, understanding/sensemaking and strategies for coping; discovering others have shared experiences can be normalising and destigmatising

Drug or alcohol rehabilitation	Positive experience of substance rehabilitation programmes or recovery fellowship; avoiding places/acquaintances associated with substance use practices/habits
Stabilization of family situation	Resolution of custody proceedings, improved management of children’s health/disabilities, leaving a dysfunctional relationship
Resolution of court proceedings	Conclusion of proceedings relating to accusations of criminal behavior and/or being a victim of crime
Alleviation of distress caused by engagement with the welfare system	Relief of being free of regular or mandatory interactions with the Jobcentre/DWP due to change in benefit status, or by disengaging entirely from the system
Psychological benefits of working, including volunteering	Work helping mental health when it is appropriate and fulfilling work
Other coping strategies	Self-harm as release, drug/alcohol use as coping response to adversity or to depression/anxiety, smoking as stress/anxiety relief, masking, putting on a façade, physical violence as release

Regarding **consequences** of mental health problems, our analysis was particularly concerned with the consequences that participants perceived for their ability to engage in paid employment. This aspect of the data was analysed in greater depth and forms the focus of the following section. To summarise the key finding that we will elaborate throughout the remainder of this report, mental health problems affected people’s capacity for work in significant ways at certain times, but for the majority of participants, **mental distress was one of multiple interwoven work-limiting factors, at the social, structural, economic and interpersonal level**, all of which need to be taken into account if a person’s capacity for work is to be meaningfully understood and supported.

Relationships between mental health and capacity for work

Impact of emotional and physical manifestations of distress

Whilst a small number of participants did not draw any direct connection between their experiences of mental distress and their ability to do their job[13], for the majority, there had been at least some times in their life where the manifest symptoms of psychological distress posed a functional barrier or limitation to their capacity for work. Emotional and physical symptoms of distress that had a direct and (at times) absolute impact on people's capacity for work included: shaking, crying, nausea, vomiting, dizziness, fainting or blackouts, palpitations, digestive discomfort, fatigue, lethargy, low motivation, feelings of emptiness, states of high energy and frenetic activity, agitation, sleep problems or irregular sleep patterns, changes to appetite and related weight loss or gain. Some participants had experienced visual or auditory hallucinations, intrusive thoughts, paranoia, disorientation and altered perceptions. People also described feelings of anger and aggression; these could be connected to past trauma or abuse which brought about a sense of threat or need for high vigilance and self-protection. Thoughts or acts of self-harm were also mentioned by some participants, including plans or attempts to end their life. Illustrative quotes from the interview data, relating to these various impacts, are shown in Table 5.

Table 5. Emotional and physical manifestations of distress described by participants

Shaking, crying, nausea, vomiting, dizziness, fainting or blackouts, palpitations, digestive discomfort, fatigue, lethargy, low motivation, feelings of emptiness, states of high energy and frenetic activity, agitation, sleep problems or irregular sleep patterns, changes to appetite and related weight loss or gain	*"I'm not fit for work. At the moment, since losing my mum, my depression's got a lot worse. I don't sleep. In fact, I sleep- I sleep all the time, but I'm not sleeping, if you know what I mean. I'm lying down but I'm not actually asleep. So I'm awake. I'm so tired but I try and keep myself busy just to get through every day."* (F18)
	"I really suffer with my mood. I'm not bipolar but I have- when my mood goes up and down it's very everywhere… I just don't know where I am at the moment inside my head. It's just – it's really hard. It feels quite dark… I would love to have some medication that would help stabilise my mood, help me with not feeling chronically empty because that's – you just don't want to feel like that, it's just horrible." (F03)
	"The guilt that was laid on me when I was trying to find work and seriously mentally ill with depression and anxiety… I was actually blacking out two or three times a day… [from] *stress and distress. My body would simply decide it couldn't deal with this and I'd just put my head down and be away."* (F09)
	"I know for a fact that if I was working I would have to go out and then deal with customers or deal with people or phone calls and I obviously don't think I could do that right now, but I have tried. I've been phoning call centres like [company name] *and I'll talk to them but afterwards I'll hang up and I'll feel shaky, dizzy, I'll even pass out or throw up or both."* (F34)
	"I only sleep two hours a night as well, so nothing is actually functioning… My head is like a time bomb and the worst times are night times. I lay down from twelve o'clock last night until five this morning not able to sleep." (F27)
	"I don't sleep but then I could go for days on end where I'll sleep all the time. There'll be days where I just don't feel like doing anything; I don't even get dressed… Sometimes I don't even go to bed; I just sleep on the sofa." (F26)
	"I take anxiety attacks, I take sharp pains in my chest, and everything. And just like dealing with people on the phone, and not getting anywhere, it's just like melt down. And I can't deal with it." (M15)
	"I had a panic attack or whatever, when I was sitting in the surgery. [The doctor] *was questioning everything or whatever, a letter, and I was fighting for my breath kind of thing. Sometimes I just can't catch my breath and I'm panicking sort of thing."* (M06)
	"I definitely do feel very down and very low and very unmotivated and very hopeless at times… Sometimes I'll get up, have breakfast, take the dog out for a bit and I'll come back and I'll just feel absolutely exhausted." (F05)
	"Because of my anxieties and fears, I get panic attacks, and pains, and heart palpitations, and dizziness, and cramps, and I think that's because you get so- I don't really know. But it is mental, but it affects me physically." (F23)

Visual or auditory hallucinations, intrusive thoughts, paranoia, disorientation and altered perceptions	*"I get very anxious and paranoid about everything… Just all kinds of things.* [My flat] *has not got double glazing windows and any noise I hear I think it's towards me. I do get very badly paranoid and things, and anxious… Trust is a big thing with me. To trust people… Already I'm thinking* [the neighbours] *think I'm junkie and they're deliberately making noises to wake me up. You know, these kind of unwanted thoughts. I try not to dwell on them… Every day I'm consumed by fear… I'm not scared of anybody but I'm consumed by fear, and I don't know what from or why."* (M17)
	"At times I hear as if somebody's shouting my name. I actually hear my name being called… I'm looking about and I'm thinking it's people from my past who I've harmed." (M11)
	"I've got voices in my head constantly every day, every hour, every day… One night I blacked out, voices kicked in, next thing I know the police are in." (M21)
	"I do work really hard to keep my mind occupied, because I'm still under the psychiatrist. I can't be on my own for longer than three days without having stupid thoughts." (F22)
Feelings of anger and aggression, a sense of threat or need for high vigilance and self-protection	*"I could flip out or throw a wobbler for no particular reason apart from frustration but sometimes I didn't even know that I was doing it… I'd just hit out. The frustrating thing is it wasn't the other person's fault or they didn't even know anything. They didn't know what I'd been through, what I've lost in life but how could they understand the way that I felt and why I was so angry?"* (M26)
	"I feel people are looking at me and they're talking about- I feel they know what's happened to me and they're looking at me. It's horrible… It's like they know what I've been through and they're looking." (F16)
Thoughts or acts of self-harm	*"There were periods where just not committing suicide really was a win on that day."* (F13)
	"I do at times want to commit suicide and things, but I'm too scared because my belief's with God and things. But say if somebody shot me, I would love it, I want it, I would love somebody to kill me. But I wouldn't want them to feel bad, you know, like- but really I'd welcome it." (M17)
	"I fell off a building. Well, as much as I fell off but I'm liar; I threw myself off it… That's what homelessness does to you." (F28)
	"Anxiety could take me to a very, very dark place where I would consider actually harming myself." (F12)
	"I suffered with mental health issues, done a lot of silly things, self-harming, and just really wanted the world to just swallow me up and take me away." (F18)
	"Basically I wanted to kill myself but I didn't dare but it was terrible having that thought, man, that you might do yourself in." (M11)

Functional impacts of emotional and physical symptoms

The associated functional and social-interactional effects of these emotional and physical states included reduced attention to personal care, difficulties maintaining general domestic activities and daily routines, withdrawal from family and friends, significant difficulties leaving the house, avoidance of formal or informal social interactions, heightened distress during essential social interactions, and difficulties being in public spaces, including the use of public transport. Some participants felt that at times of most acute distress and disorientation, they could pose a risk to others. Examples from the data are shown in Table 6.

Table 6. Functional impacts of emotional and physical states described by participants

Reduced attention to personal care, difficulties maintaining general domestic activities and daily routines	*"Sometimes I don't get out of bed. I don't wash. I don't eat or I eat too much...* [My daughter] *looks after me. She goes to school but then she'll come home and she'll check to see if I've eaten, she'll check to see if I've washed, those sorts of things. Sometimes I just stay in bed."* (F14)
	"Sometimes I cannot get motivated for to do things. I mean, at times I don't go out the house for two and three days and then I need to go out because I need to get cat food or cat litter or I need to get gas or electricity or tobacco. I wouldn't go out. If I never had the cats, I wouldn't go out. I'd only go out to get my tobacco and what I'm going to need to get and that'd be it." (M11)
	"I didn't really eat, to be honest. I didn't really care about it either; I wasn't really looking after myself... I stop doing things I should be doing at home like washing everything; clothes, me, dishes. You can't do that; your mind just goes out. I can't think about doing tasks. Or if I start to do a task, I find it hard to complete a task when I'm facing these extra sorts of stresses." (F23)
	"There are days when I just literally can't get out of the house and I just can't do anything and as a result, I do drink a hell of a lot more than I should." (M05)
	"Basically I did nothing. I mean I didn't do any housework... I literally struggled to do everything. I couldn't be bothered to shower; I'd stay in the same clothes for days on end. I mean I literally, to put a better word, I stunk because I couldn't do anything... I am getting there. I'm a lot better than what I was. I still have the odd day where I still I get up and I'll just get up, come down here, lay on here, watch the television all day, curtains stay closed all day." (F26)
	"Sometimes, as soon as I get in, I can't keep my eyes open and I have to go to sleep... It's like since I went to town yesterday, because I had bits and pieces that I had to get, when I came back I couldn't pick up the children. I had to get somebody to pick up the kids for me from school. I couldn't make dinner. I had to get a takeaway. I had to go to sleep in the day. Like, when my children came home, I had to send them upstairs and I had to sleep for an hour." (F08)

