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research article

More than a mental health issue: broadening the concept of 'work capability' through qualitative secondary analysis of claimant narratives

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This article offers a perspective on the policy problem of rising mental-health-related economic inactivity and associated health and disability benefits claims in the UK. Rather than engage directly in debates about whether these health problems are 'real', or if and how health assessments should be reformed, we ask a more fundamental question about the way the problem of economic inactivity is being represented in policy. Drawing on Bacchi's 'what's the problem represented to be?' approach, we consider whether the important but increasingly dominant focus on mental ill health as the cause of inactivity is obscuring understanding of the broader set of factors that *simultaneously* constrain people's capacity for work. Through secondary analysis of a large qualitative longitudinal dataset, we illustrate how a multiplicity of structural, economic, social and relational factors shape and constrain people's capacity for work. Participants gave rich, nuanced and complex accounts of their capacity for work, which revealed that mental distress is just one dimension. However, placed within a welfare system that takes a narrowly medicalised approach to assessing work capacity, coupled with a punitive regime of conditionality and sanctions for those not meeting this criteria, people's difficulties retaining and regaining work were not comprehensively acknowledged, and mental distress inevitably became the primary lens through which their difficulties were bureaucratically legitimised and responded to. Throughout the analysis, we emphasise that people's distress is real, genuine and often severe, but it is rarely the whole story of what is blocking their pathway to fulfilling, sustainable employment.

Keywords economic inactivity • medicalisation • mental health • Work Capability Assessment • Welfare Conditionality

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Introduction

The rising number of working-aged adults who are economically inactive due to long-term illness is currently generating significant political concern in the UK (HM Government, 2024). Between 2020 and 2023, self-reported inactivity due to long-term ill health rose by 470,000 (Atwell et al, 2023), reaching a high of almost 2.8 million in early 2024 (Powell, 2024). Over the same period, the UK saw an increase of around 1 million people claiming incapacity and/or disability benefits, and this is forecast to continue, reaching record costs of £62.8 billion per year by 2028–29 (Ray-Chaudhuri and Waters, 2024). Within both economic inactivity and benefits trends, mental health issues are prevalent (Ray-Chaudhuri and Waters, 2024; Commission for Healthier Working Lives, 2025).

Detailed endeavours to understand the drivers of these increases (Gregg, 2024; Ray-Chaudhuri and Waters, 2024; Commission for Healthier Working Lives, 2025) have sat alongside media and political commentary that queries the veracity or seriousness of people's distress (Daily Telegraph, 2024; Parris, 2024; Sunak, 2024). While these debates about deservingness and boundary-setting within sickness and disability benefits have become an ever-present feature of welfare policy in the UK and beyond (Soldatic and Pini, 2009; Jeene et al, 2013; Geiger, 2021), the goal of this article is to introduce a slightly different question to this space. Standing somewhat aside from debates on deservingness or on what constitutes 'real' mental illness (Haslam, 2016; Foulkes, 2021), we raise the question of whether policy needs to look at the drivers of economic inactivity rather more broadly. Drawing on in-depth qualitative longitudinal interviews with benefit claimants who experienced mental health difficulties, we shed light on the wider set of structural, economic, social and relational factors that shape and constrain people's capacity for work, thereby posing a more fundamental question about whether a narrow administrative focus on *health*-related inactivity is perhaps becoming something of a self-fulfilling prophecy. We ask whether, in an ever more complex and precarious social world, the descriptive category of mental ill health is 'doing the work' for a much wider set of barriers to employment.

In one form or another, a benefit category for people deemed too unwell to work has existed since the earliest days of the welfare state. Gulland's (2019) fascinating account of the UK incapacity benefits system over the past century shows us that the issue of defining (in)capacity has a long history. Gulland's analysis reveals how early understandings of capacity had both *social* and *health* components. However, an increasingly narrow focus on health throughout the welfare reforms of the late 20th and early 21st century led to the point where our current system is one which understands work capability only through an 'entirely individualised medical assessment' (Gulland, 2019: 35). Yet, as Gulland points out:

> It is not possible to make a purely medical assessment of person's capacity for work … to separate out a person's individual incapacity for work from the labour market, structural barriers to work and discrimination. So long as benefits systems maintain this fiction, there will be no way to square this circle. (Gulland, 2019: 1 and 105)

This article builds on these observations, using a rich source of archived contemporary data which illustrate the limitations of an individualised, medical conceptualisation

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of work capability. The core argument of the article is that, while the psychological distress of claimants who report mental health difficulties is never in doubt, a *much wider range of factors* are involved in determining their capacity for work, and 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[1].

Our analysis was motivated by, but also departs from the many important studies (Barr et al, 2016; Hansford et al, 2019; Porter et al, 2021; Pybus et al, 2021; Wright et al, 2022, to name but a few) that have exposed the flaws and harmful effects of the UK's current process for assessing capacity for work, the Work Capability Assessment (WCA). The WCA is a test of 'functional impairment' administered to UK claimants who wish to apply for health-related benefit components and/or reductions in mandatory work-related activity conditions attached to benefit eligibility. The assessment covers a number of 'activities' and 'descriptors' for which points are allocated. Reaching a certain threshold of points provides access to health-related benefits and conditionality exemptions.[2] Extant research[3] has repeatedly demonstrated that the WCA is both an ineffective method of establishing the nature of functional impairment caused by mental distress, and is itself a source of significant additional psychological harm. There is urgent work to be done to improve the design and administration of the current WCA, making it better tailored and less distressing for people experiencing mental health issues. However, our aim in this article is to illustrate that, irrespective of these well-established problems with the WCA, its fundamental focus on *health* as the shaper of work capacity provides only a partial – and insufficient – understanding of people's lived experience.

Mental health and economic inactivity: what's the problem?

We frame our argument through Bacchi's (2009) 'What's the Problem Represented to Be?' (WPR) approach to policy analysis. Our focus is on the dominant policy stance that the growing problem of economic inactivity is predominantly one of health, and (of specific interest to the present study) rising rates of mental ill health. Bacchi (2009) argues that by looking at the policy proposals put forward to address a given issue, we can identify how that problem is being *represented*, which then points to the values and assumptions that underlie that policy standpoint. Bacchi invites us to dissect policies by asking what the 'problem' is represented to be, what is presupposed by that representation, what is left unproblematic or silenced, what are the effects of that representation, and could the problem be thought about differently. These questions matter because, 'the way in which the "problem" is represented carries all sorts of implications for how the issue is thought about and for how the people involved are treated, and are evoked to think about themselves' (Bacchi, 2009: 1).

