New Labour, Welfare Reform and Conditionality:

Pathways to Work for Incapacity Benefit Claimants.

Aimee Grant

Thesis submitted for the degree of Doctor of Philosophy

School of Social Sciences,

Cardiff University,

2011

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Abstract

This thesis is an exploration of New Labour's approach to Incapacity Benefit (IB) claimants, and is primarily concerned with 'Pathways to Work', a policy piloted in 2002 and rolled out nationally in 2007. Pathways, as it is commonly referred to, introduced a requirement for new IB claimants to attend compulsory Work Focused Interviews (WFIs) with a Jobcentre Plus Advisor. Furthermore, the claimants were to be offered support in the form of a range of voluntary work-focused initiatives. The most innovative of these was the Condition Management Programme (CMP), which was funded by the Department for Work and Pensions (DWP) but delivered by the NHS, primarily by Occupational Therapists.

A non-traditional approach to the thesis has been adopted. The prologue comprises two complete stories of how IB claimants have experienced the policy change. Following this, an exploration of the way in which the unemployed and long-term sick have been supported by the state since 1834 provides the context for New Labour's policy change. However, the literature reviewed shows that those who implement policy, in this instance Jobcentre Plus Advisors, have considerable discretion, which can impact on how claimants experience the policy (see for example Lipsky, 1980). Consequently, the research used a qualitative mixed methods design in order to find out how Jobcentre Plus Advisors, Condition Management Programme clinical staff, and IB claimants experienced the policy change. The research design used semi-structured interviews, observation and documentary analysis.

The empirical basis of the thesis is a focus upon three substantive areas: IB claimants' routes on to IB; experiences of compulsory Work Focused Interviews with Jobcentre Plus Advisors; and experiences of the Condition Management Programme each of these areas will be covered within a chapter. Within the three empirical chapters, a review of selected literature occurs before presenting the original findings alongside existing research. The discussion returns to the issues of policy intention, policy implementation and claimant engagement. Within the discussion, further exploration of original data occurs. Finally, the conclusion recognises that the policy context in this area has already significantly shifted since the time of the field work (2008). The increasing conditionality attached to claiming IB will be discussed alongside recommendations for policy and further research.

Acknowledgments

Declaration

This work has not previously been accepted in substance for any degree and is not concurrently submitted in candidature for any degree.

Signed ....

Date ...24\2\2011.

STATEMENT 1

This thesis is being submitted in partial fulfilment of the requirements for the degree of PhD.

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STATEMENT 2

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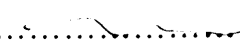
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STATEMENT 3

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and summary to be made available to outside organisations.

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Contents

Chapter Outline

Detailed Contents

List of Tables and figures

Abbreviations

a4e	Action for Employment, a private provider of return to work activity
ADF	Adviser's Discretion Fund
CMP	Condition Management Programme
DEA	Disability Employment Advisor, employed by Jobcentre Plus (also referred to as 'Advisor')
DoH	Department of Health
DWP	Department of Work and Pensions
ESA	Employment and Support Allowance
HA	Housing Association
NHS	National Health Service
IB	Incapacity Benefits
IBPA	Incapacity Benefit Personal Adviser, employed by Jobcentre Plus (also referred to as 'Advisor')
JCP	Jobcentre Plus
NDDP	New Deal for Disabled People
PCA	Personal Capability Assessment
RTWC	Return to Work Credit
SLB	Street Level Bureaucrat
WFI	Work Focused Interview, compulsory interviews for IB claimants introduced in 2002 by *Pathways to Work*.

Prologue: Two stories of attending the Condition Management Programme

0.1 Introduction

This thesis opens with the biographies of two Incapacity Benefit (IB) claimants. It is often suggested that the introduction of a PhD thesis should contain a justification for the research. I believe that showing these stories in isolation from any analysis will position the reader in the everyday reality that policy change can create for users. A sharp focus on these realities provides a powerful demonstration of why the research is necessary. Furthermore, due to the space constraints within the thesis, it is not possible to provide such detailed narrative accounts later. Therefore, the prologue should be seen as providing a fine-grained, detailed narrative account of two claimants' lives which can be used as an illustration of more general trends. It will be shown that with New Labour's reform of IB, there were those who benefited, in this instance Paul, and those who did not benefit but had increasing conditions applied to their benefit claim, such as Jo.

Very briefly, New Labour introduced *'Pathways to Work'* (DWP, 2002), where new IB claimants had to attend 'Work Focused Interviews' with a Jobcentre Plus Advisor. Advisors could offer claimants a range of voluntary initiatives known as the 'menu of choices'. One of the initiatives on the menu was the Condition Management Programme, a project that utilised health care professionals, such as Occupational Therapists, to attempt to better 'manage' a claimant's health conditions.

Paul was recruited for this research from the Condition Management Programme (CMP), and tells a largely positive tale of attending CMP, although he acknowledges his continuing health difficulties. On the other hand, Jo was recruited from the Citizens Advice Bureau. Whilst she also

took part in the CMP, she did so because she believed that it was a compulsory part of claiming IB. She tells a very different story and found CMP to be much less useful than Paul.

Paul's story is told through his interview and also through his CMP file[1] which contained detailed descriptions of his health condition and the interventions that the CMP provided him with. Paul's underlying conditions are physical, although he is beginning to experience an increase in frustration and depression related to his reduced abilities. Jo's story is told exclusively through her interview, as Jo participated in a privately run CMP, and it was not possible to gain access to her CMP file[2]. Jo suffered from a wide range of physical conditions and was also diagnosed with depression almost a decade ago.

0.2 Paul's story

Having worked as a gardener since leaving education, Paul later diversified in to repairing old buildings using traditional materials and methods. During a minor accident at work, Paul 'snapped' his Achilles' tendon resulting in having some time signed off work by his GP. However, Paul then developed a clot on his lung which resulted in several complications necessitating long stays in hospital, some of which were in the Intensive Care Unit. Paul still has regular problems with his chest. Likewise, his ankle injury has resulted in a permanent limp and considerable pain that is aggravated by activities such as walking and cold weather. Whilst Paul did not mention it at interview, his Condition Management Programme records note that he also has a 'bilateral carpel tunnel' which 'may need surgery'

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[1] Examples of key elements contained within the CMP files can be found in Appendices 11-16.

[2] The privatisation of CMP and the implications for research are discussed further in Chapter 8.

and for which he 'wears splints', although it was not noted if Paul always wears the supports.

Paul's first interaction with Jobcentre Plus was through a telephone support line after having been informed by letter that his Incapacity Benefit application form was incorrectly completed. This was an extremely frustrating experience for him as he believed that with common sense, what he had written could have been correctly interpreted. During his compulsory Work Focused Interviews, Paul also found the approach of his Advisor irritating. At the time of the research, Paul had not accepted that he might not be able to return to his old job which was still held open for him. As such, Paul was not ready to consider that he might need to retrain for a new career and as a result felt very frustrated when his Advisor suggested that he try training for an alternative role. However, whilst he found the relationship somewhat difficult, he did appreciate that his Advisor had noticed his low mood and, as a consequence, suggested the Condition Management Programme to him.

As part of Paul's compulsory Work Focused Interview, he also had to agree to an 'Action Plan' which was written by his advisor. Paul's Action Plan suggests that he thinks he may need a change in career and that he has been to see the Careers Service. This level of acceptance of his inability to return to his previous job was not seen during his interview or his Condition Management Programme file. It also states that Paul is attending his local college for adult literacy lessons and that although he is not diagnosed, it is likely that Paul has dyslexia.

During Paul's Initial Assessment with the Condition Management Programme, the clinician noted on a Risk Assessment form that Paul exhibits 'anger towards self'. Such notes were uncommon, and as such it is likely that the clinician was worried about his level of anger. The clinician also noted that Paul's current level of frustration 'is not normal for him' and that Paul had confided that he thought that he might be depressed but that

3

he had not felt able to discuss this with his GP. In addition to this, the OT noted that Paul's level of concentration, planning and memory were 'poor'. Paul also reported problems with sleeping and 'can't clear (his) head at night.' Prior to the deterioration of his health, Paul 'enjoyed work' and socialising with friends. However, he now finds it difficult to socialise as he does not feel that he fits into his group of friends in the same way.

As part of the Condition Management Programme, Paul saw an Occupational Therapist (OT) seven times. During these sessions, he discussed his frustration and feelings of emasculation from not being able to work and from losing his strength. The majority of the work that Paul's OT carried out with him was to encourage Paul to look at his condition differently and to more effectively pace himself in order to be able to achieve more. At the time of the research interview, Paul was still very frustrated and sometimes felt angry at his inability to do things that used to be easy for him to do, but his CMP file shows that subsequently he has realised that when he paces himself, he is able to do more. For example, Paul had been attempting to do some decorating in his kitchen, but had done too much at once and spent several days in bed as a consequence. Discussing this in a CMP session, Paul was encouraged to not attempt the work again until he felt stronger, not for at least a month, and then to decide if it was a realistic goal to be able to do it at all. If Paul did feel strong enough, the OT suggested he should do it one step at a time. Following this approach, Paul was able to achieve part of his DIY task in one afternoon; a job he estimated would have previously taken him one hour took three and a half hours, which he found frustrating, but he felt extremely pleased that he had been able to complete something.

During his OT sessions, Paul was also taught some relaxation techniques, and was given an accompanying CD. Initially he reported these were not working, 'but when using it before sleep he has slept really well.' After several more weeks, however, Paul reported that he felt that the use of the CD 'is beginning to work now he is using it more regularly.' In addition to

4

this, through discussions regarding pacing, Paul reported being able to accept help from others more easily when it was offered and visited his GP with his wife to discuss his low mood. A further benefit of CMP for Paul was that he began to feel able to socialise again and this was helping to elevate his mood although on occasions he felt that he might have been too active when friends visited and had to rest for several days afterwards and then felt frustrated by this.

After seeing an OT four times, Paul began to work on a one-to-one basis with a physiotherapist. The physiotherapist noticed that Paul's posture was not correct; because of the pain in his ankle, Paul was placing more weight on one leg resulting in poor posture. Likewise, to reduce pain in his ankle, Paul was walking up stairs in an atypical way. As such, his physiotherapist has given him exercises to try to help him straighten his posture. Paul has been told that if he does not 'straighten up' his posture, he will permanently damage his back by moving this way.

In order to try to relieve some of Paul's ankle pain, he was given exercises for his ankle. However, Paul found these exercises very difficult and painful. During his next session, the physiotherapist attempted to correct Paul's technique to reduce the pain, however this did not sufficiently help. Therefore at his fourth appointment, Paul was given 'a smaller version of (the) exercise'. At this point, Paul was also referred to the gym for 'prescribed exercise', a scheme run by the local Council where benefit claimants with health conditions can use Council facilities for free. Having attended twice an improvement in Paul's fitness level was noted by his Physiotherapist. However, regarding his ankle injury and posture, the physiotherapist stated 'Patient improving but minimal.'