Withdrawal from family and friends, significant difficulties leaving the house, avoidance of formal or informal social interactions, heightened distress during necessary social interactions, difficulties being in public spaces (including the use of public transport), lowered ability to 'deal with' other people, fluctuations making it difficult to plan ahead	*"I don't really know how to relax. I don't go out anywhere because I'm scared of what's happened and I'm always on the lookout. I don't really like meeting people because they always want to talk about things that I don't, and I think what's the point if I don't want to talk, do you know what I mean?... I don't like big groups of people or certain people. It would upset me and I just go quiet and want to go and I can't stand it and I want to run off."* (F11)
	"I really don't head out. I don't want to see anyone. I don't know what it is. I just don't like being around other people too much for too long. I think that's the other reason most of the time work gets to me. Too much time with other people drives me insane. I find it really hard to deal with other people because I find if I find fault with them it will get in the craw with me and that's it." (M09)
	"I struggle with a lot of public places. I get really anxious and things like that... Some days I don't even leave my house. I'm just curtains closed like they were when you came. I feel safer that way." (F16)
	"All these things that we all do on an everyday basis are the very things that people with mental health struggle. Because just like talking is hard. I remember when I was so depressed, at my worst ever point, it's hard to get the words out. You can't talk. Literally you can't talk. It's so hard." (M16)
	"I'm not very good with people. I get very, very anxious... My anxiety around people that I don't know at the moment, especially in a professional environment. I can't cope with it... I'm scared about what people are thinking of me and stuff like that, and that I'm not good enough." (F08)
	"I'm just not capable of going to any kind of job at the moment because I can't even get out of the flat much. So even to do part-time work I wouldn't be able to do it... As I can't be around people, how am I meant to try and get a job? I can't even go outside without my earphones on because I have to block out everything around me... I'm acting like a prisoner in my own flat... I go out and I'm tied up in knots as soon as I get out the flat." (F27)
	"I'm all right in my home because it's my territory. But if I go out I'm very nervous and I get quite anxious now; if there are too many people that I don't know it's, 'Argh!'" (F14)
	*"I've got depression and I keep having panic attacks going out the front door... Last time I was going to the shop it took me 25 minutes to get out of the flat front door. I must have looked like a right **** standing there in front of the glass doors, hand on the thing shaking like a leaf. It took my neighbour to come down and say, 'Are you all right?'"* (F34)
	"I just had a thing where I wouldn't answer the phone, I wouldn't answer the door, I wouldn't go out of the house. I'd tell the doctor I'd just shut the living room curtains and wrap this blanket round me and just get out of the way. That's how bad I've got with this situation at the minute." (M30)
	"Sometimes I get very anxious if I'm on a bus and there's too many people on it. I just get off the bus and I just start walking, because I'm like, I can't... because I just start sweating and I panic. I start taking panic attacks and stuff." (F10)

Continued overleaf

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Withdrawal from family and friends, significant difficulties leaving the house, avoidance of formal or informal social interactions, heightened distress during necessary social interactions, difficulties being in public spaces (including the use of public transport), lowered ability to 'deal with' other people, fluctuations making it difficult to plan ahead	*"Every morning when I get up there's a constant feeling of dread and it takes me a couple of hours to psych myself up, if I know I've got to go to the shops, and I have a constant feeling of dread all the time, and it's horrible. It's just the way I constantly feel… I know I wouldn't be able to go and sign on and stuff like that… because I don't like going out on my own… And I wouldn't have the confidence to be going out and looking for work."* (F10)
	"I can't get on a bus if there's too many people. I can't go into a supermarket, there's too many people that sort of thing and that's why I had a problem with this job club, because they were putting me in there with a lot of people really close together. Do you know what I mean? It's just my anxiety and my panic attacks and that. That's where it's detrimental." (M25)
	"Just because someone can wash themselves and someone can walk 50 yards, that doesn't mean to say they're in the right frame of mind mentally to work. Especially if you've got a job obviously where you're working with people, you've got to be in the right frame of mind and put a smile on or something, you can't do that if you're like mega depressed during a dark moment. Sometimes you can't get up and you're just hating wanting to go because you're so depressed." (M01)
	"I don't like being in and round about lots of people because I feel like, at times, I feel like I'm hemmed in and all that kind of stuff and all that, 'Oh, I need room here', you know what I mean? 'Oh, I need to get out, man', and you're like, can't breathe in it." (M11)
Potential risk to others, including acting on feelings of anger and aggression at times of extreme distress or disorientation	*"If I was all right to work I'd go back to work because I love to work, but I couldn't. I physically couldn't do it in that busy environment and all the surroundings I couldn't do it. I'd end up dead or some ****** else would… I wouldn't like to put other people in risk of being round me at this time do you know what I mean? I could hurt somebody and I wouldn't like to hurt somebody for nothing. That's why I like sitting here by myself… I'm not going to hurt anybody else am I?"* (F16)
	"I'm not ready [for work] *yet at all because of my voices, they're horrible… I could get told to kill someone, stupidly, if they just wind me up that much. All it takes is overload and that's it, I'm no longer me… I'm not fit to work at all."* (M21)
	"My biggest fear is ending up getting so angry at somebody that I end up getting fired… My moods just go from zero to hero, and it's not because I hate that person. It's just because something's happened… I know there are people that are amazing at not showing any of that and just getting on with it, but I don't know if I'm that good at that kind of thing, especially right now." (F31)
	"I won't use public transport, so I can't get on- I couldn't sit on a bus, it would drive me round the twist. I'd end up kicking off, like, all those people. So I really can't." (M25)
	"I said to [WCA assessor]*, 'I maybe look all right, but I'm not. I'm not well and it wouldn't be fair for you to put me in a working environment with folk because I'm volatile. I just change like that.' If I think somebody's taking the Mickey, I have a go at them. It's not that I go and think about it, I just have a go."* (M11)

A number of participants spoke about how the functional effects of distress could make them 'unreliable' as an employee. People's concerns related not only to perceived attitudes of employers but also stemmed from their own work ethic, in that they did not want to take on a job role that they did not feel able to perform consistently:

> *"I definitely want to get back to work, but I know myself that I couldn't give 100 per cent to any employer at the moment. And just doing part-time, I don't even think that I could even cope with an hour, and I wouldn't want to put an employer in that position of taking me on and then I've had to walk out because I can't cope. I don't think that's fair on myself or the employer."* (F27)
>
> *"I'm beginning to sort of accept that there's a lot of things that are very difficult for me to do and I don't know- I wanted to go back to work, I have no idea what I could do that wouldn't cause me problems and that I would be useful for the people that I was working for. I wouldn't want to be having to be off work all the time. I want to be able to do a job and do it well because, as I say, that's my work ethic, you do a job and you do it right, you know. I wouldn't be able to do that. That frustrates me, you know."* (F07)

More generally, unpredictable fluctuations in mental health made it difficult for some people to make commitments or plan ahead in their personal lives:

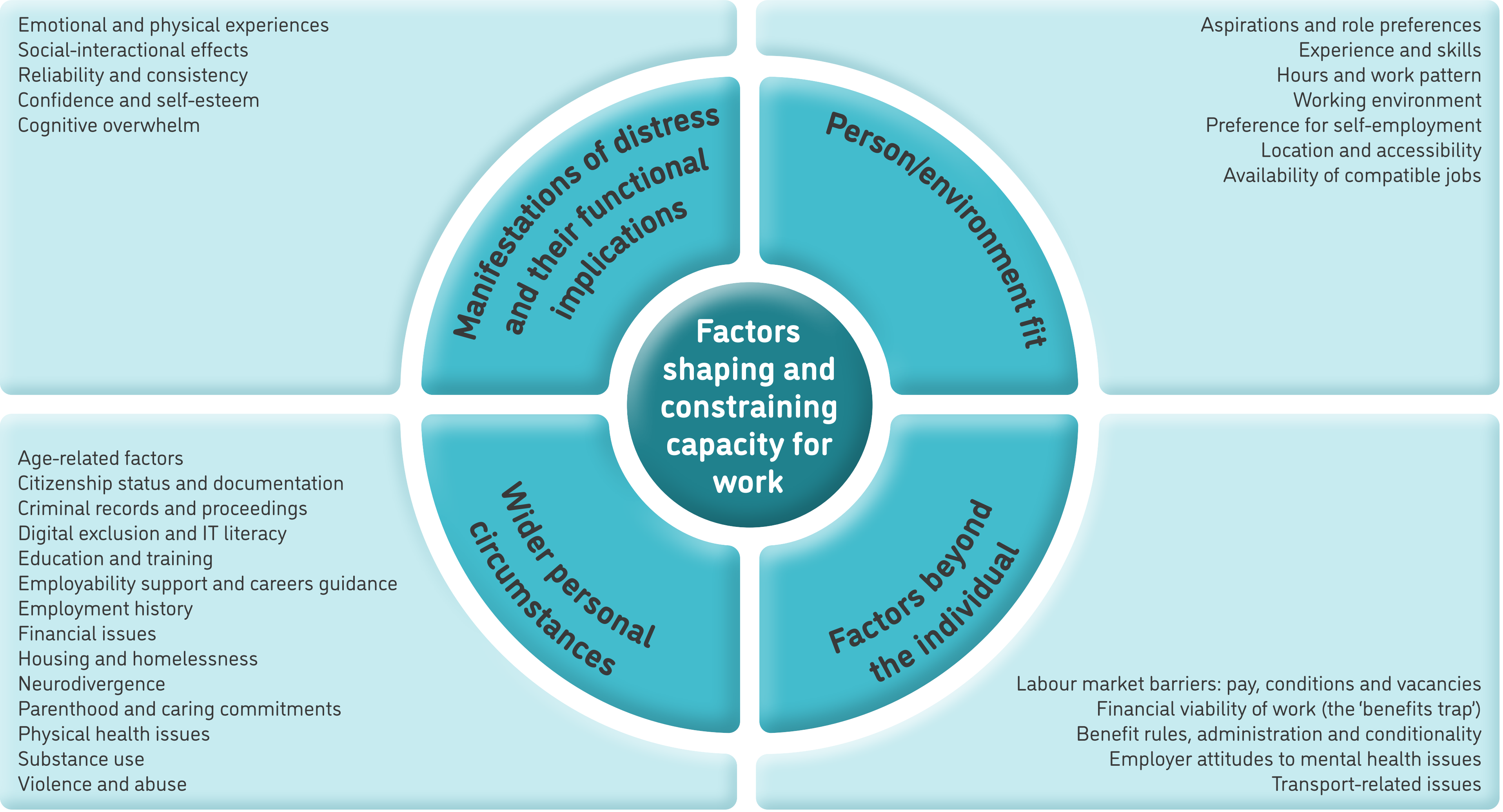
> *"I literally take every day at a time. I don't plan ahead, I don't make future- no arrangements, I don't- because I can't, yes? I don't know where I'm going to be tomorrow, I don't know what frame of mind I'm going to be in tomorrow so I can't make any plans, so it's hard."* (F18)
>
> *"Some days I wake up and I'm disappointed that I've woken up. Then other days I'm up. Just, it's like a- it's not nice. One, you can't plan ahead, sometimes, you know, because you don't know how you're going to feel the next day. If someone says, 'Do you want to do this tomorrow?' I can't- I could feel like death tomorrow. So it's hard, it is hard."* (M17)

Beyond mental health: a holistic analysis of factors shaping capacity for work

In the previous section, we have provided numerous examples of how the emotional and physical symptoms of distress could limit people's capacity for work at times of acute distress. However, what came through strongly in this analysis was that **whilst people's distress was real, genuine and at times severe, it was rarely the whole story of why they had fallen out of work nor what was now preventing them from returning to work**. The direct emotional and physical manifestations of distress were undoubtedly a feature in people's accounts of reduced capacity for work. However, by engaging closely with people's narratives, over multiple waves of interviews, it became clear that **many other factors played a critical role in how people understood and assessed their own 'capacity for work'** and what was now shaping and constraining their ability to find and sustain suitable employment.