Since the first introduction of decontextualised checklist assessments of 'functional capability' in the 1980s (Gulland, 2019), the primary policy solution to rising health-related claims has been one of ever more stringent assessment of people's health limitations with ever narrowing eligibility. Shortly before the recent change in UK government, the Conservative party ran a public consultation on proposals to amend or remove eligibility criteria relating to mobility, continence and social engagement from the WCA (DWP, 2023). The incoming Labour government announced within the

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first months of coming to power that another public consultation on disability benefit reform would be launched in early 2025 (HM Government, 2024). Ahead of this, in the same employment White Paper 'Get Britain Working' (HM Government, 2024), the government pledged substantial additional investment in cognitive behavioural based talking therapies. Thus, while we see a querying of the deservingness or severity of some people's mental health issues, the core political *representation of the problem* of rising economic inactivity continues to be one of ill health. The policy spotlight remains on *health-related* incapacity as the problem that requires tighter definition and more stringent gatekeeping, with provision of *health-related* interventions for those affected.

In this article, we offer evidence that invites a more complex representation of the problem of economic inactivity – one which widens the torch beam to shed light on the range of *other* significant factors that are preventing people with experience of mental distress from moving into employment. It is imperative to make explicit, at this early point in the article, that we are in no way suggesting that claimants are not experiencing genuine distress – sometimes very severe distress.[4] What we wish to illuminate, through close analysis of claimant narratives, is the wider set of circumstances that *simultaneously and interconnectedly* contribute to people's difficulties in finding, securing and sustaining employment, but which receive markedly less attention in current policy discourse around economic inactivity. As we will describe, mental distress is undoubtedly one important factor in this picture, but it is not the only one, nor is it necessarily the primary driver. Current policy represents the economic inactivity problem as one of ill health. We put forward evidence to suggest that this problem representation may be obscuring a more comprehensive understanding of why people are unable to work, and what effective policy solutions might therefore look like.

Methods

This paper is based on a Qualitative Secondary Analysis (QSA) of the Welfare Conditionality Study dataset (Dwyer et al, 2019).[5] The Welfare Conditionality Study (henceforth WelCond) was an exceptionally large-scale qualitative longitudinal study conducted between 2013 and 2018, which explored benefit claimants' experiences and perceptions of sanctions and support within the UK welfare system (Dwyer, 2018). The study involved almost 500 participants, most of whom were interviewed at two or three timepoints over approximately three years (2014–17). Benefits claimed by participants in the highly diverse sample covered a wide range of those available within the UK at the time the WelCond study was conducted, including health/disability related and non-health benefits.[6]

While mental health difficulties were not an explicit sampling criterion of the primary study, the WelCond researchers identified over 200 participants who mentioned experiences of mental distress (Dwyer et al, 2020). This included several participants who were not necessarily in receipt of health/disability benefits. Drawing on this valuable data source, the overarching aim of our secondary analysis was to deepen understanding of the experience of psychological distress among people engaging with the UK welfare system, in order to improve the health-related benefits assessment process and enhance effectiveness of welfare-to-work support for people experiencing mental distress.

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Building on the large body of evidence on the flaws of the WCA, our original intention was to investigate claimants' narratives in more granular linguistic and discursive detail to advance understanding of *why* the assessment was such a poor method of establishing mental-health-related incapacity. However, as we will describe our initial focus on how participants 'made sense of' their distress shifted to an unanticipated reframing of the problem as one that required looking *beyond*, rather than more deeply into, the specifics of mental health symptomatology.

The extensive and rich qualitative dataset, from which we could draw upon an abundance of relevant material, meant that our study did not suffer from the potential limitation that QSA may offer reduced scope for analysis (Hinds et al, 1997; Irwin and Winterton, 2011). A strength of QSA is that approaching an existing dataset from a new angle presents opportunities to explore themes that arose in a more unprompted fashion during interviews, perhaps denoting their salience to the participants (Bornat, 2003; Corti and Thompson, 2004). However, being unable to seek clarifications from participants, or probe more deeply into topics of emerging interest to the secondary study, are inherent limitations of QSA. As neither author was part of the primary study team, we did not have the embodied experience of meeting with participants and absorbing the material aspects of the encounters, which can enrich qualitative understanding (Irwin and Winterton, 2012). This signals one of the key ethical considerations of QSA, that secondary analysts have a duty to treat participants' accounts with sensitivity and care, maintaining the same principles of confidentiality, anonymity and respectful handling of personal narratives as the primary researchers (Irwin, 2013; Yardley et al, 2013; Mozersky et al, 2020). QSA also brings ethical considerations in respect of the relationship between the primary and secondary research teams. These relate to an 'ethics of care' in acknowledging the practical, intellectual and emotional investments of the primary researchers (Weller, 2022), and an 'ethics of ownership', particularly when primary researchers may be still actively working with the data (Irvine, 2024).

Sampling

Our secondary analysis drew on a subsample of those 200+ WelCond participants who described experience of mental distress. Following the 'breadth and depth' approach to sampling in QSA (Davidson et al, 2019; Edwards et al, 2020), we used keyword searches across the full WelCond dataset to both 'map and mine' the content of the corpus. The keywords were mental-health-related terms common in contemporary Western discourse, including: depression, anxiety, psychosis, schizophrenia, PTSD, bipolar and OCD. Truncation ensured capture of variants (e.g. depress* to capture depression, depressed and depressive). All archived transcripts (n =1081 transcripts from n = 481 participants) were quantitatively mapped and then arrayed from most to least frequent users of the keywords. From this process, we constructed a subsample of 70 cases where participants spoke in particularly rich narrative detail about their experiences of mental distress. This purposive approach to sampling is appropriate in QSA research, where the researcher interrogates an existing corpus to identify the most relevant and fruitful cases that can provide insights into a specific new question of interest (Chatfield, 2020; Edwards et al, 2020). We ceased incorporating further cases when we became confident that each additional case was confirming

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but not expanding or elaborating on the themes already identified. That said, we by no means exhausted the archive and there remain many more unique narratives that could have been included.