Unlike the other interviewees, Paul did not complete the CMP evaluation process. Paul's discharge session with CMP took place in the gym and he was given forms to complete and post back. It is not known why Paul did not complete these, but perhaps his difficulties in reading and writing played

some part. Paul's Occupational Therapist felt that he might benefit from some longer term support to manage his condition. As such during his first session, she discussed the possibility of referring him to the Chronic Disease Management Nurse and, with Paul's consent, contacted the District Nurses' office to attempt to arrange this. Unfortunately after several letters and phone calls, the District Nurses' office felt unable to support Paul. This was a result of their high work load as they were only able to accept the most serious cases.

0.3 Jo's story

Jo's experience of *Pathways to Work* is very different to Paul's. Although at first Paul was somewhat frustrated by the system, he spoke very highly of the Condition Management Programme and its staff. Furthermore, although Paul was frustrated by the process of claiming IB, he described his Advisor in mostly positive terms. Jo's experience of *Pathways to Work* was largely negative, having felt forced to attend the (voluntary) CMP. Unlike Paul, Jo did not feel that CMP helped to improve her health conditions.

Jo was 48 years old at the time of the research, and had a long term partner and an eight year old son. She had been claiming IB for 15 years at the time of the research. Jo's original claim for IB was for arthritis and a bad back which continued to trouble her: 'I can't sit down for long, I can't stand up for long. If I'm having a real bad day, I just stand and I lean...I can't sit down because I can't get back up'. In addition, Jo had a 'massive heart attack' in 2005 and now suffers from angina. Furthermore, Jo has severe eczema which can cover her entire body, necessitating hospital stays in the past, which is aggravated by stress. On a day to day basis, following her heart attack, Jo describes herself as 'so tired'.

In addition to her physical problems, Jo has suffered with depression for the past ten years, for which she was prescribed anti-depressant medication.

Jo attributed her depression to providing care for both of her parents whilst one suffered with senile dementia and the other Alzheimer's. This was further affected by post-natal depression two years later. Jo became pregnant when she was 40. She had been told that she was unable to have children, and the pregnancy was a 'big shock' to her. Jo describes how she would prefer to spend her time 'I like time on my own. I don't do nothing, I sit and I mope but I like that time that you haven't got to put a brave face on, you haven't got to go smile...'.

Having left school 'as soon as I could' at the age of 15 without qualifications, Jo has gone on to work in a number of different roles. Initially upon leaving school, Jo worked in a shop, she then worked in a factory for several years, becoming a supervisor. Later, Jo ran a public house, before her first experience of unemployment. At this time, Jo reports, the 'only jobs going' were as sewing machinists. When she asked in the Job Centre about getting training for this, she was told that she was ineligible as she had not been unemployed for long enough! Jo describes a lengthy argument with Job Centre staff which resulted in her completing the training and working in a sewing factory for a year. Following a spell of working abroad, Jo returned to the factory, although her new role required a lot of heavy lifting. When she was laid off, Jo found work in a factory producing detonators. She stated that they would 'Blow your finger off. But that was enjoyable because it was no heavy lifting, it was just that you had to be careful...'. She describes one day how she picked up a box and 'done my back in...'. At that time, the accepted medical advice for a bad back was to rest, Jo states that 'For years I couldn't get out of bed some days, because then you were told 'rest, lay down'.

Having claimed IB uneventfully for 13 years, Jo's IB suddenly stopped. She reported that a letter was apparently sent to her that she was supposed to return, but that she had not received anything. At this time, Jo had to return to her GP to get regular sick notes for the first six months. She was then: 'invited... to talk about finding a job...' by Jobcentre Plus.

When Jo attended her first compulsory Work Focused Interview, she insisted on seeing her Advisor downstairs because of her difficulties in climbing stairs, after this, she was always seen downstairs which she appreciated. She describes her Advisor as 'a very nice girl, doing her job...no complaints about her.' However, during her second or third WFIs, Jo agreed to participate in the CMP, although she felt that the Advisor 'just managed to sneak it into the conversation; well (CMP'll) see you in two weeks.' At this time, Jo felt 'pressured...I just thought I'll do it because I can't afford to lose my benefit.' She reported that this was a common feeling among CMP attendees: 'I know a lot of people did feel (pressured).'

Jo described her reluctance to take part in CMP reporting that during her first session she felt 'I didn't want to be there.' Jo attended an initial assessment and a one-to-one session, where she reported that she felt unable to work due to the severity of her multiple health conditions. The idea of compulsion to attend CMP was apparent throughout Jo's story, including during her CMP participation: 'I still **had to** go to the meeting, the group therapy...'. Furthermore, it appeared to Jo, that the CMP's primary, if not only, aim was making IB claimants work-ready in order to remove them from Incapacity Benefit.

Jo believed that as she did not feel capable of working she should have been discharged. Jo did not want to attend a CMP group; she did not wish to share her feelings in front of others ('I'm not going to stand up and say to people "look I cry all the time"') and believes that she made this clear during her first two sessions. However, when Jo arrived for her second session, she found that it was 'group therapy'. Jo stayed for the group, but found some of the exercises to be 'silly' and patronising.

Jo subsequently did not attend the following two group sessions and was then phoned by a clinician, where she tentatively said that she would not be returning: 'She asked if I was going back and I said "No, not really..."'.

Whilst Jo felt able to be honest during her interview about how little she felt CMP had benefitted her, when she was sent evaluation forms, she did not fill them out. She believed that the evaluation was not anonymous and her comments may have resulted in her benefits being stopped. Additionally, Jo wanted to spare the feelings of the clinicians, as she felt that 'they thought they were creating miracles' through their efforts and she did not want to hurt their feelings.

Jo stated that it would have been more useful for her to learn how to use a computer than participating in CMP, and was surprised to learn that those types of courses could also be part of *Pathways to Work*. Jo's story shows the importance of wanting to engage with CMP. It was clear from the beginning that Jo attended because she was scared of losing her benefit if she did not. Consequently, she dropped out of CMP without having experienced any benefit from it. Thus if *Pathways* were to be compulsory, it is likely that the benefits seen in the engaged group would not be transferred to the less willing participants.

Having shown two detailed examples of attending CMP, it is possible to see the tensions inherent within *Pathways to Work*; for Paul referral to the CMP was a positive experience, that is, supporting him to accept his reduced physical capabilities. However, for Jo, pressure to attend CMP caused her anxiety, and she did not benefit from her participation. The tension between compulsion that helps claimants and compulsion that hinders claimants will be revisited throughout the empirical chapters. The next chapter will formally introduce the thesis, providing the policy context and an outline of the rest of the thesis.

Chapter 1: Introduction

When New Labour came to power in 1997, they did so on the back of a Manifesto that stated that they would 'be the party of **welfare reform...**' (their emphasis) (Labour Party, 1997:5). Initially such reforms were aimed at the unemployed, particularly those aged 25 or under, and single parents. However, four years later in their 2001 General Election Manifesto, the Labour Party stated that responsibility would be 'demanded' in return for support for those who had previously been 'denied' the opportunity to work such as the disabled (Labour Party, 2001: 26). Such a policy was also seen as enabling the aim of reaching full employment (DWP, 2005c) as numbers of working age IB claimants were greater than the numbers of unemployed people and lone parents claiming benefits combined[3] (DWP, November 2002). In 2010, some 7.2 per cent of all working age people were claiming IB (or its successor, Employment and Support Allowance) (National Audit Office, 2010), and as such, this policy change has an impact upon a large group of vulnerable people.

Whilst the Labour Governments used discourses of empowerment (DWP, 2002; DWP, 2004; Johnson, 2004; Kennedy, 2004; DWP, 2005a; PMSU, 2005, DWP, 2005c, 2006b, 2007a), they also suggested that many claims were inappropriate as people were claiming IB as a result of individual or cultural failings (PMSU, 2005; DWP, 2005b, 2005d, 2006, 2007b). Discourses about fraudulent claiming, however, remained out of political documents, although they continued to be newsworthy.

The two narratives shown in the prologue, however, showed that living with incapacitating conditions can be extremely difficult for some people; they

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[3] Whilst traditional concerns have focused entirely upon the unemployed, the 'economically inactive' are a wider group than those claiming unemployment benefits and include Incapacity Benefit claimants and lone parents.

are literally incapacitated by their conditions on a daily basis. In describing the difficulties that she experiences on a daily basis, Jo conveys the impossibility of dealing with multiple health conditions *and* a full time job. Likewise, Paul's chest condition has left him frail and weak, and he requires frequent hospital admissions. It is this everyday reality that is neglected within the policy documents.

Furthermore, the media neglect cases where individuals are legitimately claiming IB, focusing upon isolated cases of fraud, which they claim are widespread. Katz's (1987) exploration of how crime becomes newsworthy can be applied here by using the common denominator of delinquency. For Katz, the reporting of crime within the media is restricted to four particular types of story. Adapting Katz's explanation to the reporting of benefit claimants, three parts of his typology of crime can be utilised: reports of exceptionally audacity, stories in which an entire community can be viewed as deviant, and cases in which a particular group are demonised (this group can change over time). Within the analysis, Katz also identifies that some victims are particularly newsworthy, consequently, within Britain's media, stories of fraudulent benefit claims, such as those who have claimed IB whilst appearing to, for example, be involved in sports, may be contrasted sharply with cases of 'deserving' benefit claimants (see for example the BBC (2010) documentary 'Saints and Sinners'). Furthermore, these kind of cases are presented as ordinary, rather than exceptional. It is also important to note that the public have a preoccupation with these kind of stories (Katz, 1987).

It is the intention of the thesis to show that a polarised notion of 'deserving' and 'undeserving' Incapacity Benefit claimants is not appropriate. The three empirical chapters will provide evidence to show that Paul and Jo's cases were not unique. I believe that all of the claimants who were interviewed were 'genuine' in their incapacitation. Such stories make poor news, however, and accordingly the media have continued to focus on cases of 'scrounging'.

Likewise, as Katz's (1987) typology would suggest, the BBC identify some parts of South Wales as particularly in need of adopting workfare principles. It was argued by an American scholar, Dr Merrill Mathews, that the Gurnos estate in Merthyr Tydfil needs extra attention in order to encourage work shy individuals to return to the work force (BBC, 2008). The contrast between good and bad benefit claimants is strongly defined in these media representations. Furthermore, whilst the media of the 1980s focused upon the unemployed (Moore, 1981), today's media is much more focused upon Incapacity Benefit claimants, showing a new moral slant to scrounger discourses.

The thesis will go on to show that since the 1970s, the number of people claiming out-of-work benefits because of incapacity has grown significantly. During the 1990s, this came to be seen by the Government as a social problem in need of redress. It was argued that Invalidity Benefit was too generous, resulting in a culture of 'malingering' (Lilley, 1993). The then Conservative administration replaced Invalidity Benefit with Incapacity Benefit, and in doing so, drew upon a fertile source for media support in creating the image of the Incapacity Benefit scrounger (see for example: Press Association, 1994; Scotland on Sunday, 1995).

The New Labour governments applied a similar logic to all Incapacity Benefit claimants. There are deserving claimants, who 'play by the rules' (Blair, 1997) and therefore should receive extra (non-financial) support, and undeserving claimants who demonstrate their 'undeservingness' by not taking up the support offered. The undeserving claimants will have their benefits reduced accordingly (DWP, 2002). During the past fifteen years, it will be shown, incapacity has come to be viewed as a form of hidden unemployment by some academics (eg: Beatty and Fothergill, 1996) and that this argument has been adopted by the New Labour Government (DWP, 2002). Consequently the New Labour approach is built upon the rationale that to reduce the numbers of people claiming IB, activation policies are the solution.