As already noted, for the majority of participants whose experiences are included in this analysis, mental distress was perceived as a *correlate and upshot* of a range of social, structural, economic and interpersonal challenges. The longitudinal narrative nature of the data also showed that, for many participants, this same set of social, structural, economic and interpersonal factors were significant and direct shapers of their capacity for work over time. As such, it was clear that **mental distress was one among many interwoven factors influencing people's ability to obtain, retain and sustain employment.** This did not make people's distress any less real; at times, the emotional and physical manifestations of distress, and the functional limitations these caused, posed an absolute barrier to work. However, the detailed narrative accounts showed that for most participants, a much wider set of concurrent and interwoven factors played a role in shaping and constraining their capacity for work. These multifaceted components of work capacity are summarised in Figure 1, below, grouped into four thematic categories: manifestations of distress and their functional implications; person-environment fit; wider personal circumstances; and factors beyond the individual[14].

Figure 1. Factors shaping and constraining capacity for work: perspectives of claimants with experience of mental distress



In this study we have been deliberate in not positioning any experience of distress as more 'serious' than another or dividing the study sample into those with more or less 'severe' conditions. At the same time, we recognise and appreciate that some people live with symptoms of enduring mental illness which are, in and of themselves, experienced as a fundamental and absolute barrier to employment. However, for the majority of participants in this QSA study, the picture emerging from their longitudinal narrative accounts was of **a more nuanced, multi-faceted and contextually contingent set of factors influencing capacity for work**. It is this complexity and holistic set of influences on capacity for work – **including but not limited to mental distress** – that we wish to convey through this report.

To give one example among many, a female lone parent in her late 50s described how her husband of 20 years had deserted the family, leaving large debts after years of financial abuse. She and her children became homeless around the same time, due to their private landlord selling the property. This combination of circumstances led the participant to leave her job and claim ESA on the grounds of depression and anxiety. The ongoing unstable housing situation at the time of her first research interview was holding her back from taking more definitive steps towards work. When asked at her second interview (a year later) to describe the reason for her ESA claim, the participant explained the multiple factors contributing to her incapacity for work over the preceding four years, which now included the sudden and unexpected death of her children's father. Although leading with the medicalised framing of depression, her account unfolds to reveal the multiple social, structural, economic and interpersonal factors underlying her constrained capacity for work:

> *"It was depression that set me onto* [ESA] *first, and with really anxiety, stress, loss of appetite. Wanting to deal, really, with my major issues of the housing and getting* [the children] *all right, you know, and then I wanted obviously their father to see them and speak with them. Then dealing with his death… I was prescribed* [medication] *again, from my doctor, because she*

> *said it's quite common to have, like, a setback, what we've gone through, because that's quite major issues in a lot of spheres… And although you have the strength to hold it together, there comes a point when you hit the wall and you can't do it. So really on a depressive thing, and I'm a very sociable person and like – I mean, I miss the* [people at work]*; I miss obviously that aspect, but I wasn't wanting to be in company… Basically, he'd knocked all the confidence out of me. I was taking it on my shoulders that I was to blame… When their father walked out, and I had to give up my* [job]*, and then I was panicking. I was really grappling for money, and in all sorts of problems, getting financial advice and everything… He went through £70,000 of inheritance, of my money."* (F33)

Throughout all interview waves, the participant also expressed her overriding value position that she was first and foremost a mother, and any work that she took up must allow her to continue to support her children, practically and emotionally. Thus, to understand this claimant's capacity for work solely as a mental health issue would be to misrepresent and underplay the multiple interwoven factors that constrained her return to employment, and the way in which her decision-making about work was shaped by her commitment to the wellbeing of her children, who had also suffered through their experiences. Whilst depression and anxiety are present and salient factors, her work capability is shaped by a complex combination of factors that are not adequately described *only* in terms of a mental health condition.

As the participant sums up, her mental health related ESA claim was essentially the result of "quite major issues in a lot of spheres". We believe that this apt summary is a very helpful way of conceptualising the experiences of many of the participants whose stories we analysed for this QSA study. Rather than expanding on each of the individual elements shown in Figure 1 via multiple subsections and isolated quotes, we believe our analysis is best conveyed through complete case study narratives. Five further participant cases are presented below, from the many that could have been selected (names are pseudonyms). These case summaries convey the entwined nature of social, structural, economic and interpersonal factors that underpinned and operated alongside mental distress, to affect many participants' capacity for work.

Case Study 1: Kyra

Kyra is a woman in her early 30s. She had a varied work history including retail, hospitality and childcare. Around ten years ago, she was violently attacked in her home. She immediately abandoned the home, no longer feeling safe there, and thus became homeless. Having fled her city of residence, she also had to leave her employment. These circumstances led to severe depression. She sofa surfed between friends, and began to seek work, though without success. She started a relationship and became pregnant. Shortly before her child was born, she was offered accommodation.

Kyra returned to work when her child was two years old. Now a lone parent, she explained this as being a matter of financial necessity, which conflicted with her desire to be with her child for longer. She had been working part-time until a few months before the first research interview. Her role had become redundant and she had then claimed Jobseeker's Allowance (JSA). This was the first time she had claimed unemployment benefits. She wanted to work, and had approached previous employers to enquire about vacancies, but none were available. It was also important to her to have a job that fitted within school hours, as she did not want to put her child into wraparound childcare; however, school-hours jobs proved hard to find.

Kyra decided to enrol on a teaching assistant course, which would enable her to work in roles compatible with her child's school hours. She also spoke of her wish to equip herself for a career that would see her financially independent and secure for the future, rather than taking any job available. She pursued the teaching assistant qualification, whilst volunteering in a school and continuing to claim JSA.

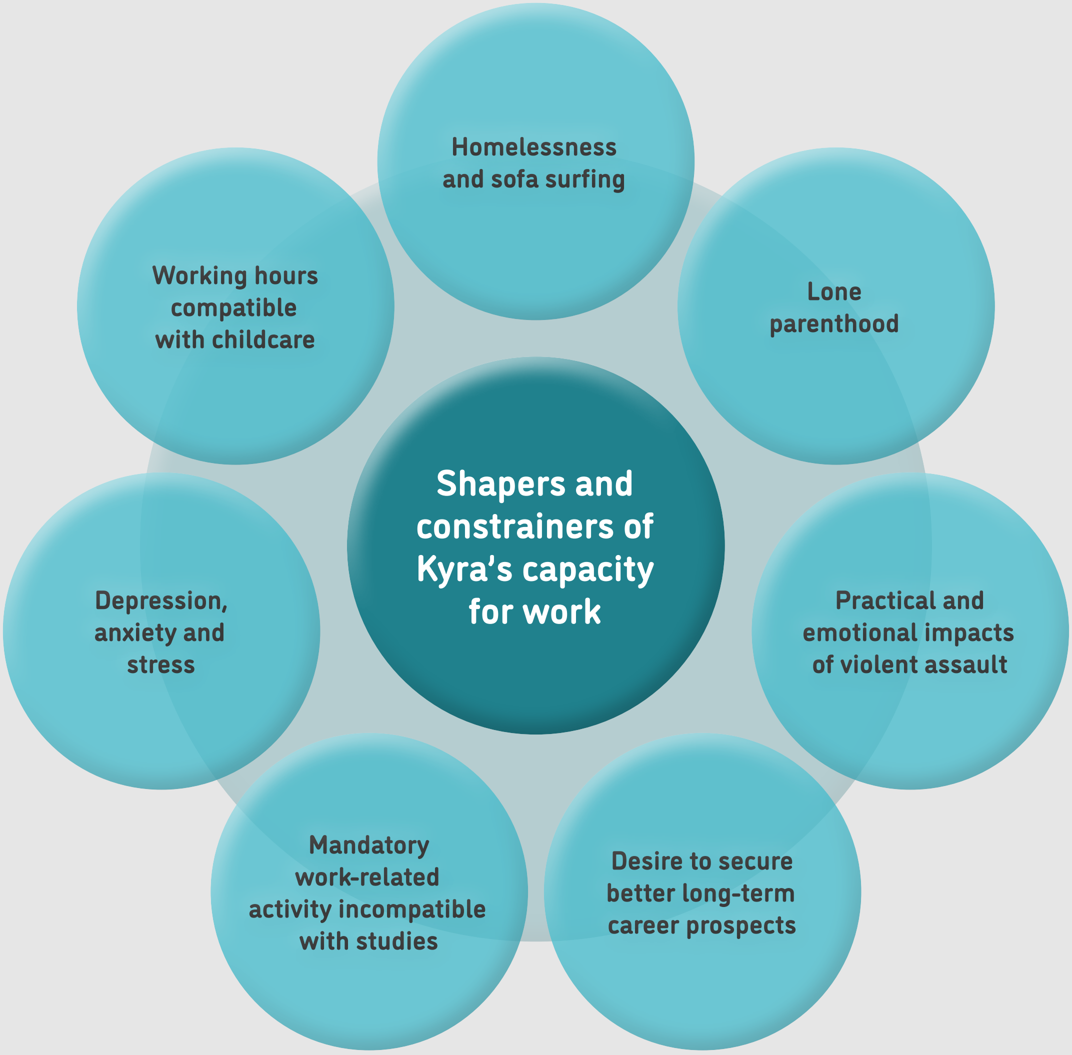
During this time, Kyra and her child were evicted due to rent arrears. They became homeless and were sofa surfing, which took a toll on her own and her child's mental wellbeing. She was then required to participate in a mandatory Work Programme. Attendance at this course clashed with the final months of her qualification, putting her at risk of not completing it. She explained this to the Work Programme provider and her Jobcentre advisor, but was told that she could not be exempted. She then spoke with her homelessness support worker, who advised her to seek input from her GP. This led to the issuing of a sick note and a move from JSA to the health-related benefit Employment and Support Allowance (ESA):