The discursively driven methods of the project meant that we were seeking narrative and linguistic depth over demographic representativeness. However, we purposively maximised the inclusion of participants from minority ethnic backgrounds, insofar as the primary dataset allowed, as well as including all participants who spoke about less common mental health diagnoses (e.g. schizophrenia, psychosis, bipolar disorder). The age and self-reported gender of participants are given in Table 1. The sample included 11 participants of minority ethnic identity (6 female, 5 male). For several participants, benefit status changed over the course of the longitudinal study, hence cannot be meaningfully quantified. Notably, however, not all had necessarily received health-related benefits and several moved between health and non-health benefits as will be illustrated in the case studies that follow.[7]

Table 1: QSA sample overview

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

Analysis

As with most qualitative approaches, QSA requires researchers to first become well-oriented within the data, through immersion and open exploration of transcripts. Our analytic approach began with the construction of detailed chronological narratives for each of the 70 participants, drawing on all three waves of interview data. We devised a minimally structured template to temporally organise the narratives, and extracted substantial amounts of detail, including extensive verbatim quotes. In the process of reconstructing and 'smoothing' the narrative data (Coley et al, 2024), we added subheadings as relevant to each participant (for example, employment history, housing history, health changes, household changes, childcare). We simultaneously added reflective and analytical memos in the margins of these narrative summaries, and – as a team of two researchers each working remotely on a subset of cases – used the @ function in Microsoft Word to draw each other's attention to notable passages, pose questions or signpost to comparable or contrasting cases elsewhere in the data set.

Although we were primarily focused on exploring the interplay of mental health and employment, as our initial familiarisation with the narrative data progressed, we noticed many participants talking about the broader set of constraints, considerations and contingencies that shaped their self-perceived prospects of being able to return to employment. These were variously framed as *barriers* standing in their way or *facilitators* that, if in place, would make work potentially feasible. Alongside our more

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linguistically driven analysis of mental health discourses, this prompted us to also conduct a systematic coding and thematic categorising of this much wider range of factors that participants saw as shaping or constraining their capacity for work. Supported by NVivo software, we thematically coded the 70 narrative summaries according to the range of work-related barriers/facilitators described by participants. From this, it could readily be seen that the effects of mental distress were but one of many influences on work capability. Close analysis of the longitudinal data, and the biographical accounts contained within, brought to light the multifaceted combination of influences that operated to constrain people's ability to gain and sustain employment over time, leading to our proposition that a narrow focus on mental health as the fulcrum for assessing work capability is invariably partial and arguably insufficient.

Findings: reconceptualising capacity for work beyond health

Thematic analysis of the longitudinal narratives generated across three waves of research interviews resulted in a four-domain typology of factors which participants described as shaping and constraining their capacity for work (Figure 1). The four domains are: *manifestations of distress and their functional implications*; *person–environment fit*; *wider personal circumstances*; and *factors beyond the individual*, each of which contains a number of components. The multidirectional arrows represent the inextricable interrelationships between the different domains of influence on claimants' work capacity.[8]

Space prevents a full elaboration of each component, and we believe our analysis is most powerfully conveyed via the presentation of a sample of narrative accounts which show how these domains interact and overlap in people's lives over time. No single narrative involved every component, but all participants' stories involved aspects within multiple domains of the typology. The four detailed case examples presented below illustrate the interwoven nature of personal, relational, socioeconomic and structural factors that constrained people's capacity for work. However, to situate our analysis of how mental distress is both an *upshot of* and *backdrop to* this broader set of circumstances that concurrently shape capacity for work, we begin with a short discussion of how participants conceptualised the impact of manifestations of distress on their work and wider life.

Manifestations of distress and their functional implications

This domain involves the range of emotional and physical manifestations of distress described by participants, and the consequent impacts on their daily function in domestic, social and workplace settings. Manifestations 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, sleep problems, digestive discomfort, fatigue, lethargy, low motivation, feelings of emptiness, states of high energy and frenetic activity, agitation, 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.

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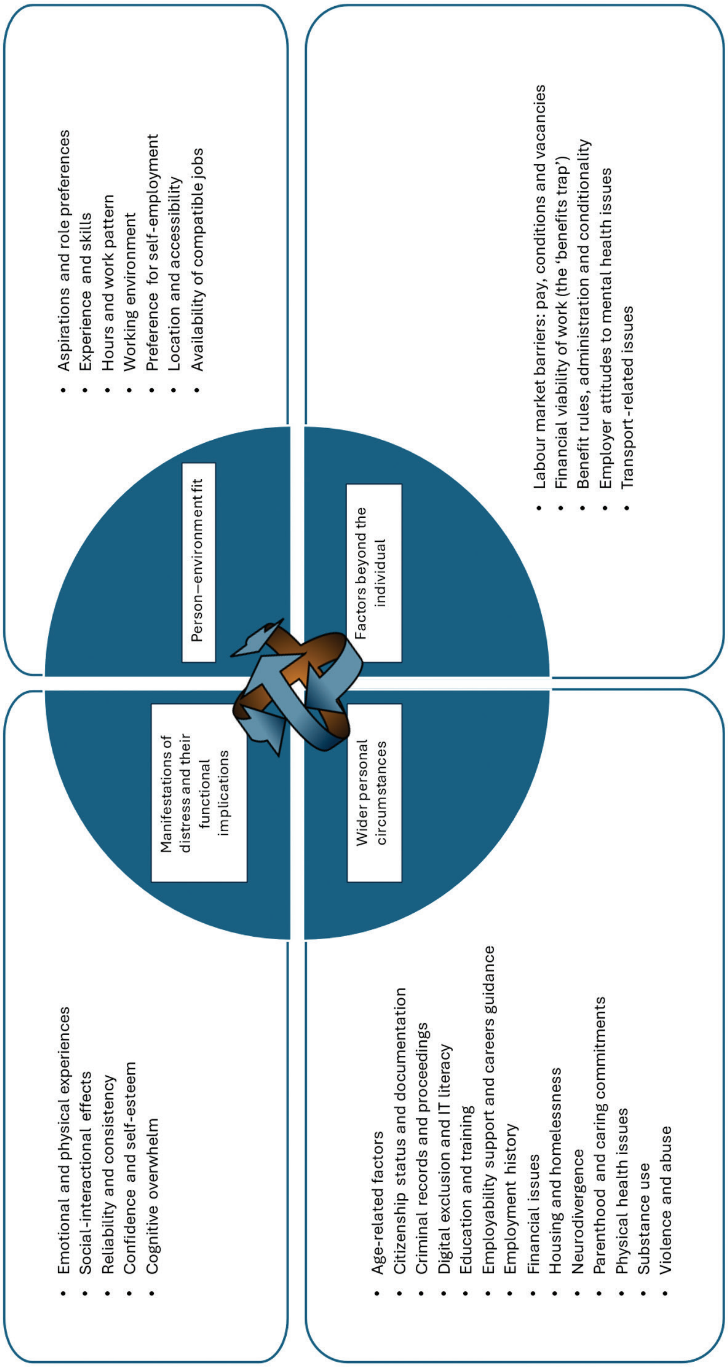
Figure 1: Factors shaping and constraining capacity for work: perspectives of claimants with experience of mental distress



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The associated 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. A number of participants spoke about how these 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.