12

The support promised for IB claimants was to be found in the *Pathways to Work* approach. This embodied the introduction of specialist Advisors: (Incapacity Benefit Personal Advisers or IBPAs) who carry out six mandatory Work Focused Interviews (WFIs) with new IB claimants. Within such interviews, Advisors can offer a range of support from the 'Choices Package' including previously-existing initiatives, such as the New Deal for Disabled People (NDDP) and Work Preparation, alongside new interventions. The new interventions included a Return to Work Credit (RTWC) of £40 per week for one year to those who leave IB and work more than 16 hours a week but earn less than £15,000 a year. In addition to this, Advisors had access to the Advisor's Discretion Fund (ADF) which allowed advisers to grant awards of up to £300, at the time of the research, which could be used to help the claimant to find or take up a job, for example the ADF can be used to provide training. Finally, *Pathways to Work* introduced the Condition Management Prorgramme (CMP).

Pathways to Work pilots, including the CMP, began in three Jobcentre Plus districts in October 2003 with a further four pilot areas introduced in April 2004. By October 2006, *Pathways* was operating in a third of the UK (Barnes and Hudson, 2006). Such expansion was targeted to areas with the highest proportion of IB claimants and aimed to enable 900,000 people to 'take advantage' of *Pathways* (DWP press release, 25.01.05).

1.1 The significance of the research

As participation in *Pathways to Work* became mandatory for new IB claimants[4], and existing claimants became subject to some mandatory interviews, the change in policy affected a significant number of people. This may have been more relevant towards the end of the field work, during

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[4] And for those claiming IB's successor Employment and Support Allowance.

a period of economic downturn. It is of particular importance to note that failure to participate in *Pathways*, unless exempt from participation, can result in benefit sanctions. Therefore, it can be seen that this policy change could potentially have a negative effect on the lives of up to 2.7 million IB claimants (DWP, 2002) as well as attempting a positive change in trying to facilitate their return to work.

More generally, this specific piece of research can be seen as attempting to fill several gaps in knowledge. A plethora of reports from the official DWP evaluation of *Pathways to Work* have attempted to understand how claimants experience *Pathways* (eg: Corden et al., 2005; Adam et al., 2006; Barnes and Hudson, 2006; Corden and Nice, 2006a, 2006b; Kemp and Davidson, 2007), showing in some instances that official policy is not being fully implemented (Corden and Nice, 2006a, 2006b). However, the role of the Advisor has been investigated much less (Mitchell and Woodfield, 2008; Nice et al., 2009), with their use of discretion primarily related to sanctioning (Mitchell and Woodfield, 2008). Furthermore, very little research exists in relation to the Condition Management Programme..

Therefore the thesis can be seen as having a high level of policy relevance in an under-researched area.

1.2 Overview of the thesis

The next chapter will set the scene for the thesis. A brief history of income maintenance policies for unemployed and sick workers will be given from 1834 to the present. In doing so, the literature review is able to show significant areas of continuity towards the unemployed, with discourses of 'scroungermania' present throughout this period (Moore, 1981). The chapter will argue, however, that whilst the disabled were traditionally seen as largely exempt from these negative discourses, since the 1990s, the long term sick have begun to be treated as another 'undeserving' group. I will

14

argue that within *Pathways to Work* (DWP, 2002), there has been a convergence of policy for the long term sick and the unemployed. The second part of the literature review examines policy implementation. It will be shown through a review of policy documents that although *Pathways to Work* (DWP, 2002) introduced increased conditionality for IB claimants, it is up to those Advisors administering the policy within Jobcentre Plus to determine how strictly the policy is implemented (Lipsky, 1980; Wright, 2003).

Chapter Three will outline the research question to be addressed before introducing the research strategy. An interpretivist qualitative multi-method approach was utilised, and this will be described fully. Whilst contemporary disability studies (eg: Barnes, 2001) argues for a full emancipatory approach, the limitations of this approach for answering the research questions will be explored. A full description of data sources, including sample selection and access arrangement will be given. It will be shown that four groups took part in the research; eight Jobcentre Plus Advisors, 13 Condition Management Programme clinical staff and managers, ten engaged IB claimants (who took part in voluntary work-focused activity and were recruited through their participation in the CMP) and 11 unengaged IB claimants (who generally had not taken part in voluntary work-focused activity and were recruited from non-CMP venues). Thus the data comprised transcripts of 42 semi-structured interviews with the individuals described above, observation of 14 Work Focused Interviews conducted by one Advisor in one Jobcentre Plus office, and 10 Condition Management Programme case files. Data were analysed using the Miles and Huberman (1994) three stage technique, involving data reduction, data display and conclusion drawing. The use of this strategy and examples of its implementation will be given. Finally, the chapter ends by describing some of the key ethical issues within the research.

The three empirical chapters (Chapters Four – Six) cover the chronological journey of IB claimants. Firstly, their background, work history and why they

began their claim for IB. The second chapter will focus upon attending compulsory Work Focused Interviews at Jobcentre Plus offices. The final empirical chapter presents data from the (voluntary) Condition Management Programme. The three chapters follow a non-traditional format. Each chapter will provide an overview of selected literature in the area before presenting data alongside a discussion of the literature.

The first empirical chapter, Chapter Four, presents a range of arguments for why the IB claimant count has risen over time. In addition to this, specific *Pathways* onto IB are mapped, and presented in diagrammatic format by the author. It can be seen that routes onto IB are a complex interaction between many factors, including health conditions, employment type and security, and knowledge of the benefit system. The chapter continues by presenting empirical findings, specifically detailing the 21 IB claimants' journeys from work to IB. Work and employment histories are examined before moving on to describe the onset of ill health and its deterioration into worklessness. Conclusions will be drawn by linking data to the existing literature.

Chapter Five focuses upon IB claimants' and Jobcentre Plus Advisors' experiences of compulsory Work Focused Interviews that are part of *Pathways to Work*. Firstly, the small amount of existing literature is examined. The second part of the chapter focuses upon data from semi-structured interviews with Advisors and claimants, and also draws upon the fieldwork undertaken where 14 Work Focused Interviews were observed. Exploration of the data occurs in a broadly chronological pattern, beginning with claimants' early contact with Jobcentre Plus when making their first attempt to claim IB; such attempts did not always result in IB being awarded.. The chapter then describes what occurs within WFIs through the Advisors' perspectives and the claimants' experiences with reference made to the observation period where relevant. Advisors' experiences of attempting to refer claimants to work focused activity, including their relationship with targets will be discussed. Furthermore, claimants'

decisions to participate in work focused activity will be described in some detail, before moving on to look at sanctions imposed by Advisors.

The third empirical chapter, Chapter Six, will guide the reader through the small amount of previous research carried out on the Condition Management Programme. The rest of the chapter will present the results of the research project as a chronological account of attending CMP, contrasting participants' views with those of staff and case files. Where possible such views will also be compared to the literature. The results will be arranged around key themes including initial assessments, the content of interventions, and outcomes of participation. The chapter concludes by asking if *Pathways* is achieving its aims.

Chapter Seven follows a non-traditional discussion format. The chapter returns to the key themes identified in Chapter Two, examining the political intentions behind the *Pathways to Work* policy and returning to the data to examine how Jobcentre Plus Advisors and CMP clinical staff use discretion within their job roles. In order to do so effectively, both Advisors' and clinicians' opinions of IB claimants are examined. Alongside this, IB claimants' views of other claimants are described and analysed alongside the literature. Finally the chapter asks, based upon the data from this project in isolation, did *Pathways to Work* meet its aims?

The final chapter concludes the thesis. It provides the reader with an account of the ways in which *Pathways to Work* and IB have changed since the research began. It will be shown that increased conditionality is now applied to sick and disabled claimants, which neglects their vulnerable labour market position. The thesis ends with recommendations for policy change and future research.

Chapter 2: Social Security, the Long-term sick and Discretion

2.1 Introduction

This chapter sets the scene for a discussion of New Labour's policies for people claiming benefits on the grounds of sickness or disability. In order to do so effectively, it is necessary to examine income maintenance policy in relation to both unemployment and sickness over many years, showing the ways in which the state has attempted to regulate these groups. By doing so, it is possible to see a great deal of continuity in policy towards the unemployed. It will also be demonstrated that until the 1990s, there was a significant difference in the way that unemployed and long term sick people were treated within social security, adhering to the age old distinction between deserving and undeserving status.

Since the 1990s, however there has been a convergence of these two, previously separate approaches as the long term sick and disabled began to be viewed as a similar 'problem' to the unemployed, underpinned by a philosophy that everyone, except the most severely ill and disabled, can and should work. Thus it will be shown that in the past two decades policies for those with health conditions in Britain are now reliant upon similar rationales as unemployment policy. As such, it can be argued that disability is no longer seen as a legitimate reason to be economically inactive. Consequently IB claimants have had their 'deserving' benefit status removed. New Labour also argued (PMSU, 2005) that the long-term sick deserved the opportunity to be able to work, which had previously been denied to them, providing a dual rationality.

The chapter concludes by examining the way policy is implemented in practice. It will be argued that those administering social security, by virtue of the discretion involved in their occupation, can choose to be either more

or less lenient than policies intended. Such decisions are based upon the moral views of administrators, or 'Street Level Bureaucrats' (Lipsky, 1980) as they are also known, alongside constraints that they face. As such, the morals[5] of both Governments and those implementing policy on the ground have a crucial effect on how users experience policy. This can either work in favour of claimants, by making harsh policies more lenient, or against them, by placing bureaucratic obstacles in the way of policies intending to support the vulnerable.

2.2 Policy responses to unemployment and sickness

2.2.1 Introduction

It is beyond the scope of this chapter to detail fully the policies in use from 1834 to the present, although the chapter will focus upon the most significant changes to policy for the unemployed and long term disabled. Alongside this, statements of policy intent will be included, showing the moral judgements made by such policies. It will be shown that notions of deserving and undeserving benefit claimants have only ever left the political agenda for short periods. Consequently, considerable continuity can be seen between the policies of the Poor Law (1834) and those of the 1980s (Dean and Taylor-Gooby, 1992). However, it is in the 1990s, when Invalidity Benefit was replaced by Incapacity Benefit, that discourses associated with the unemployed begin to be tied to the long term sick. The chapter will show that the line of demarcation between these groups was almost entirely eroded under New Labour's twin strategy of *Pathways to Work* policy (2002-2010) and the replacement of Incapacity Benefit with Employment and Support Allowance.

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[5] 'Morals' in this instance should be taken as a shorthand to describe the more complicated set of intentions, ideology and political positioning which are contained, often somewhat ambiguously, within policy documents.

2.2.2 The Poor Laws

Significant attention has been given to the Poor Laws (Fraser, 2003). Briefly, prior to the 1834 Poor Law Amendment Act, a system of wage supplements, not dissimilar to today's tax credit system, existed. At this time, the workhouses did exist, but they were not the main form of assistance. After the 1834 Poor Law Amendment Act, the principle of 'less eligibility' or making the prospect of poor relief less attractive than working was adopted. The essence of 'less eligibility' was clear throughout all of the New Labour Government's social security policies for the unemployed, where policies have always aimed to 'make work pay' (eg: Blair, 1994; Brown, 2010). However, the Poor Law created a distinction between those who were able – and expected - to work and those who were not (Marshall, 1985; Stone, 1985). This distinction has been eroded in recent years and will be discussed further, later in the chapter.