> *"I spoke to my Jobcentre advisor and I said to him that I think it's really unfair what they're doing. Why should I have to forfeit my 12-month course just to fulfil government legislation? He said, 'Sorry there's nothing I can do'. And then I spoke to my support worker and I said, 'I'm highly stressed about it. I don't know which direction to move in'. She went, 'Call your doctor. Ring your doctor and tell her how you're feeling... And now my doctor has signed me off. So now I've gone from Jobseeker's Allowance to ESA... Depression, but she said it's depression in relation to the circumstances... That's why I got signed off by ESA, because I was so depressed that I wouldn't be able to finish my course."*

Whilst on ESA, Kyra continued with her course and voluntary placement. She was also looking for paid work, but the stress of being homeless was making it extremely difficult to focus on employment. However, being moved onto ESA was providing some breathing space to complete her qualification, which she hoped would lead to a more sustainable career in the future:

> *"I don't not want to work, but just to have that alleviation to be able to finish my course and be able to say, 'Right, okay actually now I feel like I've breathed a little bit, maybe I could just get on'... I want something that's going to continue to build and I can work around my child. That's why I did this* [course]*... I'm not really looking to be on ESA for very much longer... I just need it as a bit of breathing space from that* [Work Programme]*, which I felt was completely unnecessary from my perspective because I've already got a career in line."*

However, at the final interview, eight months later, Kyra was still sofa surfing with her child, and experiencing higher levels of anxiety than she had in the past. Some recent therapy had revealed the extent and continuing impact of the trauma of the assault. A combination of things were now presenting barriers to work, among which her lack of secure and stable housing was predominant in her narrative. She also worried that with her current levels of anxiety, she may be volatile at work and thus lose any job she was able to get. She was close to completing her teaching assistant qualification, but was struggling to find the headspace to compile her final portfolio. She remained on ESA, claiming on the grounds of stress and depression.



Case Study 2:
Nihal

Nihal is a male in his late 20s. He had a mixed work history, with periods of seasonal work interspersed with unemployment, and a brief previous claim for ESA due to a physical injury. He also had past experience of homelessness. Nihal aspired to find steady work and to be able to save up for a deposit to buy a house. Between the first and second research interviews, his partner had become ill and moved in to live with him. Meanwhile, an administrative issue during a recent transition between JSA and employment had interrupted Nihal's housing benefit payments, leading to arrears and subsequent eviction from his flat. He and his partner then moved into a mobile home, located at his work site. Whilst living in this situation, his partner sadly died.

Nihal continued in his job for a further six months after the bereavement, but found he was increasingly unable to face being at the work site, it being also where the death had occurred. He went to stay with relatives, but this could only be short-term due to strained family relationships. He moved on to sofa-surfing, then a temporary shelter, and later was offered homeless accommodation where he was permitted to stay for up to two years.

Upon leaving his job, Nihal had initially claimed JSA, but after three months found that he was unable to maintain jobsearch and mandatory appointments due to the impact of his grief. He approached his GP and moved to ESA on the grounds of depression:

> *"It started getting a lot difficult and harder to go into work every day with the reminder of what happened there. So it came to the stage where I just mentally couldn't handle going into work anymore… First of all, I started claiming Jobseeker's Allowance, but I just found the meetings and the work you have to put in for it and that just all too much to process and to be able to do. It was just getting me more and more stressed… I wasn't sleeping at all and just wasn't eating. So the doctor signed me off just because my general health just wasn't in a good way at that time."*

His goals at this stage were to stabilise his housing situation, and find some calm and time to work through the bereavement. At this point, he felt he would not have been able to meet the requirements of mandatory work-related activity, and referred to the non-conditional health benefit as providing this psychological space:

> *"That was sort of the main reason to go on ESA, was so then I didn't have any commitments; I could just be free to sort of grieve in my own- recover in my own time, and just work through everything that had happened, and get myself back to being able to- well, not control it, but just sort of live with the past and what's happened."*

Following a Work Capability Assessment, Nihal was placed in the Work Related Activity Group. At his final research interview, around six months later, Nihal was currently required to attend a supported jobsearch session for two hours per week. He was finding this mandatory activity unhelpful and unproductive:

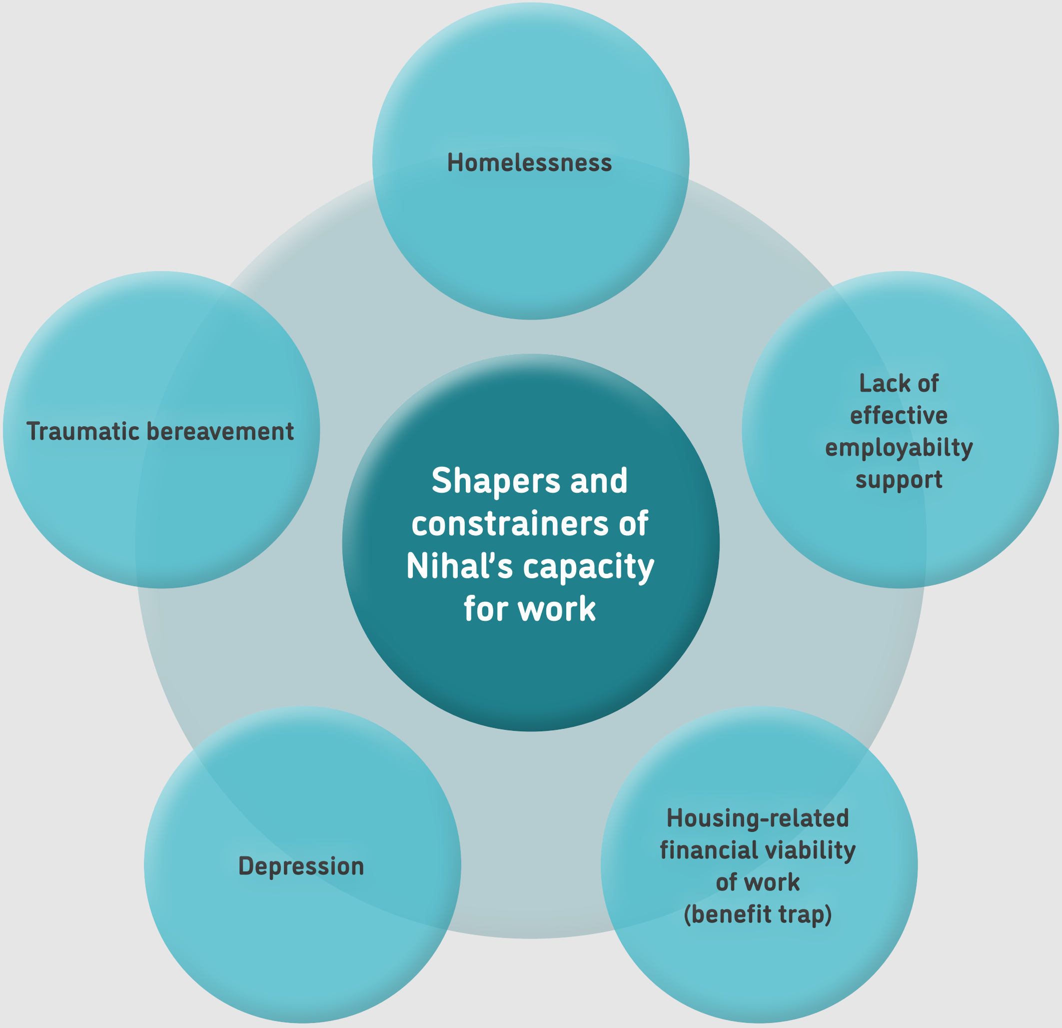
> *"They're supposed to be helping me, like putting me onto courses, and helping you look for jobs, helping you with your CV and things like that, but I've actually received no guidance from them in any way…* [I have to] *sit on the computer and look for jobs that I would never be able to apply for. Well, not that I wouldn't be able to apply for it, but I wouldn't be able to get."*

By this point, Nihal felt generally able to work again, both physically and mentally, and there was the possibility of resuming work with his former employer. However, his situation was now complicated by the fact that he would not be able to afford rent if he moved back into paid employment and thereby became ineligible for full Housing Benefit:

> *"I'm always held back by my housing situation… I have employment that I could just walk back into tomorrow, if I had somewhere to live… It's with my ex-employer, which I really want to do. I mean, quite happily, if I got a place to live, I could quite happily move out now and get back to work tomorrow. That is the major issue, is finding somewhere to live… Even for a room to share in a shared house, the benefit paid for my half would cover*

> *nowhere near the amount… That's the thing that's really holding me back… I want to get housed so I can get back to work, so I can start to save and start making plans for the future."*

With this primarily housing-related barrier in place, Nihal therefore remained on health-related ESA and had recently been encouraged by his housing provider to make a claim for Disability Living Allowance, as this would support his application for social housing.



Case Study 3:
Marta

Marta is a female in her early 40s. She migrated to the UK six years prior to the first research interview. She holds a professional qualification from her country of origin, and on coming to the UK had a confirmed employment role to take up. However, within a month of arrival, her circumstances changed (for reasons not elaborated in the interview), meaning she had to claim asylum status. She met a partner and had a child, but the relationship ended soon afterwards due to physical and financial abuse.

At the first research interview, Marta had not been in paid work for six years. She was living in temporary council accommodation, with her now four-year-old, in receipt of Income Support as a lone parent. She stated that she did not consider herself to have any physical or mental health problems, though she mentioned that she was attending counselling relating to the domestic abuse. These sessions placed some practical limits on her availability for work, as did appointments with social services relating to child safeguarding. The predominant work constraint within Marta's narrative during the first interview was the availability and cost of formal childcare, and the need to find financially viable work. However, she intended to seek work as soon as her child started school the coming September.

Marta was currently attending Work Focused Interviews every three months and was aware she would be moved from Income Support to Jobseeker's Allowance when her child reached five years of age. She was conscious that her higher-level education made her overqualified for certain jobs, and that this could deter employers:

> *"They say you've got a professional degree so the superstore will not take you. They will think you will leave one day because it's in your CV that you are a professional."*

Because of her overseas qualifications and lack of UK work experience, she could not directly enter her professional field at the level she had previously been employed. She also had no

UK references. Through her own enquiries, Marta had identified a specialist organisation which supported people with overseas qualifications to re-enter their profession. This organisation had advised her to try and find voluntary work as a stepping stone towards a return to her previous level of seniority. This was her goal at the first research interview, and she intended to engage more fully with the specialist organisation once her child was in full-time education.