We include this more detailed discussion of the *manifestations of distress* domain to underscore the reality of mental health difficulties and how – at certain times, and with fluctuating intensity – these bodily and emotional experiences pose a genuine and significant barrier to sustained or consistent engagement in paid employment. However, the overarching finding of our analysis is that this aspect of lived experience offers only a *partial* understanding of what shapes people's capacity for work. Therefore, the welfare system's imposition of a categorical delineation around health as the defining determinant of capacity for work (and associated conditionality rules) may be contributing to ongoing problems in understanding and responding effectively to the 'problem' of economic inactivity.

A broader conceptualisation of capacity for work

The rich narrative and longitudinal data showed that a much wider set of concurrent and interwoven factors were invariably at play in shaping and constraining people's capacity for work. As illustrated in the four case examples that follow, people's capacity for work was shaped by the combined impact of historic and contemporary factors, which variously included homelessness, addiction, early childhood trauma, violence and abuse, court proceedings, neurodivergence, physical illness or disability, debt, relationship breakdown, and lone parenthood, *alongside* the consequent distress associated with these experiences, which together summed to a situation of feeling unable to sustain paid employment at certain times. To expand on just one factor by way of example, being homeless or in temporary, unsuitable or insecure accommodation could be a significant cognitive load that caused or exacerbated distress and, in turn, constrained people's practical and emotional capacity to think clearly about work and take proactive steps towards employment (see also Devine et al, 2020). Being street homeless presented a barrier to seeking or securing employment, due to the lack of a fixed address, employer attitudes and preconceptions, or the sheer practicalities of managing personal care and essential needs, when rough sleeping.

When explaining their self-perceptions of capacity for work, many participants also referred to factors reflecting the notion of 'person–environment fit' (De Cooman and Vleugels, 2022). This included the type of work they felt able to do with regard to their aspirations, preferences and skills; the amount and schedule or pattern of work in relation to health, age or caring commitments; and the physical and social environment in which they would be working, which for some people included a preference for lone working or solo self-employment. While specific role aspirations and preferred working environments varied considerably, the point to emphasise

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is that people's perceived ability to *obtain work that fitted their preferences* could be a distinct factor in their self-assessments of capacity for work, when weighed against the realities of the local labour market and employer attitudes.

Factors more typically conceived within notions of 'employability' were also mentioned, including lack of or outdated qualifications, low levels of IT literacy and digital exclusion. As we will see in the case studies, benefit rules and inflexible practices within Jobcentres could constrain people's ability to train towards a longer-term goal that might in due course provide them with a more sustainable and fulfilling career. Beyond this, external factors of the labour market, welfare systems, access to public or private transport, and perceptions of employer attitudes to age, criminal records and fluctuating work capacity also shaped people's assessment of whether (or under what circumstances) they were able to work. Reflecting the concept of the 'benefit trap', several participants talked about the financial viability of moving into work, whereby they did not believe they would be financially better off, to any meaningful degree.[9]

While we have constructed a discrete four-part typology, it was clear from participants' narratives that these dimensions worked in overlapping, interconnected and compounding ways. However, the current UK welfare system reduces the assessment of capacity for work to a unidimensional conceptualisation centred on health alone. Before moving to discuss the implications of this partial and narrowly medicalised framing of capacity, we present four detailed (pseudonymised) case examples, which illustrate the multifaceted influences on claimants' self-assessment of capacity for work, *including* but going far beyond a singular dimension of mental distress.

Case examples

Kyra's story

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 by a former partner. 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. The relationship did not last, though the father remained involved in the child's life.

Kyra returned to work when her child was two years old; 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).[10] 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 (now aged seven) 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

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for the future, rather than taking any job available. She pursued the teaching assistant qualification, while 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 preparation scheme. Attendance at this mandatory scheme clashed with the final months of her qualification, putting her at risk of not completing it. She explained this to the work scheme provider and her Jobcentre adviser, 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):[11]

> I spoke to my job centre adviser 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.'

While 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 [teaching 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 preparation scheme], 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. The factors shaping and constraining Kyra's capacity for work are shown in Figure 2.

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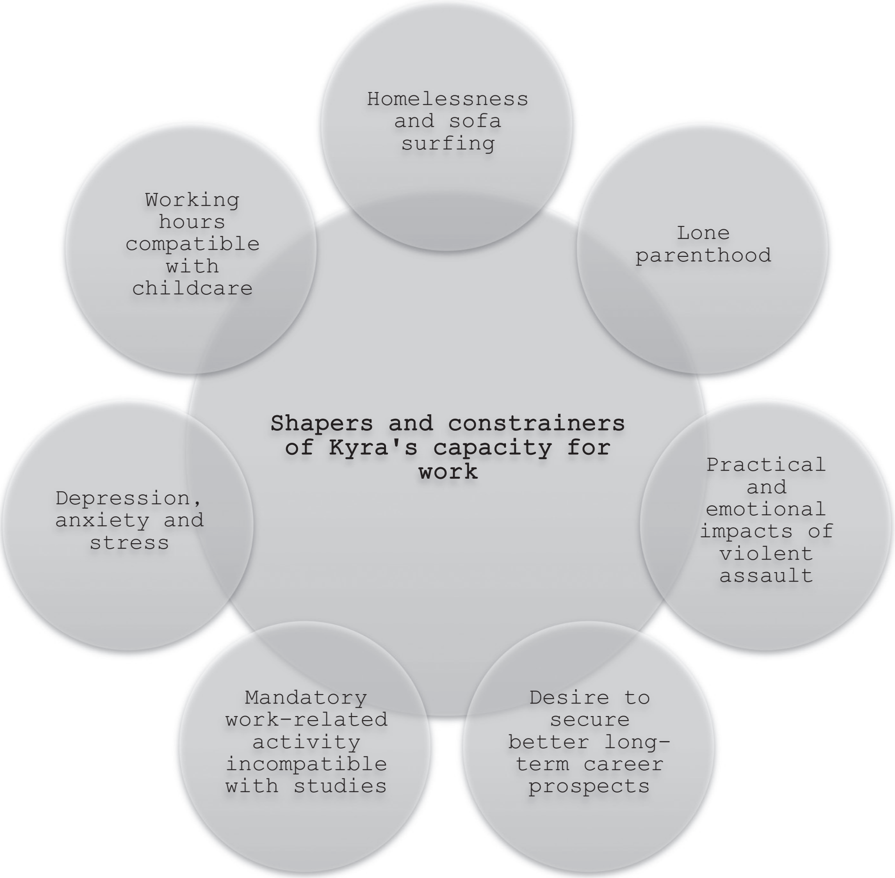
Figure 2: Shapers and constrainers of Kyra's capacity for work



Nihal's story

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[12] 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. While 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: 'That was just too much for me going in there every day, sort of being reminded by it all … So that sort of took its toll, and that's how I ended up homeless.' 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.