Deborah Stone (1985) suggests that the differentiation within the Poor Law Amendment Act between those who were able to work and those who were not was one of the crucial first steps in socially constructing disability. She argues that as it became necessary to distinguish between three categories: the 'genuinely disabled person'; 'honest beggars' and those who were illegitimately attempting to portray themselves as falling into those categories (1985: 29). Whilst the first two categories were seen to need state assistance through no fault of their own, and as such were seen as deserving of such support, it was believed that some people from the third category were pretending to have a disability. Thus the link between disability and the lazy, dishonest and criminal individual was formed.

Stone (1985:23) states that 'the concept of disability has always been based on a perceived need to detect deception'''. Consequently, the association between disability and deception was firmly cast before disability existed as a sociological concept. As such, definitions of disability have always aimed to distinguish between those who are genuinely disabled and those who are

fraudulently presenting themselves as disabled. Considerable continuity exists today *within* the category of IB claimants. Whilst in the past the vast majority of IB (or its predecessor Invalidity Benefit) claimants were seen as honest, since the mid 1990s, it has been widely reported by the media that many benefit claimants are fraudulent (Moore, 1981; BBC 2010). This is because during the 1970s and 1980s, when numbers of IB claimants rose, IB was seen as a more attractive benefit than unemployment benefits, partly because of its greater financial security, but partly because of the negative connotations associated with being 'on the dole'. Furthermore, IB had the practical advantage of not requiring claimants to 'sign-on'.

2.2.3 Beyond the Poor Laws

This distinction between the unemployed and the sick has continued since the Poor Law Amendment Act. Whilst, until recently, the sick had continued to be seen as deserving of support, views towards the unemployed have generally changed from seeing 'honest beggars' as victims of a difficult labour market to a lazy and dangerous group who could find work if they tried harder (Deacon, 1976; Hewitt, 2001).

The 1834 Act settlement remained largely intact until the period commonly known as the Liberal Reforms, 1906-1914, when a wide variety of legislation was enacted on issues of social security. Most importantly, however, the Royal Commission on the Poor Law reported, as a majority and minority, in 1909. Whilst the majority report saw poverty as a result of individual failing and argued to maintain the Poor Law, the minority report, written by Sydney and Beatrice Webb, opposed this view, believing that poverty was as a result of structural causes (Vincent, 1984). As such, the minority report argued for 'labour exchanges[6] to be set up to enable the unemployed to find work, which the state should provide in times when the market could

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[6] 'Labour exchanges' have evolved through various incarnations into today's Jobcentre Plus offices,

not. Shortly after, the National Insurance Act (1911) was passed. The Act insured workers against unemployment, on a ratio of one week's payment for five weeks' contribution, and is seen by Fraser (2003) as providing the origins of the welfare state.

Deacon's (1976) detailed analysis of unemployment policy from 1920-1931, however shows how changing political priorities can result in increased conditionality being imposed upon claimants. At this time, questions of inappropriate claims resulted in unemployment insurance being subjected to new regulations, the 'genuinely seeking work test' and a household means test which was deeply intrusive for those who did not have the security of insurance-based provision (Fraser, 2003). The 'genuinely seeking work' test is similar to today's requirement to 'actively seek work' in order to claim Job Seekers Allowance, showing consistency within social security policy. Fraser (2003) reports that the Government argued that this approach was necessary to save Britain from bankruptcy. Rates of disallowance from unemployment insurance peaked at one third of all claims in some areas (Deacon, 1976:9), although Deacon argues that the Government silently acknowledged that such work did not exist. As such, it is possible to see the need to search for work, regardless of whethersuch work existed, as a form of social control at a time when the unemployed were seen as dangerous (Mann, 1992) and costs needed to be cut (Fraser, 2003).

It will be argued in the concluding chapter of the thesis that the increasing regulation of IB claimants, and those claiming Employment and Support Allowance (IB's successor), after the 2008 recession, can be linked to attempts to make the benefits seem less attractive than work in a period of high unemployment. This is a different rationale than the one arguing for the policy in 2002 when unemployment was in decline. In times of high unemployment, the harsh treatment of economically inactive groups can be seen as sending a message to other people who may be at risk of exiting the labour market and claiming benefits, as occurred after the First World War (Deacon, 1976).

High levels of unemployment, and receipt of unemployment insurance and means tested assistance, continued into the 1930s (Mann, 1992), and it was not until the Beveridge reforms after the Second World War that the stigma introduced by the genuinely seeking work test was removed from policy relating to social security benefits (Fraser, 2003). It has been argued that shared dangers, such as bombs, and the need to secure cooperation from the population shifted the nation's political priorities, resulting in more of a culture of universalism that continued after the War (Glennerster, 1995). Furthermore this ideal was publicised widely as being able to create a better society, including by the Beveridge Report (1942), the church and the media (Page, 2007). Beveridge's 'strong analysis' of how a post-war social insurance scheme could be constructed (Hill, 1990:28) was largely implemented in the post-war period.

2.2.4 Welfare consensus? 1945-1979

Amongst other key reforms which arguably created the welfare state as we know it (Glennerster, 1995), Beveridge (1942) recommended full employment, managed by the state, combined with insurance provision for 'unemployment and disability' (s.19(v)). Alongside this, means tested assistance was to play a part for the small and diminishing minority who were not covered by insurance. However, within Beveridge's proposals and their subsequent implementation the principle of 'less eligibility' was still clear; unemployed people could be expected to attend 'a work or training centre' (s.19 (vi)), unemployment insurance would not be paid indefinitely, despite Beveridge's proposal that it should, and family allowances were to be paid universally, rather than only to the poorest families to prevent worklessness being the more attractive option.

At this time, disability and unemployment were clearly separated; for the first 13 weeks of 'disability due to industrial accident or disease', the claimant

would be treated the same as other disabled people (s.19 (vi)). Thereafter, they would be able to continue claiming the benefit indefinitely, on the condition that they undertook medical treatment or retraining, or claim an industrial pension. Attaching the condition of seeking medical treatment for claiming disability benefit allowed the disabled to be controlled, although social security for disabled people could still be viewed as more attractive than that for unemployment.

Glennerster (1995) argues that despite considerable public support for the post-War settlement, there never was a golden time where Beveridge's proposals worked perfectly; poverty was not abolished as benefit levels were inadequate. Support for this argument can be seen by the attempt to de-stigmatise National Assistance in the 1960s by rebranding it Supplementary Benefit in a further attempt to remove it from the connotations of the Poor Law (Hill, 1990). Alongside this, the level of National Insurance benefits was increased in an attempt to prevent widespread reliance upon means tested assistance to top up insurance provision.

In 1971, coinciding with the growth of the disability rights movement, Invalidity Benefits (IVB) were introduced by the Heath Conservative Government for the long-term sick (beyond 28 weeks). These were to be paid at a higher rate than 'sickness benefits', as those eligible for IVB were thought to be in more need because of the extended duration of their claim (Waddell et al., 2002). In addition to IVB, an Additional Pension, related to previous earnings, was to be paid and an Invalidity Allowance was also payable to those who were younger and claiming IVB, as a result of their perceived greater loss of earning potential throughout their life course. This policy was considerably more generous than that aimed at the unemployed, showing that the long-term sick were seen as deserving of considerable financial support as some kind of compensation for them being seen as disadvantaged in the labour market.

24

The period of economic growth and low unemployment from 1945 to the early 1970s required an expanded labour force, however this was provided by migrant workers and women, as opposed to the disabled, who remained a marginalised group at this time. Timmins (2001) states that during this time a consensus can be seen to have operated between the political parties, although this is challenged by Glennerster (1995) who identifies areas of contrasting policy intent. If a consensus did occur, in the early 1970s, this situation changed rapidly as a result of pressure from changing economic and social conditions.

It is important to note that although the Beveridge report relied upon the assumption of full employment of men with female dependents, a significant difference to today's labour market, reference is often made by politicians and the media alike to today's policies 'going back to (the principles of) Beveridge' particularly in relation to policy for the unemployed (see for example Independent, 2008; DWP, 2005b). This can be used to illustrate the positive connotations that Beveridge still holds today among the public.

2.2.5 The Conservative Governments 1979-1997

During this period, concerns about reducing reliance upon the state and Government spending were at the forefront of politics, providing what Page terms as 'the first concerted challenge to the "classic" post war welfare state' (2007:72). At the heart of the Conservative five point strategy was 'To restore incentives so that hard work pays...' (Conservatives, 1979:3), by proposing a tax credits scheme – to be enacted when resources were available – in order to make people better off in work and to reduce the 'poverty trap' (Conservatives, 1979:21).

During the early period of Conservative rule, major changes were made to Supplementary Benefit by the Social Security Act 1980. The Act reduced the amount of discretion within the scheme by introducing a new series of

regulations. Walker (1983) argues that this was an attempt to cut spending on Social Security without an assessment as to whether the changes were suitable to allow Supplementary Benefit to meet its aims. In addition, benefit levels were cut in real terms, by removing the link with wages, and means testing was increased. Further evidence of Thatcher's desire to minimise the role of the state can be seen in the introduction of sick pay, funded by employers, introduced by the Social Security and Housing Benefit Act 1982. However, as a result of ever increasing unemployment, the cost of providing such assistance continued to grow (Hill, 1990).

In 1986, as a result of the Review of Social Security carried out by Norman Fowler, Supplementary Benefit was replaced by Income Support. Such a change, in direct contrast to the rationale behind replacing National Assistance with Supplementary Benefit, increased the stigma that claimants were likely to face (Timmins, 2001). One of the key policies introduced by the 1986 Act was the removal of an automatic right to Income Support for 16 and 17 year olds; if young people wished to claim benefits, they could do so only on the condition of participating in the Youth Training Scheme. Craig (1998) argues that policies such as this were designed in an attempt to manipulate statistics by appearing to lower rates of poverty and benefit claims and thus lowering the claimant count. Furthermore, the changes to Income Support can be seen as defining a large group of claimants as undeserving of state support. However, whilst the unemployed were subject to harsh policy reform, Timmins (2001) states that pensioners and families were marginally better off under the Review, presumably because of their more deserving status. Furthermore, Fowler did not include the disabled in his review of Social Security, allowing their status as a deserving group to continue.

At this time, discourses in both policy documents and the media alike implied that many unemployment benefit claimants were fraudulent 'scroungers', despite little evidence to support such a claim (Moore, 1981). Such discourses were accompanied by debates surrounding the prevalence

of an 'underclass' (Murray, 1990, Field, 1989) and a 'dependency culture' (Dean and Taylor-Gooby, 1992:3). Both Murray (1990) and Field (1989) argue that decreasing worklessness is key to reducing the underclass, although they do not agree on its cause.[7] As such, the introduction of these prominent arguments can be seen as influencing policy change in the Governments of John Major.