At her second research interview, a year later, Marta had moved from Income Support to JSA and had been actively applying for jobs, but with no success, because of her overqualification. Her mandatory Work Focused Interviews sometimes clashed with sessions at the specialist organisation, but her Jobcentre Work Coach refused to reschedule their meetings to accommodate this. Within the year, Marta had moved from JSA onto ESA. This shift was apparently initiated by her social workers, who asserted that she was not in a position to undertake mandatory work-related activities, and was supported by her GP:

> *"My* [child] *turned five, so I went to Jobseeker's. Then I was on Jobseeker's, but the social services said, 'You need to stay home'. So the doctor made the letter that* [said]*, 'She is suffering from domestic violence; she needs to attend counselling, cognitive behavioural therapy,' I don't know what, 'So she needs to stay home.'"*

Marta continued to see a counsellor and at the time of the second interview, had been taking prescribed antidepressants for around one month. She attributed her distress to recent financial difficulties arising from the transition between benefits and the ongoing safeguarding situation with her ex-partner. Marta recognised that she experienced anxiety and panic when outside the home and around groups of people. However, she seemed to resist medicalisation of her situation, explaining that what she needed was practical support:

> *"The doctor put me on antidepressants, sometimes I attend counselling, but it is not going to help me because it's not practical. I know what domestic violence is, I know how to move on; I need practical support."*

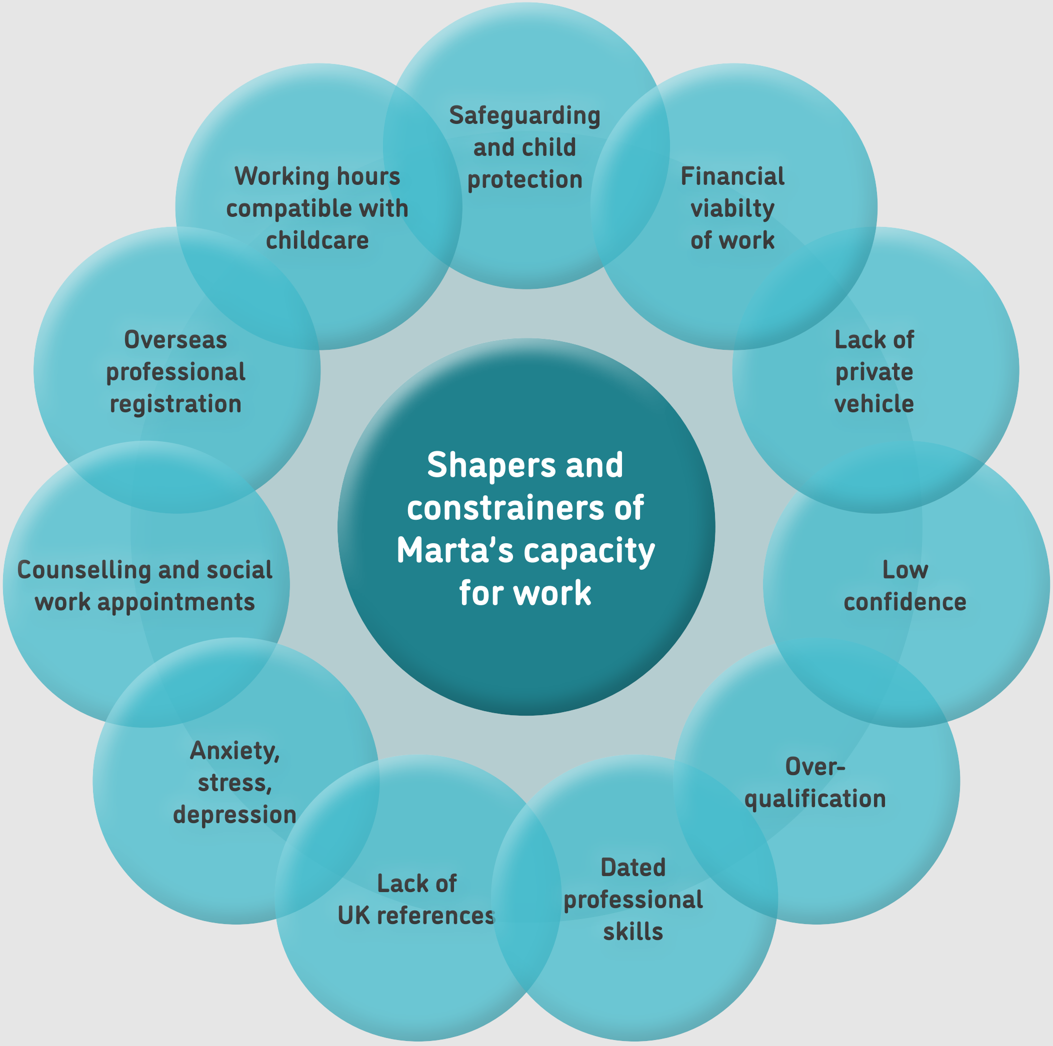
As planned, Marta was now actively engaged in support from the specialist employment organisation. She was attending support sessions based at the university, and felt comfortable in this setting, as it was reminiscent of her previous career, which she hoped one day to return to. However, seven years on, she was conscious that her professional skills were becoming dated. Marta acknowledged that her confidence was low, after such a long period out of work and the traumatic events she had experienced in the meantime:

> *"It's a confidence problem here, definitely... There is almost a seven-year gap. I've suffered a lot so it will take time."*

Marta was open to taking up a paid role at a much lower grade than she had held overseas, in order to get back onto a career track. However, she noted that some of these roles were out of scope because they required a private car, which she neither had nor could afford. Marta also reiterated that any job would need to be financially viable, in order to move off benefits and become liable for her full rent and council tax.

By her final research interview, just under a year later, Marta had been moved off ESA and back onto JSA, following a Work Capability Assessment. She was still taking prescribed medication and was about to begin a more intensive form of therapy, following a referral from her GP. Meanwhile, Marta had taken a number of courses via a parent support organisation and was now working for them in a voluntary role as an outreach worker. This was boosting her confidence, helping to bridge the gap in her CV and would also provide a reference in due course. This organisation had made a further offer of counselling, but Marta had declined this, seeking only their practical support to return to employment:

> *"When they asked me to go counselling, I said, 'I have got enough counselling, help me to get back into work, help me to find something!'"*


Shapers and constrainers of Marta's capacity for work
Safeguarding and child protection
Financial viabilty of work
Lack of private vehicle
Low confidence
Over-qualification
Dated professional skills
Lack of UK references
Anxiety, stress, depression
Counselling and social work appointments
Overseas professional registration
Working hours compatible with childcare

Case Study 4:
Simeon

Simeon is a man in his early 30s. He gave some brief details of his childhood, which included losing a close male relative to alcoholism and being raised by a grandparent. He has dyslexia and felt unsupported and 'ignored' throughout his school education. He had experience of homelessness during early adulthood. For over a decade, he had worked in security, interspersed with periods on JSA. He had a long-held aspiration of a career in public service and in his 30s (whilst also claiming JSA) had begun a full-time college course that he hoped would be a gateway to his desired profession. A few months into the first year of this course, he was asked to attend some mandatory training arranged by the Jobcentre. Having explained that he would not be able to attend because this clashed with his college classes, he was told that if his course precluded mandatory activity, then he was not eligible for JSA. His benefit claim was closed, leaving him with no income.

Simeon had been told he was ineligible for hardship funds, and was sometimes using food banks. Nevertheless, he continued into the second year of his studies and maintained his aspirations, supported by his partner who was also claiming benefits. A previous employer offered him weekend security work that was compatible with his college hours and would have significantly improved his financial situation. However, to do so, he needed to renew his security licence. At a cost of over £300, and now ineligible for JSA-linked funding schemes, he was unable to afford this. Acquaintances suggested he claim incapacity benefits, but he did not want to as it conflicted with his work ethic and (he felt) would also affect his employment prospects:

> *"I've had people say to me, 'Why don't you go on depression?' Well if I was to go on depression I would then become like the rest of them that don't want to work for a living, and also when it does come to me applying for* [public service role] *they're going to take one look at my medical notes, see depression on there and say, 'Sorry, we can't hire you.'"*

Meanwhile, he and his partner had made a formal complaint about the poor condition of their flat, but were then issued with an eviction notice. They began sofa surfing. Simeon then had a period of ill health, which he feels was brought on by pushing himself too hard at college. His absence from college led to him being removed from the course.

He found paid work, but the role involved working up to 15 hour shifts, which affected both his sleep quality and overall quality of life. He changed to a different job but was allocated tasks that were challenging due to dyslexia. He raised this with the employer, but was told that alternative roles were not possible. His mother then passed away. Simeon described how his mother's death triggered the upsurge of years of suppressed trauma:

> *"For I'd say 20 years, I've locked away everything that's happened, sort of like, 'Oh yes, open a big container, throw that in there, lock it away, forget about it'... But the day my mum died it's as if that lock fell off and nothing is able to keep it shut. It's just constantly coming out and, yes, I'd say it's like 20 years of pent-up depression."*

He went off sick from his job, on the grounds of anxiety and depression, and at the time of his final research interview, had recently submitted a claim for ESA. He was struggling to go out due to depression and anxiety, and alluded to suicidal thoughts. He had hopes of restarting in education the following academic year, but felt this would only be feasible if the course fees could be subsidised, which was unlikely as he was an adult learner. He seemed frustrated at having been let down by systems throughout his life. He wanted to work and again emphasised his work ethic and worker identity, but felt he was likely to be on ESA for quite some time.


Shapers and constrainers of Simeon’s capacity for work
Homelessness
Childhood trauma
Percieved employer attitudes to mental health problems
Financial barriers to renewing professional certification
Further education constrained by benefit eligibilty rules
Depression and anxiety
Bereavement
Lack of support for neurodivergence during education and employment

Case Study 5:
Cheyenne

Cheyenne is a female in her late 30s. She is a lone parent, with two children, one in primary and one in secondary school. She last worked around four years ago and has a work history including cleaning and fundraising. Cheyenne explained that she had struggled with depression for many years, which she associated with loss and bereavement earlier in her life, and later domestic abuse. She was on a long-term dose of antidepressant medication.