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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 [more] 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', a claimant category which did not require active jobseeking but did require certain mandatory work preparation activity. At his final research interview, around six months later, Nihal was at that time 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 the high rent at the homelessness accommodation if he moved back into paid employment and thereby became ineligible for 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 … That's

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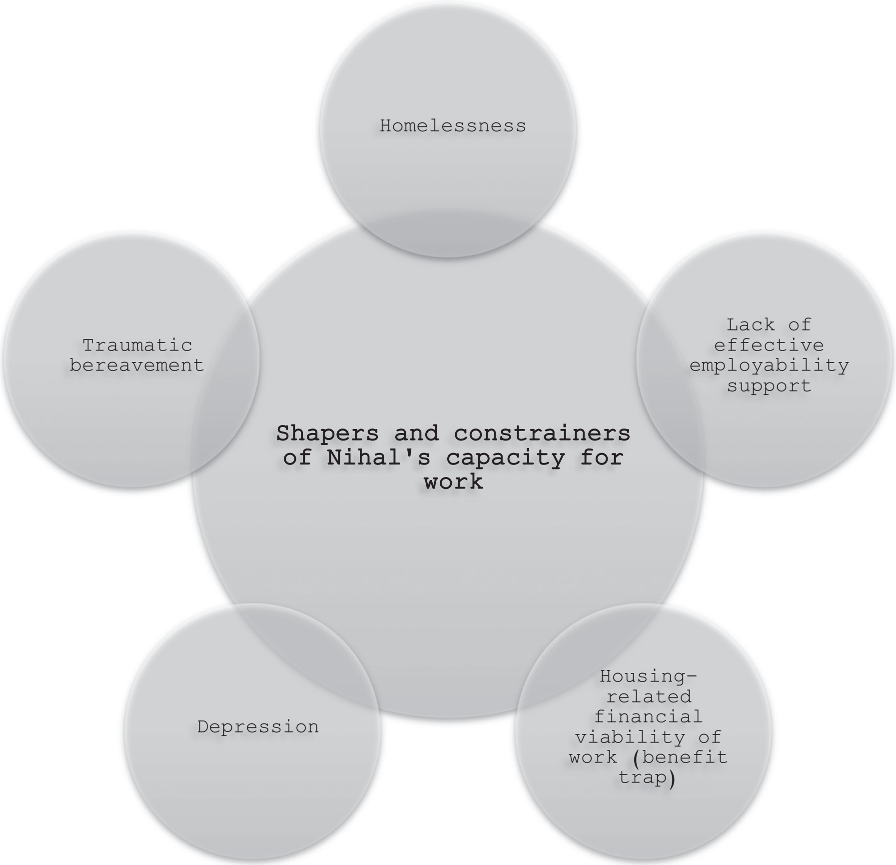
> the thing that's really holding me back … I want to get housed so I can get back to work, so I can start to save and start making plans for the future.

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 the disability benefit Disability Living Allowance,[13] as this would support his application for social housing. The factors shaping and constraining Nihal's capacity for work are shown in Figure 3.

Figure 3: Shapers and constrainers of Nihal's capacity for work



Marta's story

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.

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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[14] 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 son started school the coming September.

Marta was currently attending work-focused interviews at the Jobcentre every three months and was aware she would be moved from Income Support to Jobseeker's Allowance when her son 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 at which 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 son 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 adviser 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 son 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: 'My partner was troubling me indirectly so of course I get depressed or stressed.' 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:

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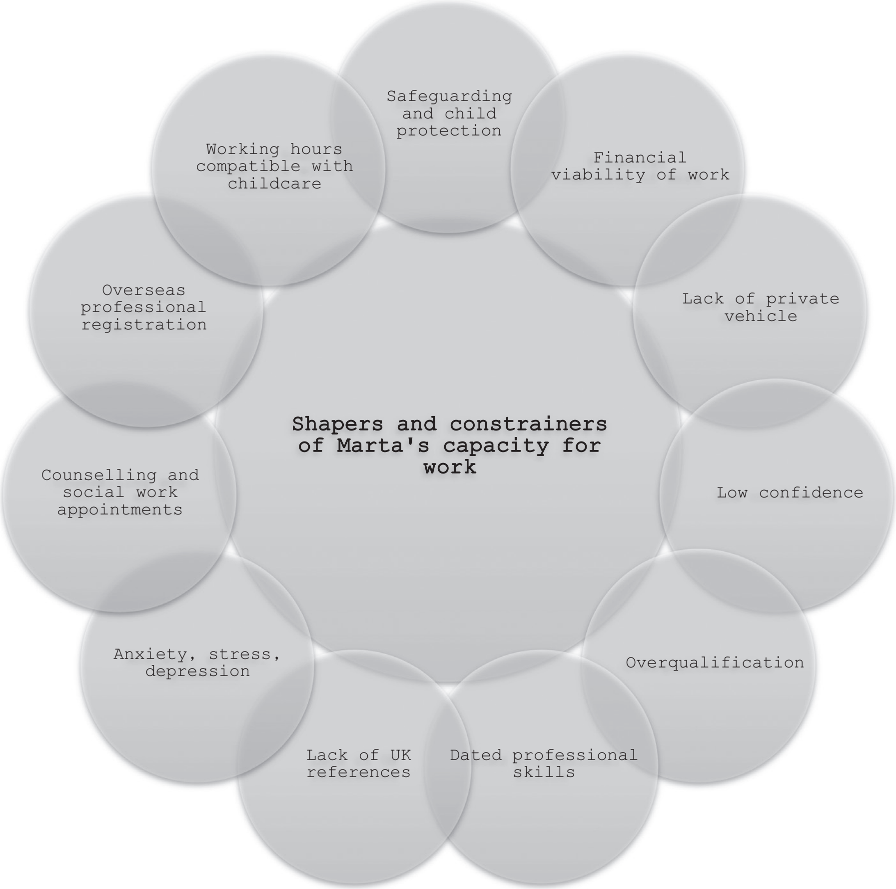
> The doctor put me on antidepressants, sometimes I attend counselling, but it is not going to help me because it's not practical. I know what domestic violence is, I know how to move on; I need practical support.