Towards the end of the Conservative Governments a change in attitudes towards the long term sick, who had previously been shielded from such language, could be seen. The first time the term 'malingerer' was used by Peter Lilley, the Secretary of State for Social Security (Lilley, 1993), can be seen as the time where people who were economically inactive as a result of sickness were collectively seen as undeserving. The introduction of Incapacity Benefit (IB) some two years later was not surprising. Replacing Invalidity Benefit, Incapacity Benefit introduced the 'all work test'. Whilst previously IVB claimants had only to show that they could not continue to work in their previous occupation, the 'All Work Test' assessed how well a claimant could do any kind of work.

Furthermore, the change to Incapacity Benefit resulted in the loss of the Additional Pension which made disability benefits much less financially attractive to those who had a high rate of Additional Pension, primarily older male workers (Bell and Smith, 2004). However, at this time treatment of IB claimants remained less harsh than treatment of the unemployed (Hill, 1990). This change was one of several which aimed to make the welfare state 'active' as opposed to its previous 'passive' nature (Page, 2007).

Alongside the change to IB, in 1996 Job Seekers Allowance (JSA) replaced what was previously known as 'National Insurance Unemployment Benefit'. The language used – a benefit becoming an allowance, shows the

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[7] It is beyond the scope of this chapter to fully detail these arguments, although it is important to note that Mann (1992) provides a comprehensive argument that the 'underclass' is simply a new name applied to the undeserving.

increasing conditionality applied to this group. In order to continue to be eligible for JSA, claimants had to document their attempts to find work. If claimants' attempts were seen as inadequate, their JSA could be sanctioned. Hewitt (1999) argues that in introducing JSA, and dismantling the majority of National Insurance related benefits, the Conservative government broke the Beveridge welfare state. As a result, it can be seen as laying the foundation for the reform of Incapacity Benefit a decade later.

2.2.6 The New Labour Governments 1997-2010

When Labour came to power in 1997, they promised a 'Third Way' (Giddens, 1998) in policy development, moving away from traditional Labour principles (Sullivan, 1987, 2003). This included policies relating to Social Security, although it is possible to see considerable continuity with Conservative policies in their first period of office (Hewitt, 1999, 2002). Within this first period, Job Seekers Allowance was retained in its original form, although the New Deal programme was created and expanded. At this time, concerns about the escalating cost of providing social security resulted in a plethora of policies that attempted to 'make work pay'. These include back to work initiatives, such as New Deal programmes aimed at older people and lone parents, accompanied by the introduction of tax credits (which had been proposed by the Conservative Governments in 1973 and 1979 but never implemented). At this time, tax credits were only available to those who were working. Hewitt (1999) argues that, in order to make work an attractive prospect within an economy that utilises significant amounts of low-waged labour, the use of tax credits was necessary. However, this is criticised by Lister (1997) as being unsuitable in an increasingly flexible labour market where spells of unemployment were highly likely for some workers. Furthermore, an increase in means testing occurred, with pensioners offered a 'Minimum Income Guarantee' as opposed to increasing the level of the State Basic Pension for all. As such,

28

considerable discontinuity can be seen with traditional Labour policies which relied on universal benefits, paid for through progressive taxation.

Alongside such changes to social security, it is necessary to pay attention to discourses of 'citizenship' that are ever present in New Labour policy documents.   It is argued that good citizens take 'responsibility' for themselves and their families, alongside utilising the 'rights' offered to them. At this time, a good citizen was seen as working, and thus not claiming social security benefits (although, they may claim tax credits) (Dean, 1999). Whilst the language used might be unfamiliar, the concept behind 'citizenship' was similar in part to discourses utilised by the previous Conservative Governments around 'the underclass'   Whilst the neo-right approach suggested that the 'underclass' was created by individual flaws (eg: Murray, 1990), for New Labour, the problem was embodied by Frank Field's (1989) underclass who have inadequate opportunities. Consequently, people who did not take up opportunities offered to them were the new problem to be tackled by New Labour's policies.   This sentiment was embodied in the often cited 'work for those who can, security for those who can't' (Labour, 1997).

The changes contained in later Labour administrations were not unexpected; in the Labour Party General Election Manifestos of 1997 and 2001, welfare reform was high on the political agenda.   The aim of decreasing economic inactivity was seen as essential to strengthen the economy (Labour, 1997:15), cutting social security costs and to 'stop the growth of an "underclass" in Britain' (1997: 18, see also DfEE, 1998). However, at this time, the long term sick were not part of the targeted group.

By 2001, however, the declared rationale for increasing employment among inactive groups had changed subtly (Labour, 2001). Although the reasons found in 1997 were still present, the emphasis on unemployment as something that was harmful for the individual had been added. As found in discourses going back to the Poor Laws, worklessness was associated with

29

irresponsibility and a lack of dignity (Heron and Dwyer, 1999; Powell, 2000a). In addition to this, economic inactivity on the basis of sickness becomes seen as a problem. As such, it is 'demanded' that disabled people, in addition to other workless groups, become responsible and take up opportunities for support that are offered (2001: 26). At this time, the Labour Party also imply that Incapacity Benefit has been used to disguise hidden unemployment and that this will not continue: '(Labour) will not use disability benefits to disguise unemployment' (2001:27). Alongside this, it is argued that by doing nothing to assist disabled people to enter the labour market, the Conservative Governments allowed them to become 'socially excluded'. Furthermore, Hewitt (2002) outlines a number of investigations in to the fraudulent use of disability related benefits between 1997 and 2001. As such the link is once again made more firmly between disability and potential dishonesty (Stone, 1985).

2.3 The Convergence of policy for unemployment and sickness

2.3.1 Pathways to Work (2002)

Whilst the introduction of Incapacity Benefits in 1995 can be seen as a shift in ideology towards the treatment of the long term sick, in 2002 their status as another group who were capable of work, like lone parents, was confirmed within Pathways to Work (DWP, 2002). Returning to the notion of 'security for those who can't', the Green Paper can be seen as shifting the line of demarcation between the categories of 'can' and 'can't'. Within the Green Paper, it was suggested that in the past disabled people have been 'written off' and as such have not been able to actualise their ambitions (2002: v). As such, it is right and proper that they should be supported to become more independent and functional within the economy and wider society

In making these assertions, however, the DWP sub-divided the disability category. It was stated that 'for those with the most severe conditions, work is not an option and Incapacity Benefit will continue to provide support.' (2002: v). This very clearly sent a message that for all but the most severely incapacitated, estimated to be only 24% of claimants (p.12), by changing their attitude and improving their employability, work would become a realistic outcome. This argument was supported by some of the medical profession, who saw the pre-*Pathways* IB system as too attractive (Henderson et al., 2005). Consequently the policy implied that the majority of IB claimants who did not have the most serious conditions were not working because of their individual failure or that of the system, rather than their health condition or other legitimate barriers to their employment. There is a wealth of evidence to discredit such an assumption[8]. Furthermore, the Green Paper suggested that by remaining outside of the labour market, a claimant's condition may deteriorate further (p12). Therefore, the Government was attempting to improve the health of individual claimants by facilitating a return to work. This logic, however, assumes that IB claimants are likely to be able to find 'good' work; that is secure, fulfilling and well paid. This is clearly not the case for IB claimants who would be some of the most disadvantaged participants in the labour market by virtue of their low skills and health conditions (Kemp and Davidson, 2007). To some extent, this was acknowledged as the document states that only one quarter of claimants would be at least £40 a week better off and that some 300,000 would have a worse income if they worked for 30 hours a week at the National Minimum Wage (p16).

It is within *Pathways to Work* (DWP, 2002) that the first suggestion of combining social security with health care, in the form of the NHS, occurred, although details were vague within the 2002 Green Paper. Furthermore, *Pathways* acknowledged the barrier of discriminatory employers, although it

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[8] Details of this argument will be given in Chapter 4.

does not suggest a policy solution to rectify the situation. As the *Pathways* pilots were introduced, the idea of employers discriminating against disabled people was played down. For example, in a press release (DWP, 2004) Andrew Smith, the then Work and Pensions Secretary, stated that employers were supportive of *Pathways* as a way to bring skills and experience back in to the labour market. Likewise, Alan Johnson, the then Work and Pensions Secretary, claimed in 2004 that discrimination in the work place was in decline as the employment rate of disabled people was increasing (Johnson, 2004). Within the same speech, Johnson stated that the needs of employers should be considered and that 'lack of skills increases the likelihood of being unemployed...'. Implicit here is the suggestion that if only IB claimants would up-skill themselves they may be fortunate enough to find work with an employer. Furthermore, later in 2004 Johnson 'urges GPs to help end the "sick note culture"' (DWP, 2004b:1), stating that the majority of IB claimants would be able to return to work. The BMA and other related groups have been relatively quiet regarding their role as gatekeeper to IB. The relative neglect of this area by the BMA could be as a result of administering sick notes being low on the list of doctors' priorities. However, a belief that this role is seen as time-consuming and sometimes problematic is found within Wynne Jones et al.'s (2010) research with GPs.

Despite limited evidence available from the pilots that began in 2003, *Pathways* was extended in 2004 and again in 2005, allowing more IB claimants to 'take advantage' of the opportunities offered to them (DWP, 2005a:1). Alongside this, *Improving the Life Chances of Disabled People* (PMSU, 2005) argued that in today's 'opportunity society...support and incentives for getting and staying in employment' will be offered to disabled people (p7-8) removing a 'culture of dependency and low expectations' (p9). Employment for disabled people should be fostered by supporting employers to enable them to create opportunities (p155). The rhetoric of changing culture and offering opportunities continued until the Welfare Reform Act 2007 introduced *Pathways* nationally for all new IB claimants.

Further developments in Social Security policy, such as the increased use of privatisation (Freud, 2007[9]) and the introduction of Employment and Support Allowance to replace IB will be discussed in the conclusion as they fell beyond the data collection period.

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[9] See Grover (2007) for a detailed analysis of the Freud Report.

Table 2.1 Benefits available for sick and disabled workers at the time of the research

Claimant	Benefits	Duration
Most employees	SSP (employer)	First 28 weeks
	Long term IB	53 weeks – retirement (claims pre 2008 or linked to a previous claim under 'the linking rules')
	ESA 'assessment phase' – basic rate payable	First 13 weeks[10]
	ESA 'main phase' – higher rate of allowance paid if severely disabled or participate in return to work activity.	13 weeks - retirement
Insufficient NI contributions	Income support (means tested) + Disability premium	Age 16 – retirement
	Income related ESA – 'assessment phase' – basic rate payable.	First 13 weeks
	Income related ESA 'main phase' – higher rate of allowance paid if severely disabled or participate in return to work activity.	13 weeks - retirement

Source: Updated from Waddell et al. (2002).

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[10] For people aged 16-19, 'youth provisions' apply after a young person has been unable to work for at least 28 weeks.

For people aged 20-24, 'you may be able to get ESA if you were in education or training during the three months before your 20th birthday and are now unable to work because of illness or disability' (Jobcentre Plus, 2010: 22).

2.3.2 Medical Assessments

The way in which the sick and unemployed have traditionally been distinguished is in relation to a set of criteria that would "prove" their sickness. If applicants do not meet these criteria, they are defined as unemployed rather than incapable of work. This situation is far from new, with tests under the Poor Laws introducing the concept (Stone, 1985). Such conditions can be seen as a response to the perceived attractiveness of sickness benefits over unemployment benefits and a consequent need to protect the scheme from abuse.