Around six years ago, as a result of domestic abuse and related struggles with alcohol, Cheyenne's children were taken into care for a period of time. Having been reunited with them after a hard-fought case, rebuilding their bond and being highly present as a mother was the highest priority for her. This shaped her views on returning to work and what kinds of work would be possible, but she knew that this was not a rationale that the Jobcentre would accept:

> *"Since I've got them back, I haven't worked and I haven't worked because I've wanted to spend quality time with my children, because I lost out in spending time with them when they weren't with me. It was through my partner being violent and stuff like that; consequently I ended up getting the children taken off me. But that's all sorted out now, but that's sort of why I don't work at the moment…* [but] *you can't say that to the Jobcentre."*

As a JSA claimant at this point, Cheyenne had been required to attend the DWP Work Programme. She had found this entirely unproductive, demoralising and highly stressful, with the exhaustion affecting her ability to care for her children:

> *"Ten o'clock to two o'clock, which is quite a long time, I'm sitting at a computer looking for a job. For all those hours. Now that is mind numbing, soul destroying, my God, I couldn't handle that. It actually exhausted me. I would go home and feel drained and exhausted and then I had dinner to make for my children, I had homework to do and I would fall asleep on the couch…*

> *Sometimes* [my youngest child] *wasn't getting his homework done."*

The distress of having to attend daily sessions that she found both pointless and in conflict with her parenting priorities led her to seek a sick note, to relieve her of the pressures and frustrations of attending the mandatory work programme:

> *"I said to the guy that was making me come in, three times a week from ten to two, 'This is too much for me. I can't handle this'. And he says, 'Oh well I can't treat you any differently from anybody else'. Because I was saying, 'I'm exhausted', you know, 'I've got stuff in the washing machine that's still wet from the day before, I'm not getting my housework done. Things are just coming on top of me'. So because of that I went to my doctors and said, I actually told him – I was honest with my doctor, I'm an honest person – I said, 'This guy at this welfare place, I'm depressed,' and it was really depressing the life out of me. I actually cried about it, I had dreams about this guy, I mean it was really taking over me as a person. So that's why I went on the sick."*

At the time of the first research interview, Cheyenne talked about feeling depressed, lacking energy, needing daytime naps and struggling with low motivation. As well as her antidepressant medication, she had been referred for exercise on prescription, though attendance at the Work Programme had precluded her from attending the gym regularly.

Beyond the effects of depression, she also spoke about numerous other barriers to work, including lack of appropriate jobs (particularly in relation to her childcare commitments), low paid jobs that were not financially viable, and wanting to find work that was fulfilling and fitted her interests and attributes. Whilst she was not expected to take a job outside of school hours, she did not believe that working part-time hours would be financially viable:

> *"I want a job that pays. There are no jobs out there that are worth me doing to be honest. And I have looked into it, and I have done the research, and it is an extra £10 a week. That's not worth it. I believe family's more important than £10 a week. If* [the Work

> Coach] *thinks I’m wrong for thinking that then I’m quite glad. I wouldn’t want to value £10 more than my children.”*

Her Work Coach had also been focused on cleaning jobs, which did not fit with her own aspirations:

> “[The Work Coach] *constantly talks about cleaning jobs, even though I told him cleaning depresses the life out of me. I would hate to be a cleaner. I’ve done other things. I did go to university for two years… I do believe I’m capable of doing better jobs than cleaning. I just felt he dismissed that. And I felt my age, you know a woman* [in late 30s] *cleaning, I don’t want to do a cleaning job for the rest of my life… I have done cleaning in the past, and I’ve done it for reasons of money… But to be your career at my age, when I know whatever I do next, I’m probably going to be stuck there, I don’t want to be a cleaner.”*

Wanting to prioritise her role as a mother was the dominant theme in Cheyenne’s narrative, and remained strong at all three waves of the research:

> *“I’m a mother, I want to be a mother, I want to give my children their breakfast in the morning. I think it’s wrong to demand I work and a stranger gives them breakfast. As I say, I didn’t have them for a few years, I lost a lot of time, I want the bond to be really strong. Family is more important than money. You do get people that have got big high shot careers. I think they neglect their children to be honest. I think more people should stay at home with their children. Unfortunately now if your child is over the age of five you must look for work… I didn’t want to shove my children into afterschool care when they’re trying to get the bond back with their mother. Why’s that wrong, for me wanting to be a mother and to be there for my children?”*

An incident where Cheyenne had lost her temper in a Jobcentre after being threatened with a sanction had led to a community service order. This was now a further obstacle to securing work. At the end of the first research interview, Cheyenne expressed a desire to work but felt pessimistic about the prospects of finding something viable in the near future.

Between the first and second research interview, Cheyenne submitted an application for ESA and by the second interview was in the ESA Work Related Activity Group (WRAG), on the grounds of depression and anxiety. Although she remained open to the possibility of working, she felt that the pressure and lack of personalisation in the Work Programme had pushed her further from work readiness:

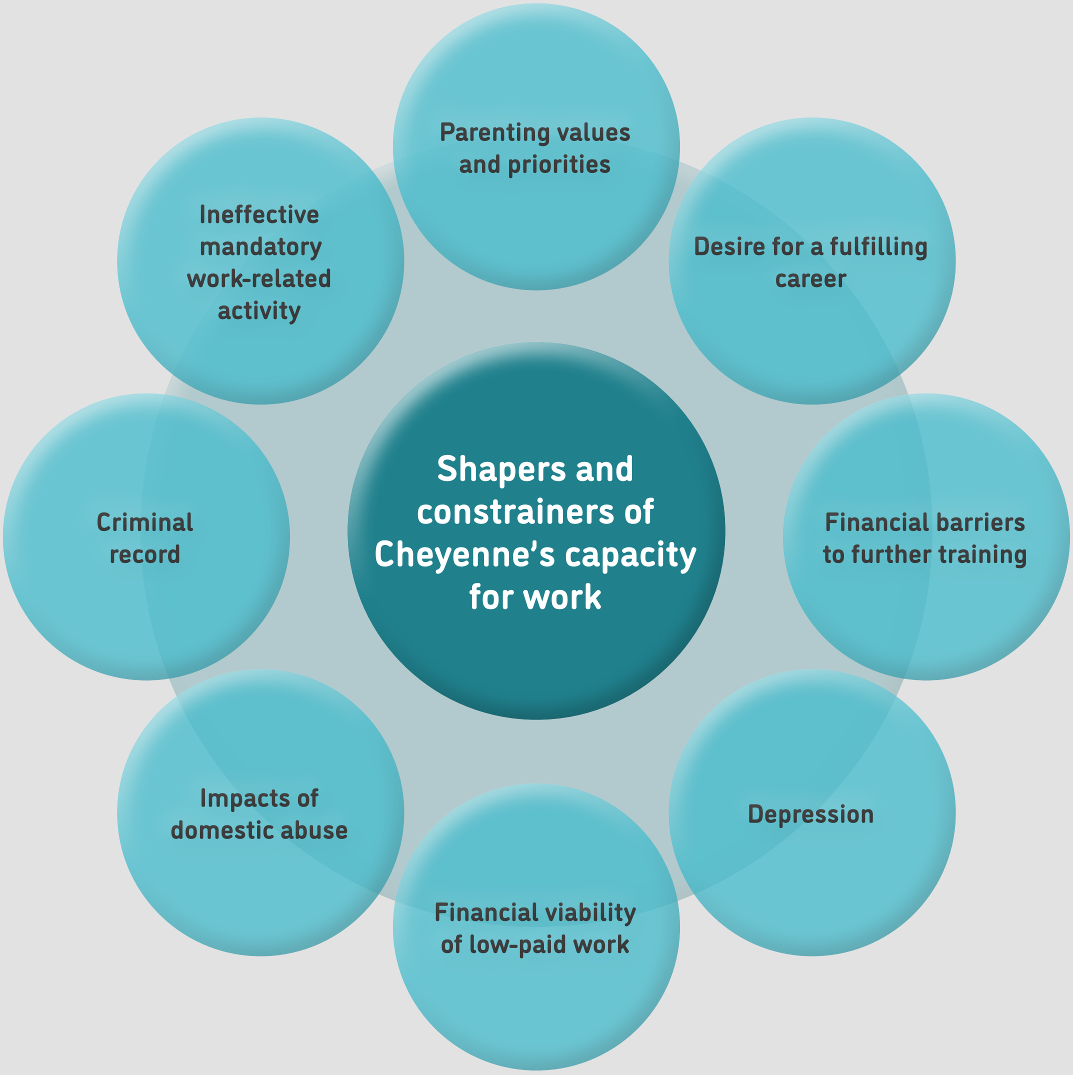
> *"It was very unhealthy for me. Because I suffer from depression and stuff like that, I need upbeat, I need my confidence to be boosted. I need encouragement, praise - not what you get when you go to these places... What they've done to me mentally, it's put me off trying, because I've spent so long job searching for hours. I don't want to do it anymore, I don't want to job search for hours; I think that's too much. If I need to do that, no, I'll just be unemployed, to be honest. I don't see why I should go through all that to get a crap job and be £15 a week better off."*

Cheyenne expressed an interest in undertaking further training but noted that if she became a full-time student in receipt of a bursary, this could make her liable for her rent, which she did not feel was financially viable.

Although she was still required to maintain some contact with the Jobcentre whilst in the WRAG, her fear of being forced to undertake mandatory activity that she felt was incompatible with her parenting circumstances was leading her to limit these contacts as far as she could, repeatedly deferring appointments and requesting telephone interactions only:

> *"It's terrible the lengths you need to go to - or the lengths I'm going to - just to stay away from these work-related things because I really, really, really can't handle it... Anything they ask of me, I see it as they're bullying me and I feel bullied and I feel defensive. I don't see it as them helping me, so I get anxious about anything they want to do with me at all."*

She was therefore not receiving any form of productive employment support, and remained on ESA for the remainder of the research study.


Parenting values and priorities
Ineffective mandatory work-related activity
Desire for a fulfilling career
Shapers and constrainers of Cheyenne's capacity for work
Criminal record
Financial barriers to further training
Impacts of domestic abuse
Depression
Financial viability of low-paid work

The case studies selected for this report, which are only five among many which could have been chosen, illustrate how factors including homelessness, lone parenthood, violence and abuse, bereavement, neurodivergence, limited access to training, citizenship status, the economic viability of work, and welfare conditionality figured in complex combination in people's lives, together shaping and constraining their capacity to secure and sustain fulfilling and appropriate employment.