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. The factors shaping and constraining Marta's capacity for work are shown in Figure 4.

Figure 4: Shapers and constrainers of Marta's capacity for work



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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!"'

Simeon's story

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 the emergency services and, in his 30s (while 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 work-related 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 [emergency services 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,

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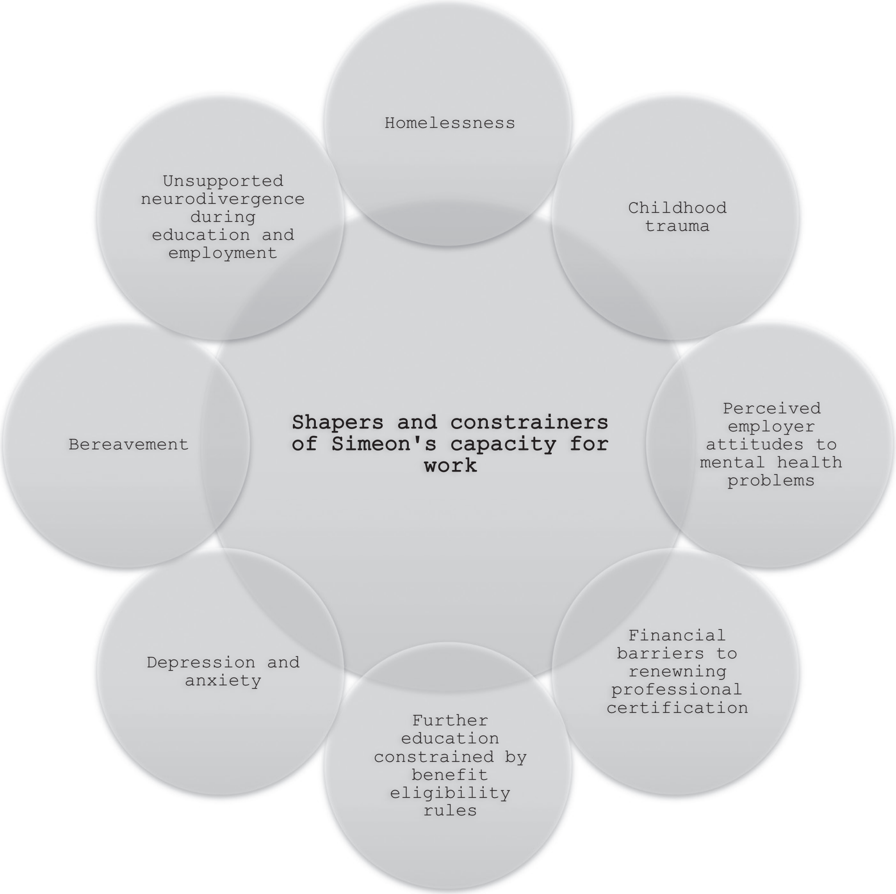
but was told that alternative roles were not possible. His mother then passed away. Simeon described how his mother's death triggered the upsurge of years of suppressed trauma:

> 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. Simeon 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. The factors shaping and constraining Simeon's capacity for work are shown in Figure 5.

Figure 5: Shapers and constrainers of Simeon's capacity for work



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Discussion

These stories all illustrate how mental distress is both an upshot of social and structural harms and forms part of a broader ongoing backdrop to the complex set of circumstances that shape and constrain people's capacity for work over time. Both Marta's and Kyra's stories show how distress can arise from situations of relational harm and abuse, the consequences of which include unstable housing, derailed employment pathways, isolation, and more complex childcare and parenting situations. It is entirely understandable that these women experienced anxiety and depression. However, to assess their capacity for work on the basis of mental health alone is to take a problematically partial view of the range of factors that constrained their ability to regain and sustain employment. Nihal suffered a highly traumatic bereavement and, despite his best efforts, was temporarily unable to sustain a return to his previous role, so bound up as it was with that tragedy. A shift to health-related benefit afforded him time to process his grief without the demands of punitive conditionality. As the intensity of his grief eased, he felt ready to return to work, but homelessness and the associated benefit trap now had him stuck in a situation where maintaining his health-related claim was the only financially viable option. Simeon endured multiple structural and systemic obstacles in his path to pursuing studies that would lead to a fulfilling and sustainable career while simultaneously maintaining a viable degree of financial stability. On top of eviction and homelessness, the loss of his mother was the last straw, pushing him to psychological breaking point and triggering the release of suppressed emotions from earlier in his life.

For all four participants, distress was absolutely real. But representing their economic inactivity as a problem of mental ill health offers only a *partial* understanding of why these men and women were unable to work, and of what support they needed to move closer to work. When circumstances reached a critical mass of complexity and intensity, their physical and emotional manifestations of distress became the only institutionally validated way in which they could be granted 'breathing space' from punitive conditionality and inappropriate work-related requirements, while they navigated a much broader range of personal, social, and economic challenges, all the while trying to maintain a long view on their career aspirations.

Their trajectories illustrate the effects of benefits policies built on the combination of a narrowly medicalised framing of capacity operating in tandem with a conditionality regime that is poorly tailored to individual circumstances and predicated on the threat of sanctions. For these four individuals (and numerous other WelCond participants) mental distress was the only institutionally legitimised aspect of their experience, while they endured multidimensional situations of hardship that shaped and constrained their capacity for work. As observed by Gutin (2024: 116), this reflects the wider picture of medical(ised) problems enjoying a higher 'symbolic and bureaucratic' legitimacy across a range of social institutions. Gutin continues:

> Across a broad set of legal and political venues, individuals' social circumstances are only seen as legitimate once they are manifest in poor health and disability … Those experiencing extreme poverty or homelessness are only afforded public sympathy, material support and various rights once an explicit connection is made between their social circumstances and poor health. (Gutin, 2024: 117)

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Framed in more conversational terms by Massey (2019: 148), 'The snag of medicalisation is that all attention is then focussed on the final straw, which is to miss the point that it is the heavy load of life that has brought the person to their knees.' We therefore suggest that these *structural mechanisms of medicalisation* are to an extent 'self-fulfilling' and provide at least some of the explanation for why we continue to see the exponential rise in mental-health-related incapacity benefits claims. Of all the barriers and constraints people face, illness is the only one that 'counts'; thus it is the one that gets counted.