Whilst the rationale behind the current testing regime has remained the same since its inception in the 1980s, the tests themselves have changed over time. It can be seen that in line with discourses challenging the status of long term sick and disabled people as 'deserving', which happen periodically as a result of the cost of providing such assistance (Williams, 1991), the tests in the past two decades have become more demanding. Furthermore, the tests now require greater conditionality, as claimants have been unable to insist that they will only return to their previous occupation since the introduction of the Personal Capability Assessment in 1995. This is another parallel with benefits for the unemployed, as the introduction of Job Seekers Allowance in 1996 ended the 'Professional Register' which allowed 'professionals' to only seek work in their own occupation for six months.

Alongside the introduction of Employment and Support Allowance, a new, stricter medical assessment has been introduced in order to distinguish between the most ill, and those who are capable of some work. It is beyond the scope of the thesis to focus fully upon ESA, as the majority of sick and disabled people continue to claim IB. However, Bambra and Smith (2009) state that the introduction of a two tiered system within ESA, requiring work-based activity from the less ill, is a major step towards full workfare. This is

an extension of the undeserving and potentially fraudulent status assigned to the long term sick.

2.4 Stigma and Social Security

It is clear to see that during almost the entire period described above, stigma has been attached to claiming unemployment benefits (Page, 1984). Research has shown that stigma can have more of an effect on claimants' behaviour than legal sanctions (Yaniw, 1997), therefore its use as a way of regulating numbers of those claiming is interesting. It should be noted, however, that a much lower burden of proof is required to remove a claimant from social security than in a court of law (Moore, 1981). Becker (1963) argues that in creating stigma, policy is attempting to create and label deviant behaviour. Becker states that the public could reject these labels. However, widespread media support for scrounger discourses, such as the reporting of 'common knowledge' until it creates 'the very mythology it seeks to evoke', makes a public rejection of such a myth unlikely (Golding and Middleton, 1978:195). Thus, the assertions present in recommendations for policy change that cite the prevention of abuse as the key factor for reform (see for example, Murray, 1990) should be regarded with caution.

Stigma can also be used, particularly in times of economic difficulty, as a way to prevent rising costs (Moore, 1981): attaching stigmatising conditions to benefit receipt can also be seen as a policy tool to attempt to regulate demand. Although this phenomenon is described much less within academic texts, it is possible to see that policies such as *Pathways to Work* include references to wide-scale savings as 1 million people exit IB (DWP, 2002). Various ways can be used to attach stigma to social security including demeaning and time-consuming procedures to claim the benefit (Craig, 1998) and the attachment of conditions (Bastagali, 2008). As such, Page (1984:38) argues that those who administer benefits 'will often be the

perpetrators of such stigmatization.' This theory will be examined in more detail in the next section.

However, Page's (1984) work also shows evidence from a number of American studies that show that public attitudes towards benefit claimants are sometimes more harsh than those of benefit administrators, particularly to groups that they consider to be less deserving such as lone parents. Later research in the UK carried out on behalf of the DWP found that the public were 'comfortable' with the idea of conditionality being attached to the receipt of benefits (Williams et al., 1999:1). Respondents in the Williams et al. (1999) research were also able to differentiate between groups that they thought were deserving and undeserving of state assistance, such as those who were not trying to get a job whilst claiming Job Seeker's Allowance. Relating such a phenomenon to Talcott Parsons' (1951) concept of the sick role, Williams (2010) argues that the concept of getting better and thus exiting the sick role, one of Parson's key principles, can be seen as being breached by those who remain on IB for some time. Following Becker's (1963) theory, it can be argued that these individuals are seen as breaking one of society's norms, and as such they are labelled negatively by people who perceive themselves to be law-abiding. However, it is important to note that those who are labelled as undeserving, or deviant, may not believe that they deserve such a label and may choose to apply that label to other people in a process know as *othering* (Becker, 1963).

On the other hand, Dwyer's (2002:280) focus group research with benefit claimants found that 'the state should continue to have a centrally important role in meeting future welfare needs.' Thus, this more recent research undertaken before the financial down-turn shows that this representative group of claimants were not persuaded by discourses about welfare scroungers. Furthermore, the participants were not convinced about the suitability of conditionality regarding social security for groups beyond the unemployed, with a strong minority group arguing against conditionality for all claimants. This group viewed unemployment as a result of structural

37

failings (Field, 1989) as opposed to individual failings (Murray, 1990). It should also be noted, that all of the participants thought that some groups should be excluded from some welfare rights. However, they emphasised their need, and thus their legitimacy to be included in welfare rights (Becker, 1963).

It is also important to note that in recent years stigma has become attached to a variety of lifestyle choices which can have a negative impact on health including smoking cigarettes (Bayer and Stuber, 2006); excessive alcohol consumption and the dysfunctional use of illegal drugs (Room, 2005) and obesity (Townsend, 2009). Within the New Labour era, citizens who do not live a healthy lifestyle become labelled as a burden to the state (Dean, 1999). However, it is important to note that these 'unhealthy behaviours' are often related to poverty (Townsend, 2009) and inequality (Marmot, 2010). As a result of their poverty, many benefit claimants, therefore, may also be stigmatised for their lifestyle choice, particularly if the activity contributes towards their incapacity and thus may further reduce their deserving status. Becker (1963) would argue that this may result in the rejection of stigmatising labels and the growth of a subculture. Whilst the previous section showed that the use of stigma has been a common policy tool within benefits associated with unemployment, the next section will show how social security policy is implemented by those on the ground who can be seen as perpetuating stigma when an individual claims benefits (Page, 1984).

2.5 The administration and implementation of policy: discretion

2.5.1 Introduction

'Laws usually express a society's aspirations rather than its behaviour...' (Stone, 1985:35).

The following section will unpick the above statement from Deborah Stone. Since the 1980s, increasing attention has been paid by academics to how policy is implemented on the ground. It will be argued that differing implementation has always been a key aspect of policy delivery (eg: Marshall, 1985). The most comprehensive discussion of discretion in public administration was developed by Lipsky (1980), who labelled administrators of public policy as 'Street Level Bureaucrats'. The chapter will then move on to examine the evidence available regarding discretion and both welfare and health policy. The chapter ends by discussing the possible avenues for discretion within *Pathways to Work*.

2.5.2 The use of discretion by administrators

Introduction

It has long been acknowledged that power relations are far from equal when those who are unemployed – through sickness or lack of work - attempt to gain access to financial support (National Consumer Council, 1977). As such, benefit claimants, or 'customers' as the New Labour Government christened them, have little option but to accept conditions imposed upon them. These unequal power relations are crucial when investigating the work of those administering the Benefits system. Furthermore, Butcher (1997) notes that the welfare system is poorly organised to deal with the

circumstances of individuals because of its fragmented nature. In recent years, calls have been made for more joined up use of information to centralise services (HM Treasury, 2006), although in practice little has been achieved to date because of the complexities of the welfare state, which has been developed in a piecemeal fashion. As a consequence of such complexity, implementation of guidance with scope for discretion remains a key factor in social security benefit.

Street Level Bureaucrats

The phenomenon of policy implementation varying from its intent was given significant attention by Michael Lipsky's work, resulting in his theory of Street Level Bureaucracy in 1980[11]. Lipsky (1980:3) argues that public workers who 'interact directly with citizens in the course of their jobs, and who have substantial discretion', referred to as Street Level Bureaucrats (SLBs), have the power to determine access to services and benefits sought mostly by non-voluntary clients, often providing immediate, face-to-face decisions. In making these decisions SLBs must be aware that organisational goals may conflict, public resources are limited, and their own work load is too high providing inadequate time to deal with each case optimally. Consequently, discretion and quick decisions must be utilised by public administrators in order to carry out their role.

Thus Lipsky argues that SLBs are 'policy makers' because of high levels of discretion and low levels of supervision, from both superiors and clients (1980:13). In order to cope with the demands of their workload, SLBs must develop a strategy to cope with this, and will also attempt to retain discretion wherever possible in order to maximise their control over their challenging work role.

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[11] Lipsky began drafting his theory in 1969 and acknowledges the collaboration of colleagues in developing the theory.

In addition to this, if a SLBs own moral code conflicts with the current guidance or their manager's views, 'one can expect a distinct degree of noncompliance' (1980:17). Lipsky also argues that SLBs make moral judgements in how to treat clients, in terms of affording them time and resources, as treating all clients alike would appear unfair to those who present as most deserving. Furthermore, SLBs recognise their strong position within public sector organisations where they are unlikely to be dismissed or demoted. Non-compliance should also be expected if compliance is likely to increase the danger and discomfort associated with the SLB's role, whilst decreasing job satisfaction or income.

Whilst Lipsky's (1980) theory provides bleak reading for policy makers, who will never truly be able to realise their aims and objectives, widespread support was found in the 1980s for discretionary decision making among administrators in the public sector. As such, their influence is greatest for those with least money, who can also be seen as having less power to challenge decisions.

It is important to view Lipsky's work within the context it was written. Over the past decade, increased reliance upon technology has occurred, and accordingly some previous opportunities for discretion have been eliminated. For example, those who work in call centres, Bain and Taylor (2000) suggest, can be viewed as subjected to complete supervision as envisaged by Bentham's Panoptican. However, it is also argued that an uncritical acceptance of the Panoptican ideal fails to take into account the ways in which workers continue to find ways in which to act in an autonomous manner (Bain and Taylor, 2000).

Discretion within Social Security

This section will provide research evidence of discretion throughout UK social security. It will be shown that since the study of discretion became popular, a wide range of evidence has been produced showing that SLBs

41

need to act with discretion to complete their role and/or to make their job compatible with their beliefs. However, during the 1970s and 1980s, Adler and Asquith (1981) argued, discretion within welfare decision making came to be seen as something to be treated with caution. It will be shown that this caution is still evident to some extent.

Within DHSS offices in the 1980s, the policy of 'non-prosecution interviews' was introduced, where official guidance dictated that officers should present evidence to claimants of ways in which they could be seen to be breaching the rules, with the aim of voluntarily removing the claimant from unemployment benefit, and accordingly reducing the claimant count. However, some staff believed that interviews were intimidating and could occur without enough evidence to officially remove somebody from benefit. For this reason, some staff were more gentle with claimants than the policy dictated (Moore, 1981). Other research at this time found that practice within Benefit Offices could be particularly harsh, some of which the Government were reluctant to publish (Berthoud et al., 1981).

An alternative way in which discretionary practices could occur was at branch level, as opposed to the individual cases reported by Moore (1981). During the late 1990s, research on the 'Benefits Agency', which later became one half of Jobcentre Plus, found that decreased emphasis on national guidance resulted in very different working practices between offices (Foster and Hoggett, 1999). At that time, the concept of the claimant as a 'customer'[12] was introduced, although the impact of this varied depending on the opinions of individual staff members and the opinions held within their office. It was suggested that the view of the 'customer' was at odds with the popular image of the claimant as a 'benefit scrounger'.