At times, the direct symptoms of anxiety, depression or post-traumatic stress were salient factors in these participants' capacity for work. Their distress had multiple and interwoven causes, often spanning back many years of their lives but also (re-)triggered by more recent events and ongoing circumstances. However, a lack of stable, secure and affordable housing, difficulties finding work that is compatible with childcare, a need to support children's wellbeing during unsettling experiences, lack of workplace accommodations, financial and conditionality-related obstacles to enrolling in or completing additional training and qualifications, and a desire to pursue long-term career aspirations, were equal if not more predominant considerations in people's narratives in the immediate and longer term.

In summary, our analysis – illustrated in detail by the above case studies – shows how people's own self-assessment of capacity for work is simultaneously shaped by many factors beyond mental health alone. Childcare commitments and parenting values, lack of housing stability, financial viability considerations, access to transport, and a desire to pursue a sustainable and fulfilling career through the completion of further education and training are all salient to people's capacity for work, when considered in real-world and specific context.

However, under current welfare structures, it is only the functional impact of health-related symptoms that are taken into account when assessing someone's capacity for work and determining the conditionality that will be applied. All of the numerous and interrelated barriers to work that emerged from the narratives of participants in this study (see Figure 1) must therefore be subsumed within an illness framing.

This individualises and medicalises what is clearly a much more complex and multifaceted set of considerations and constraints. Coupled with a system of punitive conditionality which requires a medicalised understanding of capacity in order to be exempted from mandatory activity and the threat of sanctions, claimants are *necessarily* required to subsume all of their complex barriers and constraints under a category framing of mental ill health.

The implication we draw from these findings is that we need a more holistic approach to understanding and assessing capacity for work and, in turn, to determining related conditionality requirements. This would not only provide a more meaningful picture of the barriers and employment support needs of individual claimants, but may also alleviate the necessity – for some claimants – of relaying their complex combination of psychological, social, structural, economic and interpersonal barriers through the narrowly medicalised 'catch all' of mental ill health.

04.

Discussion and policy propositions

For people with experience of mental health problems, barriers to work include but extend beyond the emotional and physical symptoms of distress. Our analysis shows that a **person's capacity for work cannot be meaningfully understood along a single dimension of health alone**. Assessments of what is timely, reasonable and appropriate work-related activity must be made with regard to the holistic combination of factors surrounding, intersecting and influencing an individual's capacity for work.

In the Welfare Conditionality Project interviews, freed from the constraints of the questions in benefit claim forms, or the threatening power structures of the Work Capability Assessment, research participants gave nuanced explanations of the multiple intertwined factors that affected their capacity for work. In contrast, the current Work Capability Assessment makes health conditions the single focal point, sharpening attention on this single aspect of people's lives and forcing all other concurrent and interrelated factors to blur into the background, subsumed by a catch-all category of mental illness[15]. People's distress is undoubtedly real and is often severe; these facts are not in question. However, the necessity of presenting the reasons or causes of work incapacity solely through a narrowly medicalised framing is an institutionally-driven product of a health-centric benefit categorisation and conditionality system, which pays scant regard to people's wider social circumstances.

The 'snapshot' WCA also overlooks the antecedent events and circumstances of people's earlier lives which have influenced the work-related possibilities, opportunities and constraints that shape their capacity for work today. These might include childhood trauma and adversity which impacted educational outcomes, and which now dictate the 'baseline' from which people's vocational direction can progress, criminal convictions, or career derailment as a result of domestic abuse or migration. Whilst these events and experiences cannot now be undone, it is important that policies are designed in ways that understand and have compassion for how people's life histories exert an enduring influence on current capacities and capabilities.

The key proposition that arises from our analysis is that **we need a more holistic approach to understanding and assessing capacity for work**. To assess a person's capacity for work on the basis of health alone is to take a problematically partial view of the range of factors that may be constraining their ability to find and sustain appropriate and fulfilling employment. A more holistic approach to understanding and assessing work capability would offer a more complete, meaningful and compassionate picture of the challenges, constraints and contingencies that shape people's capacity for work.

This more holistic approach would remove the necessity for all of the social, structural, economic and interpersonal factors, which have a critical role in shaping capacity for work, to be channeled narrowly through the individualised and medicalised lens of ill health. A more comprehensive understanding of the factors shaping work capacity may also open up scope for more effective, tailored and holistic employment support. This more person-centred approach also has potential to improve levels of engagement with Jobcentres and rebuild trust between claimants and DWP staff.

We have shown in this analysis how a more holistic, whole-life perspective on capacity for work can reveal a fuller and more meaningful understanding of what shapes and constrains people's work capabilities. How might policies be redesigned in a way that invites and welcomes these 'whole story' versions, which would in turn allow for a more meaningful, compassionate and constructive response to claimants' employment support needs? We suggest that a valuable starting point may be through **more effective use of provisions that already exist within the system, regarding statutory and discretionary easements**.

Within the existing welfare system, conditionality 'easements' are in principle available in respect of circumstances including domestic violence, bereavement, domestic emergencies and homelessness[16]. However, the Welfare Conditionality Project data suggest that claimants do not have widespread awareness of these provisions and they are not routinely implemented by Jobcentre Work Coaches[17]. We therefore concur with others[18] in recommending enhanced training and support for Jobcentre staff to understand and implement the use of statutory and discretionary easements, particularly around the impact of homelessness, domestic violence and caring responsibilities for children with additional support needs. Further empirical research into the use, application and scope of conditionality easements would be valuable.

More widespread awareness and application of the existing provisions for conditionality easements could reduce the additional distress that is generated when mandatory jobsearch requirements are imposed on people at times when they are facing significant *non-health* related constraints on their capacity for work. In light of growing recognition that tighter and harsher conditionality rules could be driving up health-related benefit claims[19], a more holistic, more person-centred and less punitive approach to assessing capacity for work, coupled with more proactive use of discretionary easements, may help to stem the rise in mental-health related claims.

It is also significant to note the incongruence of current lone parent conditionality policy with some claimants' value positions on when and how much work is appropriate to their family circumstances, particularly (though not only) when there has been trauma, abuse and/or separation experienced within the family. As our case studies show, parents of older children may be forced to convey their circumstances via a predominantly medicalised lens, within the blunt administrative categories made available to them by the current system.

Greater awareness, transparency and effective utilisation of discretionary easements could create a safer space for claimants to provide a comprehensive and less narrowly medicalised account of their complex and multifaceted work-related challenges, whilst simultaneously acknowledging their experiences of related psychological distress. However, claimants' willingness to discuss personal and work-related challenges outside of a medical framing will rest on a much-improved level of trust between themselves and DWP staff. This will mean overcoming barriers that have been built through many years of punitive conditionality regimes perceived as forcing people to return to work under threat of sanctions.

Challenges, opportunities and risks

Our key proposition – for a more holistic approach to understanding and assessing 'capacity for work' – constitutes a radical shift in thinking, one that contains both opportunities and risks for claimants, services and systems. In broadening the way in which we conceptualise and assess capacity for work, it is essential that we do not deny the reality of claimants' psychological distress as a significant, interwoven and influential factor. In a system that has for so long been built around evidencing illness, there are risks inherent for claimants and services alike, in shifting the framing to something that places health on a more equal footing with other constraints on capacity for work.

Ill health has long occupied a preeminent position among the socially accepted 'deserving' reasons for exemption from work[20] and, from a structural perspective, has become the essential framing for the validation of economic inactivity within the current UK welfare system. Meanwhile, the boundaries of this deservingness are increasingly being questioned in both political and popular discourse, particularly with regard to mental health. It has become ever more important for claimants' illness status to be accepted and affirmed by institutional processes. Thus, the challenge inherent in our proposal is finding a way to 'de-centre' health from its dominant position in the conceptualisation and assessment of work capability, without denying its reality and impact on people's lives.

Interestingly, the essence of our proposition was already hinted at by Dr Paul Litchfield in his 2014 review of the Work Capability Assessment[21], when he suggested that:

> *"If any new assessment is designed, the fundamental question of whether health related capability for work is the criterion that society wishes to use to determine benefit levels should first be considered."*

Our findings are published at a time of change for the UK welfare system. On an optimistic note, Labour's Get Britain Working White Paper[22] contains much that already connects with the messages and implications of our study. The White Paper recognises that people claiming long-term sickness benefits often face a range of other barriers including multiple health conditions, lack of recent work history, few qualifications, homelessness, addiction and criminal justice system involvement. It also recognises that improving provision of and access to affordable childcare, decent housing and reliable public transport are fundamental to the success of sustainable employment. We therefore hope that this study has boosted the evidence to support this more holistically framed direction of travel in understanding and addressing barriers to work.

There are further signs of hope within the Labour government's Connect to Work initiative, in that this new programme explicitly engages claimants whose experiences include not only disability but also criminal justice system involvement, previous caring responsibilities, homelessness, armed forces, drug or alcohol dependency, care experienced young people, people with refugee status, victims/survivors of domestic abuse, modern slavery, and young people at risk of being involved in serious violence[23]. These dimensions to the programme show an acknowledgement of the range of personal, social and economic factors that shape people's capacity for work, exactly as we have been advocating in this study.

At time of writing, the publication of Labour's plans for reform of the disability benefits system is imminent. If and when the WCA is abolished, we would argue that whatever form of alternative 'conversation' it is replaced with needs to be inclusive of the full range of factors that shape and constrain capacity for work. If the system is moving towards greater discretion given to those working at the frontline, then work coaches will need to take a person-centred and holistic approach, actively listening to what claimants say about their work aspirations and how their health *and* non-health circumstances affect the type and amount of work-related activity they can feasibly undertake. However the current capacity, networks and resources available to Jobcentre staff may limit the scope for such holistic and joined up approaches. Initiatives such as the local level Trailblazers announced in the Get Britain Working White Paper[24], intended to stimulate greater joined-up activity around localised work, health and skills support, may offer new scope for improved holistic provision across a range of services.

Despite these emerging signs of hope for more holistic approaches to meeting people's employment support needs, whilst the Work Capability Assessment remains in place as conditionality-based dividing mechanism between those who are and are not deemed 'ill enough' to receive differential treatment, then the system will retain the counterproductive and harmful outcomes that stem from this. The great challenge will be to design an assessment system that acknowledges the functional impacts of mental distress, whilst also ensuring that, for the great many claimants whose capacity for work cannot be distilled down to mental ill health alone, this is not the only institutionally legitimised dimension through which their conditionality obligations are determined.

05.

Conclusion

Benefit claimants who experience mental health problems have invariably experienced and continue to live through complex and distressing social, structural, economic and interpersonal circumstances, all of which have direct and interrelated impacts on their capacity for work.