Our inductively derived typology resembles the complex mesh of factors identified in several other qualitative studies internationally (Olson and Pavetti, 1996; Audhoe et al, 2018; Devine et al, 2020; Roddy, 2023). For example, Olson and Pavetti's (1996) study of challenges to the successful transition to work among welfare recipients in the USA identified barriers including: physical and mental health conditions, child health or behavioural problems, chemical dependency, family violence, housing instability, and low basic skills or learning disabilities, while Roddy's (2023) study of female prison leavers identified transportation as the most common barrier, followed by the impacts of justice system involvement, physical and mental health issues, caring responsibilities and 'human capital deficits' (that is, work experience, jobsearch skills and qualifications). As Audhoe et al (2018: 28) note, 'unemployed workers with mental health problems have to deal with multiple problems, of which medical problems are only a part.' The present study adds to this evidence, reinforcing that, while there is no doubt that people's self-reports of mental health problems reflect genuine experiences of distress, a much more complex, multifaceted and dynamic picture is hidden behind the headline statistics on mental-health-related economic inactivity.

Our analysis invites debate about how we conceptualise 'capacity for work'. We suggest that capacity for work might be considered as a 'complex system' whereby many interdependent and moving parts must be sufficiently aligned in order for a person to obtain and sustain employment. Similar propositions drawing on complex systems theory have been made by Hernández Corredor and Beltrán Martínez (2020) in relation to the concept of employability and, more recently, Rod et al (2024) in relation to precarious work and health. Ultimately, our evidence and arguments lead us into alignment with more holistic conceptualisations of 'employability'. Two decades ago, McQuaid and Lindsay (2005) made the case that a broader conceptualisation of employability is needed, if people's potential to work is to be supported into realisation. Their holistic framework of employability involves components of *individual factors*, *personal circumstances* and *external factors*, and its range of sub-components bears striking resemblance to the thematic model that arises from the present data (see McQuaid and Lindsay, 2005: 209–210). While our model is constructed specifically from the accounts of people with experience of mental health difficulties, in McQuaid and Lindsay's (2005) discussion of the concept of 'employability' the phrase 'capacity for work' could be directly substituted, in echo of our core argument:

> Employability [*capacity for work*] it is argued, should be understood as being derived from, and affected by, individual characteristics and circumstances and broader, external (social, institutional and economic) factors that influence a person's ability to get a job … A broad approach to employability [*capacity for work*] … allows us to identify the real key interrelated barriers that actually prevent someone getting a new job, rather than merely identifying a subset … which may or may not be the actual main barrier. (McQuaid and Lindsay, 2005: 206–207)

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Based on national survey data, the new UK government has diagnosed poor mental health as 'the leading driver of ill health-related inactivity' (HM Government, 2024: 24). But if we look beyond predetermined survey response categories or blunt benefit classifications, and instead engage closely with people's stories, constraints on capacity for work invariably emerge as multifactorial, with psychological distress frequently an *upshot* or *corollary* of the antecedent circumstances that *also* led people to lose connection to their previous working life.

Moreover, the contingent and context-dependent nature of work capacity was apparent across the sample of WelCond participant narratives, revealing the nuances in people's self-assessments of what type, where and how much work might be possible for them. This nuance is lacking from the WCA, in its treatment of the individual as a discrete unit of (potential) productive labour, abstracted from any specific work context and evaluated only on the dimension of health. Turning again to Gulland (2019: 205), 'the concept of incapacity for work is meaningless outside its social context', pinpointing the fundamental flaw in the decontextualised and medicalised approach of the current WCA (Irvine and Haggar, 2024).

Key to our argument is that we are proposing a *both/and* conceptualisation of the issue. Proposing greater incorporation of non-health barriers into how we understand and assess work capacity does not mean that mental health difficulties do not form a genuine and distinct dimension of those barriers. Our point is that positioning health as the sole or primary dimension around which all assessment, eligibility and conditionality is focused misrepresents the problem and fails to address all necessary facets of the solution. For many people in the study sample, there were times in their lives where the bodymind manifestations of distress did represent the dominant barrier to work. But, in the longer term, approaching people's work capacity solely through a medicalised lens may risk looking in the wrong place (or at least not *enough* places) for the solutions. Without losing the important ground gained in understanding and awareness of mental health, and without for a moment dismissing people's lived experience of distress, we need a broadening of perspective on how we understand the shapers and constrainers of work capacity and how we – in turn – design, locate and fund related intervention and support. As observed by Devine et al (2021: 14) in the Australian context, further reform to disability employment programmes, 'seems somewhat futile unless broader social policies and programmes can help prevent and address the complex array of vocational, non-vocational and structural barriers more commonly experienced by job-seekers with disabilities'.

For over a century, health has been given a privileged status within the welfare system, as a discrete category which overrides (and thus silences) all others in bureaucratically defining capacity for work. The more holistic representation of the problem that we offer here redirects the spotlight onto the range of social policies and public services that have a role in facilitating sustainable employment. It draws into frame the role of housing, childcare, transport, education, social services, the criminal justice system, employers and labour market policies, and, not least, the harmful conditionality-driven welfare system itself. It also requires us to consider benefit claimants as individuals with legitimate personal preferences and equal rights to pursue the kinds of work that they find fulfilling and compatible with their wider lives, aspirations and values.[15]

Returning to Bacchi and the WPR, the problem of economic inactivity is represented in current UK welfare policy as primarily an individualised and

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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 and often across the life course. To use Bacchi's terminology, these social and structural forces are the relative 'silences' in the current representation of economic inactivity. Lest we have not said it enough: people's distress is real, genuine and often severe. But it is rarely the whole story of what is shaping their capacity for work. However, if ill health is the only bureaucratically legitimised framing that people are offered by the social security system through which to explain their barriers to work, then this is the one they need to use. Unless and until policy begins to allow a safe space for people to express their circumstances in full, multifactorial detail and complexity, detached from conditionality and the threat of sanctions, we will continue with an intractable 'mental health problem' in the welfare system.