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[12] Throughout the thesis when describing interaction with Jobcentre Plus, the term 'customer' has been rejected in favour of 'claimant' in order to reinforce the unequal power relations. Later in the thesis, the term 'customer' is used in relation to benefit claimants who voluntarily attend the Citizens Advice Bureau in order to gain advice. This acknowledges the claimant's status as a customer of the CAB but not of Jobcentre Plus.

Differences between offices were attributed by the authors to 'distinct office cultures', showing that managers could also have an impact upon discretion (1999:22). Furthermore, when increased use of office based targets were introduced, managers within the Benefits Agency also had the same feelings of stress and work intensification that their subordinates reported.

Like Marshall's (1985) findings regarding the old Poor Laws, Wright's (2003) observation study found that the introduction of Job Seeker's Allowance relied upon staff on the ground being willing to implement the policy. Accordingly much staff behaviour was dictated by a need to fulfil targets. As such, parts of the JSA regulations that were not subject to targets, such as the Stricter Benefit Regime, were not implemented in practice. Furthermore, staff rejected the official language used within policy documents, in particular the idea of the 'customer' ('claimant') and 'fortnightly intervention' ('signing on') were not utilised. Wright's (2003) observation period also covered the introduction of the New Deal. She found that, in order to meet targets, staff worked with claimants who were closest to the labour market.

Rowe (2002) suggested that the use of discretion by those administering Social Security could be seen very prominently within the discretionary elements of the Social Fund: Crisis Loans, Community Care Grants and Budgeting Loans, referred to henceforth as 'the Social Fund'. The use of discretion is a key part of the scheme, resulting in different outcomes for similar applications depending on the time of the month, the officer making the decision and the office in which the decision is made. This has been attributed to confusing guidance (Barton, 2002), an inadequate budget to meet demand (DWP, 2009) and insufficient workers to accept telephone applications or to process paper forms (Social Fund Commissioner, 2009). Thus, it can be argued that Social Fund Administrators have job demands that are impossible to meet (Lipsky, 1980)

However, research has also shown that Jobcentre Plus staff act as gatekeepers in order to try to limit demand. In some instances potential applicants have been denied the right to an application form (Hall, 2007; Rowe, 2002) or to submit a completed application form (NAO, 2005). Whilst priority for Social Fund payments is supposed to be based around 'need', a high percentage of successful appeals (Social Fund Commissioner, 2009) shows that other factors may be used to decide who is awarded a payment. Unfortunately, there is no recent research on those who administer the Fund.

The use of discretion within the administration of Social Security has also been studied in the USA (Kingfisher, 1998; Jewell and Glaser, 2006). Within her research, Kingfisher (1998) found that SLBs interacted with each other in order to interpret policy and decide how to deal with non-typical cases. In part, this was because SLBs felt that managers were not best placed to facilitate these decisions. Furthermore, administrators did not follow official policy guidance regarding suspected cases of fraud and often offered extra support to 'deserving' clients such as giving access to other discretionary benefits or providing information about other avenues of support (1998:134). Finally, SLBs identified negative qualities in claimants, such as laziness, dishonesty and criminality (Kingfisher, 1998), which could have an impact upon how they were responded to.

Whilst Kingfisher (1998) focuses upon one setting, Jewell and Glaser (2006) attempt to create a framework by studying multiple settings within the USA. The authors state that six factors have an influence upon discretion when administering welfare: authority, role expectations, workload, client contact, knowledge and expertise and incentives. These categories will not be discussed in detail as they can all fit within Lipsky's (1980) original theory of SLBs and can be sub-divided into the ways in which workers are constrained and the ways in which they attempt to minimise the negative aspects of their role.

Discretion within health policy

Whilst the study of discretion within social security was popular in the 1980s, it has since become a relatively neglected area in policy analysis (Wright, 2003). However, evidence on the use of discretion by health care professionals has been even further neglected within social research (Exworthy and Frosini, 2008), despite arguments that their discretion is greater than that of public administrators (Adler and Asquith, 1981), and that the effects of medical practitioners discretion can result in different levels of 'dedication' to treating patients (Lipsky, 1980:110). Furthermore, it is suggested that attempts to limit discretion by health care managers are routinely ignored in a way that those administering welfare benefits are unable to do (Lipsky, 1980).

Lipsky (1980) identified doctors and other health care workers as SLBs who had to work using scarce resources. However, Exworthy and Frosini (2008) argue that patient numbers and the need to meet institutional objectives are the key reasons why discretion is required within the NHS. Managerial changes within the NHS have resulted in a reduction in centralised power, but increased discretion at local managerial level, although this may not feed through in to clinical autonomy, and may even reduce opportunities for autonomy (Hunter, 2006). Despite this, it will be shown that opportunities for using discretion are still greater for health care professionals than for those administering welfare benefits. Within CMPs, the majority of interventions are performed by occupational therapists, however there is a dearth of literature in this area. As such, the issue of clinical autonomy will be considered in relation to doctors and nurses and inferences will be made in relation to other health care professionals.

It has been stated that the medical profession, with doctors in particular, have had extremely wide autonomy within their job role, which they were able to retain when the NHS was founded (Orchard, 1998). It has been argued that this discretion is necessary as part of clinical judgement and of

retaining patients' confidence (Armstrong, 2002). However, in recent years, doctors have undergone attempts to limit their discretion, for example in relation to prescribing non-generic drugs. Alongside this reduction in doctors' autonomy, the role of nursing has become increasingly professionalised resulting in increased prescribing powers and the introduction of consultant nurses. Thus it can be expected that nurses and other health care professionals might share in some of the discretionary powers that doctors experience by virtue of their professional similarity, although challenges to nurses' discretion have been noted (Kramer et al., 2007).

In her UK study of community nurses undertaking a new case management role, Bergen (2005) found that the role was adopted, or not, based on four criteria. Firstly, if the guidance was perceived as clear, it was more likely to be followed. However, this was the only factor relating to the policy itself, which Bergen (2005:4) describes as 'not...prescriptive' about how the policy should be carried out. The other factors were how the policy fits in with nursing values, existing local practice and the nurses' own belief system. Thus it can be seen that nurses are a group with a strong resistance to policies that are seen as undesirable within the context of their professional identity.

A further factor found in a study of mental health nursing was the adequacy of resources to meet policy guidance alongside the nurses' own perceptions of whether the policy was the most suitable way of meeting their patient's needs (Wells, 1997). Therefore, it can be argued, if a nurse believes their professional knowledge is more suitable for a patient than the Government's policy, it will not be implemented as intended. This is described by Provis and Shack's (2004:5) research on health care workers as a 'dimension of ethical obligation', or a moral responsibility to do what is in the patients' best interests. Care workers acknowledged that this may not always be in line with current guidance and felt that this was an area of tension within their working lives. This, they argue, can vary based upon the personal

relationship that the worker had with patients. The authors state that 'it is likely that care workers will be in a better position to make decisions about client needs than is possible in a general policy-making context...' (2004:9). However, this rationale failed to acknowledge that such an approach can allow notions of deservingness to be part of the decision making process regarding a patient's care.

In addition to research that shows how discretion is utilised by nurses, Healey (2010) argues that nurses' own clinical assessment of patients is as valid for predicting risk as a risk assessment tool. For this reason, Healey suggests that nurses must retain their own judgement and use any assessment criteria alongside these to ensure patient safety. This view is adopted, for example, in relation to how to carry out a pressure ulcer risk assessment (Fletcher et al., 2010). Other research, for example Kramer et al. (2007), argues that nurses' use of discretion is in the patients' best interest. Interestingly, however, earlier research by Dwyer et al. (1992) found that when nurses were required to act with clinical discretion, they were most satisfied with their job when they desired such autonomy, whereas it could be unwelcome for other nurses.

Through qualitative research with social workers, Tony Evans (Evans, 2010; Evans and Harris, 2004) has argued that Lipsky's concept of Street Level Bureaucracy fails to take in to account the concept of professionalism within the context of managerialism. Although social workers are not health care professionals, they are a group with more professional power than Jobcentre Plus front-line staff, and accordingly his arguments can be accepted as relevant. Evans states that a focus on managerialism has attempted to reduce social workers' discretion. However, the need to provide flexible, client focused services and social workers' own sense of professionalism has allowed discretion to survive through a variety of mechanisms.

Discretion and new technologies.

Within the provision of public services increased surveillance and monitoring of targets has occurred. Much of this is facilitated by new information and communications technology (ICT) in order to be able to measure effectiveness both between and within organisations (Harrison and Smith, 2004). Writing before the mass introduction of ICT, Lipsky (1980) could not have been expected to foresee how opportunities for monitoring SLBs would increase so significantly in the future. However, there has been concern about worker deskilling and the redundancy of knowledge in the manufacturing and white-collar sectors as a result of technology since the late 1980s (Zuboff, 1988). Furthermore, Rule and Brantley (1992) liken increasing use of ICT surveillance to Bentham's panoptican; their study of 186 businesses allowed them to conclude that the conditions for complete surveillance have been actualised by management capacity to monitor work electronically. However, the primary reported reason for increasing the use of ICT within business was rarely to increase opportunities for surveillance, and thus it can be considered a side-effect to meeting a business need.

The influences of technology have not yet been studied in detail regarding the administration of social security, although a body of literature from social work, which will be discussed below, provides illumination on the ways in which technology has been used within practice, and the effects that this has had for workers. It should be noted, however, that social workers are a group with a stronger professional status than Jobcentre Plus Advisers; their training occurs within the confines of a university and there is a professional body (the British Association of Social Workers). In recent years, social workers have increasingly been required to report their interventions electronically within predetermined timeframes (see for example Broadhurst et al., 2010a) as a result of government guidance arising from a need to manage risk (Broadhurst et al., 2010b). This has resulted in a reduction in

48

the amount of time a worker can spend actively supporting their clients (Wastell et al., 2009).

Wastell et al., (2009) argue, based upon an extensive ethnographic study, that an increase in targets and rigid adherence to procedures can result in compliance 'without genuine commitment' (2009: 310). This can result in ineffective practices, which can have a negative effect upon the overarching policy goal, in this instance ensuring the safety of children. Furthermore, the deskilling of the job, by creating a highly structured standardised work process can be seen as encouraging social workers not to have reflective and independent thought. Consequently, as would be expected (Lipsky, 1980), a variety of 'workarounds' are adopted by workers to make their work achievable and to ensure that the work does not conflict with their own goals (see also Pithouse et al., 2009). Changes in practice in order to attempt to meet targets, were not seen as desirable by social workers, and this could be a cause of stress where workloads were extremely high. Likewise, some social workers reported feelings of de-professionalisation from such practice (Wastell et al., 2009). Alongside such drawbacks, Broadhurst et al. (2010a) note that errors still occur within social work practice. As such, increased guidance and monitoring can not be seen as a way of removing discretion to ensure best practice, and can be seen as a hindrance to SLBs performing optimally.

Furthermore, it can be argued that the use of risk assessment tools devalue professional knowledge and reduce opportunities for discretion, whilst not always being a reliable indicator of risk (Broadhurst et al., 2010a; 2010b). Likewise, as the risk assessment is still completed by a person, it is necessary to see the practice as a social construction which can be based on factors as diverse as 'compassion, empathy and a sense of moral responsibility for others.' (2010b: 1053). In these situations, it is necessary to see the practice of constructing a report on a client as a result of tensions inherent within all SLBs' work; inadequate time and resources and moral judgements about how those resources should be used.