Whilst the psychological distress of claimants who report mental health problems is never in doubt, this study has shown that a much wider range of factors are involved in determining people's ability to secure and sustain appropriate and fulfilling employment at any given time. It is essential to bring these wider non-health factors back into the policy discussion, if government is to effectively understand and thereby address the contemporary problem of economic inactivity.

We reiterate here the recognition that, for some people, severe mental illness is experienced as a foremost and enduring barrier to engaging in paid employment. However, this study indicates that, for many claimants, capacity for work needs to be understood in more holistic terms than health alone. In understanding its relationship to work capability, the impact of mental distress must be acknowledged both on its own terms but also, crucially, in the context of the wider range of interconnected social, structural, economic and interpersonal factors that simultaneously shape and constrain people's capacity for work. For many, if not most, benefit claimants, mental distress does not emerge or operate in isolation. People's distress is genuine, real and at times severe, but it is rarely the whole story of what is shaping and constraining their ability to obtain sustainable and fulfilling work. Capacity for work is about more than mental health alone. But an assessment system that only allows people to relay their work limitations through a medicalised lens will inevitably and unavoidably generate medicalised claims. We need a more holistic approach to understanding, assessing and supporting capacity for work.

Acknowledgements

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Appendix: Deliberative Dialogue Workshop

In June 2024, we held a deliberative dialogue workshop focused on the opportunities and challenges that might arise from a more holistic approach to assessing capacity for work, as proposed by this research project. The workshop brought together policymakers, practitioners and researchers into a deliberative dialogue, seeking to answer questions surrounding capacity assessment and barriers to work.

The first session of the workshop explored the opportunities and risks of a holistic approach to assessing work capacity. Opportunities at the individual level included fostering trust between claimants and Work Coaches, enabling more open and comprehensive discussions about barriers to work, and providing better-targeted support. However, risks included raising unrealistic expectations for support, the potential for claimants to remain stuck in a 'holding pattern' if services lacked capacity, and concerns over how conditionality might be applied to broader barriers to work such as housing. Some feared that expanding assessment beyond health could delegitimise mental health conditions or increase stigma for claimants.

At a system-wide level, a holistic approach could improve claimant engagement and trust in the DWP, potentially leading to better outcomes. However, concerns were raised about increased subjectivity in assessments, complexities in appeals processes, and the quality of assessment reports. Public and political attitudes posed further risks, particularly around conditionality and the perception of fraud. Additionally, DWP capacity constraints could create short-term demand spikes as claimants engage in longer, more detailed assessments, though long-term demand might decrease with improved support.

The second session of the workshop focused on what a holistic assessment could look like. Participants emphasised the need to shift from the current health-centric WCA to a more asset-based model, which would focus on strengths, capabilities and aspirations, as well as considering a broader range of factors that influence a claimant's capacity for work. This includes non-health barriers such as childcare, housing, transport, and financial hardship. A broader approach would help identify appropriate work for claimants and improve targeted support. However, concerns were raised about the practical challenges of implementing such an approach, including the risk of re-traumatising claimants, the need for skilled Work Coaches, and the difficulty in balancing public buy-in with a more holistic assessment.

The workshop also discussed the importance of a more collaborative, triage-based system where Work Coaches could connect claimants with local services, particularly those in the third sector. However, issues with inconsistent services and long waiting lists could limit the effectiveness of such a system. It was suggested that Work Coaches might benefit from working outside traditional Jobcentre settings, in more community-based spaces.

Recommendations arising from deliberative dialogue

1. Reform the Work Capability Assessment to move away from a narrow focus on health:
    - Shift the WCA from a focus on health to a broader understanding of capacity for work, incorporating not only health but also non-health barriers such as housing, childcare, transport, employability, and financial hardship.
    - Ensure that any assessment recognises the complex, intertwined nature of these barriers and allows claimants to define and prioritise the key challenges they face in accessing work.
    - Consider adopting an asset-based approach to assessment that identifies the strengths, capabilities and aspirations of claimants, alongside their support needs.

2. Training and support for Work Coaches:
    - Provide specialised training for Work Coaches to equip them with a broader range of skills to address various barriers to work, including mental health, housing, and financial issues.
    - Explore models like the keyworker system, where claimants are matched with a consistent, trusted individual who is able to sensitively elicit information and assist with referral to experts in specific fields, such as housing or substance abuse, to better address multifaceted challenges.
    - Provide Work Coaches with training in communication approaches that avoid re-traumatisation and help them navigate sensitive conversations around difficult personal barriers.
3. Integrate support services with capability assessment:
    - Develop stronger links between Jobcentres and third-sector organisations to ensure claimants are connected to local resources that address specific barriers to work, such as childcare, housing support, or mental health services.
    - Investigate the possibility of data sharing between public and third-sector organisations to streamline access to services and ensure claimants are referred to appropriate support.
4. Improve the cultural and physical environment of Jobcentres:
    - Foster a work culture within Jobcentres that develops a greater sense of autonomy around case management and emphasises the importance of trust-building with claimants.
    - Support Work Coaches' wellbeing as they adjust to changes in this work culture and the new responsibilities it may bring.
    - Invest in improving the physical environment of Jobcentres to make them more welcoming and supportive. This could include more comfortable waiting areas and less emphasis on security to reduce claimant anxiety.

5. Reassess the role of conditionality and sanctions:
   - Work towards scaling back the punitive aspects of conditionality and sanctions, focusing instead on providing the necessary support to address the full range of barriers to work that claimants face.

A full report of the Deliberative Dialogue workshop is published as: Lawson, G., Irvine, A., Lovelock, C., Pollitt, A. and Glaser, K. (2025). *Reforming the Work Capability Assessment: Evidence from a Deliberative Dialogue Workshop*. London: ESRC Centre for Society and Mental Health.

Endnotes

Endotes

1. Department for Work and Pensions (2024) *Universal Credit Work Capability Assessment, April 2019 to December 2023*. Available: https://www.gov.uk/government/statistics/universal-credit-work-capability-assessment-statistics-april-2019-to-december-2023

2. Department for Work and Pensions (2024) *A health, social and economic profile of ESA recipients: Adult Psychiatric Morbidity Survey 2014*. Available: https://www.gov.uk/government/publications/a-health-social-and-economic-profile-of-esa-recipients-adult-psychiatric-morbidity-survey-2014

3. The Welfare Conditionality Study 2013-2019. For details: http://www.welfareconditionality.ac.uk/

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5. Welfare Conditionality Project (2018) Final Findings Report. University of York, UK. Available: http://www.welfareconditionality.ac.uk/publications/final-findings-report/

6. We received invaluable assistance from members of the original Welfare Conditionality Project team in gaining access to the data set and developing our understanding of the structure of the archived material. However, all analysis was carried out independently and the interpretations and recommendations reported here do not necessarily reflect the views of the original research team.

7. The Illness Representational Model originated from work by Howard Leventhal and colleagues in the 1980s. The model is complex in its theoretical underpinnings and continues to evolve through adoption and development by other scholars. Accessible descriptions and worked applications of the model, which we found useful to shape our own analysis, include:

   Petrie, K. J., Broadbent, E., & Kydd, R. (2008). Illness perceptions in mental health: Issues and potential applications. *Journal of Mental Health*, 17(6), 559–564. https://doi.org/10.1080/09638230802523047;

   Antoniades J, Mazza D, Brijnath B. Becoming a patient-illness representations of depression of Anglo-Australian and Sri Lankan patients through the lens of Leventhal's illness representational model. *International Journal of Social Psychiatry*. 2017;63(7):569-579. https://doi.org/10.1177/0020764017723669;

   Bear, H. A., Krause, K. R., Edbrooke-Childs, J., & Wolpert, M. (2021). Understanding the illness representations of young people with anxiety and depression: A qualitative study. *Psychology and psychotherapy*, 94(4), 1036–1058. https://doi.org/10.1111/papt.12345

8. Wording adopted from Baines, T., & Wittkowski, A. (2013). A systematic review of the literature exploring illness perceptions in mental health utilising the self-regulation model. *Journal of clinical psychology in medical settings*, 20(3), 263–274. https://doi.org/10.1007/s10880-012-9337-9

9. Hinds, P.S., Vogel, R.J. and Clarke-Steffen, L. (1997) The Possibilities and Pitfalls of Doing a Secondary Analysis of a Qualitative Data Set, *Qualitative Health Research*,7(3): 408-424. https://journals.sagepub.com/doi/10.1177/104973239700700306;

   Irwin, S., and Winterton, M. (2011) Qualitative Secondary Analysis in Practice: An extended guide. Timescapes Working Paper Series No.7, https://timescapes-archive.leeds.ac.uk/wp-content/uploads/sites/47/2020/07/WP7-Nov-2011.pdf

10. The Welfare Conditionality project team involved a large group of research interviewers. Researcher decisions to probe certain topics (or not) will have been shaped by appropriate methodological in-the-moment decisions, including their assessment of the salience of mental health to the unfolding narratives, explicit statements from participants that they did not wish to elaborate on this aspect of their lived experience, and pragmatic judgements around managing time and energies during the interview encounter.

11. A term used to denote abuse or exploitation (particularly financial) of vulnerable people by close acquaintances who they would consider to be their friends

12. This will be partly a reflection of the original Welfare Conditionality project's recruitment channels, where a number of locally based support organisations assisted with engaging participants in the study.

13. Recall here that the study sample included some people who described experiences of distress but had never claimed health-related benefits.

14. It is important to note that several participants included in this QSA study sample experienced concurrent physical health issues. For present analytical purposes, our report is focused on the experience of mental health difficulties, hence we have located physical health issues within the 'wider personal circumstances' domain of our framework. However, we acknowledge the impossibility of separating these two elements of lived experience, in the day-to-day lives of participants.

15. Here we again acknowledge that many claimants are experiencing both mental and physical health issues. Our core proposition – that we need a more holistic approach to understanding and assessing capacity for work – is generalisable to the experience of physical health conditions, be that alone or in combination with mental distress.

Endotes

16 DWP (2025) Universal Credit and your claimant commitment: https://www.gov.uk/government/publications/universal-credit-and-your-claimant-commitment-quick-guide/universal-credit-and-your-claimant-commitment#tailored-to-your-situation

17 See also: Welfare Conditionality Project (2018) *Final Findings Report*. Available: http://www.welfareconditionality.ac.uk/publications/final-findings-report/;

Wright (2020) Mental health, welfare conditionality & employment support: Policy recommendations & key findings. Available: https://eprints.gla.ac.uk/224227/1/224227.pdf

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