Conclusion

For people with experience of mental health problems, barriers to work include but extend beyond mental distress. Contemporary UK welfare policy has become preoccupied with assessing and distinguishing those who are sufficiently mentally unwell to warrant exemption from conditionality from those who are not. Our analysis invites a different framing of this policy problem. If the policy goal is to support more people towards suitable and sustainable employment, we need to shift the focus from disputes about whether people *are* or *are not* ill (enough), towards an approach that looks to understand the *complete* picture of why a person is struggling to gain or maintain employment. During the WelCond research interviews, freed from the predetermined questions on benefit claim forms or the threatening dynamics of the WCA, participants gave rich, nuanced and complex accounts of their capacity for work. These accounts reveal that mental health is just one dimension of personal evaluations of 'capacity for work' and that it may not always be the most dominant or influential barrier.

A key challenge for the alternative problem representation that we propose here is how to decentre mental health in debates about capacity for work without denying the reality of people's distress. At the time of writing, proposals for the replacement of the WCA with a more holistic and goal-focused 'support conversation' are in fact under consultation in the UK (DWP, 2025). This shift in discourse, with increased focus on personalisation, exploring aspirations and facilitating support around debt, housing, careers support and skills (DWP, 2025: 49–50) is potentially grounds for some optimism. A more person-centred and holistic assessment could improve trust in the system, relationships between claimants and frontline advisers, and outcomes for people seeking to move closer to work (Lawson et al, 2025). 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. But positioning health within a wider, contextualised framework of factors shaping work capacity has the potential to overcome conceptual, epistemic, practical and justice-based challenges in the domain of welfare-to-work policy. If we want to properly represent the problem of economic inactivity and create effective support for routes back into employment, we need a much broader understanding of what is standing in people's way. We need to step away from the stalemate of defining 'real' mental illness, and take a much more holistic approach to understanding and assessing capacity for work.

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Notes

[1] The very conceptualisation of economic inactivity as a societal 'problem' invites a more fundamental critique of ideological standpoints around capitalism, productivity and valued forms of occupation or social contribution. These debates lie beyond the scope of the present article, but should not be forgotten in this context (Frayne, 2015; 2019).

[2] For a more detailed explanation see: https://www.disabilityrightsuk.org/resources/work-capability-assessment.

[3] See: https://www.disabilityrightsuk.org/resources/work-capability-assessment.

[4] We are mindful of the diverse perspectives and controversies around use of language in the arena of mental health. In this article, we have used (interchangeably) the terms mental health 'problems' 'difficulties' and 'issues' to denote the discomforting and unwelcome nature of these experiences, for the people whose stories we draw upon. Aligning with Georgaca (2014) we also use the word 'distress' as an encompassing term which does not necessarily assume a medicalised framing on the part of those whose experiences we discuss. As Georgaca notes, a concept of distress 'acknowledges the troubling character of the experiences under consideration without subscribing to any specific model of conceptualizing them' (Georgaca, 2014: 56). At the same time, we recognise that some with lived experience *would* choose to describe their experience as illness (Chappell, 2023), while others would not necessarily conceptualise their experiences as unwelcome or problematic.

[5] The WelCond dataset is held in the Timescapes Archive at the University of Leeds (dataset identifier: https://doi.org/10.23635/13). Access to the data was granted by the primary study Principal Investigator.

[6] A detailed report of the primary study's methodology can be found in Dwyer (2018).

[7] It should be noted that in the intervening period since the primary study was conducted, there has been a significant change to the UK social security system, with six 'legacy benefits' for low-income households subsumed into a single benefit 'Universal Credit'. Hence, the majority of benefits received and discussed by participants in the WelCond study have now been superseded by this single benefit.

[8] Given this study's primary focus on mental health, we have placed physical health within the domain of *wider personal circumstances*, but acknowledge that this is itself an artificial separation, both in terms of embodied experiences and in the structures of the benefit system.

[9] The 'benefit trap' refers to a situation in which social security structures are such that a benefit claimant will experience little to no financial gain from moving into paid employment. Not clearly attributed to any individual scholar, it is broadly interchangeable with concepts of the 'welfare trap', 'poverty trap' and 'unemployment trap'. For a recent discussion of the 'benefit trap' in the context of UK disability benefits, see Evans (2025).

[10] Jobseekers Allowance (JSA) was the main UK unemployment benefit for adults of working age at the time of the WelCond study. Recipients of JSA were required to be 'available for and actively seeking' work. It has since been incorporated into the Universal Credit benefit.

[11] Employment and Support Allowance (ESA) was the main incapacity benefit available at the time of the WelCond study, for people with health-related limitations on their ability to carry out paid employment. For those in receipt of ESA, requirements for work-related activity were reduced or removed, and levels of benefits were somewhat higher than unemployment benefits. ESA has since been incorporated into the benefit Universal Credit.

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[12] Housing Benefit was a social security benefit available at the time of the WelCond study, available to people on a low income to cover some or all of the costs of rental housing. It has since been incorporated into Universal Credit.

[13] Disability Living Allowance (DLA) was a non-means tested benefit available at the time of the WelCond study, to meet the additional costs of long-term health conditions and to support independent living. It was later replaced by the Personal Independence Payment (PIP) benefit.

[14] Another of the 'legacy benefits' now amalgamated into Universal Credit.

[15] The primary research study on which this secondary analysis is based (Dwyer, 2018) analysed the effectiveness of the employment support offered to study participants. The headline finding was that statutory employment support of that period (2014–18) resulted in few participants being supported into sustainable work. The ineffective combination of poorly tailored mandatory work-related activity and punitive sanctions meant that 'stasis' was the most common outcome. While there were isolated instances of more beneficial support, the dominant experience was of 'brief and perfunctory' initial meetings, with subsequent interactions 'dominated by the threat of benefit sanctions for non-compliance' and 'meetings in which meaningful support in finding work was often lost within a system that prioritised perpetual job search' (Dwyer et al, 2023: 78). Reporting specifically on the experiences of study participants with mental health difficulties, the primary team concluded that the WCA, mandatory work-related activity and threat of sanctions 'undermined respondents' mental health and pushed people further away from the possibility of future work' (Dwyer et al, 2020: 321).

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Research ethics statement

Ethical approval for the secondary analysis study was granted by King's College London Geography, Global Health & SCRWU Research Ethics Panel (GGS REP): LRS/DP-21/22-29402.

Conflict of interest

The authors declare that there is no conflict of interest.

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