Whilst there is little option but to workaround legislated change, research with nurses and pharmacy staff found that non-legislated ICT changes could be rejected that challenged their professional identity and discretion, and also increased the potential to increase error (Novek, 2002).

Discretion and morality

It is necessary to see the decisions of the SLB as linked intrinsically to their own concepts of morality (Lipsky, 1980). However, whenever evocative and highly emotive issues are at stake, in an area with limited resources, the moral decisions of the SLB will have a bearing on their treatment within that bureaucracy (Broadhurst et al., 2010b). Furthermore, where workers can not understand the decisions of clients, negative judgements can taint the workers concept of that person. For example, in cases of child protection, the risk assessment tools available to social workers, and their own judgements may recommend a particular course, although that may not necessarily be the most appropriate for the child (Broadhurst et al., 2010b).

One of the reported benefits of systems increasingly dominated by strict guidance and monitored by ICT, is that they allow the removal of 'moral agency', and thus should create standardised, and some would claim - neutral decisions, although the ability of any system to somehow create neutral decisions is contested (see Harrison and Smith, 2004: 377).

Identity

Morality and discretion can be seen as intrinsically related to notions of identity. Within the context of this thesis, discussion of identity will be centred around two specific themes: the occupational identities of Jobcentre Plus Advisers and CMP clinical staff; and the identities of IB claimants in relation to their status as 'claimants' and/or their changed identity as a result

of illness. The social construction of identity through discursive practices has been widely acknowledged (Marks and Thompson, 2010) and will be adopted here as the basis for how workers and claimants identities are actively constructed.

Giddens' (1991) work on stigma describes the process of identity-construction in modern society, which can be seen as profoundly distinct from notions of a pre-constructed and fixed identity, as occurred in earlier societies. For Giddens, this process in late modernity is linked to structuring factors in society at the macro level (eg the media) and at the micro level, where agency and reflection and resources allow for individual assertion of self. The ways in which individuals choose to define themselves is always a source of some contingency and must, at least in part, be related to real-life events, although this does not necessarily have to relate to the individual's current circumstances. Giddens allows for a narrative of self to be constructed, allowing the individual to 'perform' being their chosen version of themselves. However, the process of constructing an identity must be constantly renegotiated within day to day society.

Professional Identity

As work is such a prominent factor in the lives of people living in the UK, it is only natural that it can be a crucial factor in creating a self-identity (Riach and Loretto, 2009). Within the context of work, it can be seen that three types of factors combine to create an individual's identity: the official organisational identity; the identity of the group of workers as a whole; the individual's experiences (Marks and Thompson, 2010). These factors work in collaboration with the individual's existing social and moral framework. Accordingly a large range of factors combine to create a professional identity, and the same factors may result in a differing identity between workers in the same organisation and professional group. It follows that whilst there are large bodies of work about the professional cultures of some groups, such as the police, these largely focus on the meso level of the

occupational group as a whole to the exclusion of the micro level of the individual worker (Paoline, 2003).

A constantly evolving sense of self can result in individuals having multiple self-identities, particularly if they are subject to strong organisational discourses that are difficult to reconcile with their personal narrative of self (du Gay, 1996; Marks and Thompson, 2010). Furthermore, the type of environment in which an individual works can have a significant effect upon their identity, and this has been related to the discretion an individual has (Jenkins, 2007 cited in Marks and Thompson, 2010) and the individual's success, or failure in the all important context of work (Gabriel et al., 2010).

Professional Identity of Occupational therapists

As CMP clinical staff are largely occupational therapists, the small body of research relating to identity of occupational therapists will be discussed here. The professional identity of occupational therapists can be viewed as less strongly defined than some other professions (see Fortune, 2000; Watson, 2006; Mackey, 2007). This has been attributed to the lack of a shared understanding of the 'history, purpose and nature of their role', as evidenced by competing definitions of the task over time (Fortune, 2000:225), the absence of a shared belief system (Lloyd et al., 2004; Kinn and Aas, 2009), and a variation in the discipline internationally (Watson, 2006). In her research with student occupational therapists, Fortune (2000) found that some students were unclear about the core purpose and boundaries of their role.

This confusion over identity is attributed to the changing clinical roles of occupational therapists over time, which has moved the profession away from its roots in patient rehabilitation (Fortune, 2000). For Mackey (2007) and Lloyd et al. (2004), losing the monopoly of control over traditional areas of occupational therapy and becoming part of multi-disciplinary teams have been significant factors. Mackey (2007) suggests that without power,

occupational therapists' identities become confused. Accordingly, it is possible to state that occupational therapy is a discipline in a state of change, literally an 'epistemological crisis' (Fortune, 2000:226), and thus a common group identity of occupational therapists may not exist. However, Kinn and Aas's (2009) research found that occupational therapists believed that they had skills that other health care professionals did not, and thus valued their contribution to a multi-disciplinary team highly. Watson (2006) argues that the adoption of a professional identity can be seen through a process of socialisation as part of training, adopting a common language and belief system. The lack of a common belief system could result in a weaker sense of individual professional identity. In order to create an acceptable narrative of self (as in Giddens, 1991), occupational therapists may use their own moral values more strongly to create a more coherent sense of professional identity and purpose (Watson, 2006). In addition, it has been suggested that in recent years occupational therapists have been subject to stronger managerial controls, and accordingly their sense of professional self would have changed to reflect this (Lloyd et al., 2004).

Despite this apparent tension within an individual's professional identity, occupational therapists report high levels of job satisfaction and self-value, although they feel undervalued by other professionals (Kinn and Aas, 2009).

Physiotherapy and Identity

Much less has been written about the professional identities of physiotherapists, however Lindquist et al.'s (2006) research found that physiotherapists in the UK and Sweden were also reacting to a changed working environment and did not have a strong professional identity. Furthermore, the research found that there was no standardised physiotherapy belief system which signified the most appropriate way for an individual to be treated. Accordingly the researchers concluded that 'Physiotherapists who develop strong professional identities which embrace a concept of life long learning and a willingness for adjustment throughout

their professional life will be better prepared for (the inevitable) change.'
(Lindquist et al., 2006:275).

Occupational Therapy, physiotherapy, identity and CMP

Whilst Fortune (2000) identified a feeling among student occupational therapists that they simply filled gaps in health provision, CMP can be seen as a strong example of an occupational therapy led health-service, where other health care professionals performed a secondary role. It is possible that this may have instilled a great sense of security among the occupational therapists to return to their occupational background, if it was facilitated by the individual services[13]. Furthermore, for Mackey (2007), professional identity is strongest when discretion is high and surveillance low. As a result of the large amounts of clinical autonomy, occupational therapists identities should be stronger within CMP than in mainstream NHS services if Mackey's thesis is correct.

It is likely that working in a way that does not involve 'treatment' will be alien to many physiotherapists, accordingly the view of Lindquist et al. (2006) that flexibility is a desirable trait in the professional identity of a physiotherapist seems well grounded for those who are moving to a challenging new service.

Jobcentre Advisors and Identity

Far less attention has been paid to the identity of staff who administer social security, either in the UK or abroad. It can be seen that within their roles during the time of the fieldwork, Jobcentre Plus Advisors typically enjoyed

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[13] As CMPs were designed with very little central guidance, it is possible that some CMPs may foster this, whilst others will not.

high levels of discretion in order to tailor work plans for different groups of claimants (DWP, 2002) and that staff felt competent in delivering such support (Bellis et al., 2011).

In describing Advisers' views of claimants, research in 1999 found that Benefits Agency front-line staff (some of whom would be the present Advisers within Jobcentre Plus) felt that many of their clientele were undeserving, and also identified themselves strongly as dissimilar to the claimants (Foster and Hoggett, 1999). Research on benefit administrators in the USA found similar negative views of claimants, including their being labelled as dishonest (Kingfisher, 1998). This shows some implicit moral hierarchy in which Advisers can be seen as viewing themselves as more worthy or deserving than claimants. Such views would likely have an impact on the way in which Advisers interact with claimants (see Lipsky, 1981).

Contrariwise, it can be noted that Jobcentre Plus Advisers believe that their role provides crucial support to the public: the 2007 Bi-annual survey of Jobcentre Plus Customer Satisfaction found that staff found high levels of job satisfaction, and felt that they were performing a useful role (Johnson and Fidler, 2008)[14]. Accordingly, Jobcentre Plus Advisers can be seen as attempting to fulfil a role where they see themselves as empowering those who are less fortunate than themselves. The caring function of Advisers has been largely neglected in the literature with the major focus upon policing functions (Foster and Hoggett, 1999; Wright, 2003). It is likely, however, that this is as a result of Jobcentre Plus Advisers having had very little face-to-face contact with IB claimants prior to the introduction of Pathways to Work, resulting in few opportunities to enact their 'caring' role.

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[14] a change in methodology resulted in this area not being included in the 2009 survey (Thomas et al., 2010).

Unlike occupational therapists, they do not appear to enjoy any long-standing professional identity, for example, there is no dedicated professional body, nor a specific trade union that can extol their particular attributes and virtues. . However, similarities in behaviour can be seen over time among those who administer social security, with research highlighting a tension between caring and policing functions within street level bureaucracies (Deacon, 1976; Wright, 2003). However, research has documented the wide-spread rejection of government initiatives, for example rejecting the changed language introduced in 1998 where claimants should be referred to as 'customers' (Foster and Hoggett, 1999; Wright, 2003). Whilst there does not seem to be a national unified approach to performing the Adviser role, strong local office cultures have been observed (Foster and Hoggett, 1999), and thus Adviser practices and identity may well vary significantly between locations.

Claimant identities

Within the UK at the time of the research, there was significant negative attention paid to unemployment and incapacity, with New Labour suggesting that unemployment was largely 'voluntary' (see for example Labour, 1997), and that those claiming IB lacked motivation or were too disengaged from the world of work (DWP, 2002). Similar views can be seen within the attitudes of members of the public (Patrick, 2011a, 2011b). Hence, the way that IB claimants chose to identify themselves during the period of the research could be different to how a similar cohort of claimants would have self-identified a decade previously, although there is a lack of comparative research to support this assumption.

As noted earlier, Riach and Loretto (2009) argue that work is crucial in identity formation. Therefore, when a person leaves work and becomes a benefit claimant, a significant challenge to their self-identity occurs, particularly if that person is absent from formal work for a long period of time (Amundson, 1994; Nixon, 2006; Garrett-Peters). For example, respondents in Willott and Griffin's (2004: 59) study of unemployed men reported feeling

'down', 'less of a man' and 'older'. It has been suggested that at this stage, the newly unemployed person can take two paths: to retain their previous identity with modifications to accept their new situation, or to adopt a new identity as a benefit claimant or, in the case of IB claimants, a 'sick' person (Riach and Loretto, 2009). The negative stereotypes associated with claiming benefits are well documented (see for example Gallie and Marsh, 1998). Therefore, in order to retain a crucial sense of self-worth, claimants must form their new identity carefully (Amundson, 1994). Tactics can include continuing to have a strong work ethic (Dunn, 2010); adopting a disabled identity or adopting an identity that is 'active' in a non-work way (Riach and Loretto, 2009).

Dunn (2010) argues that unemployed people often exhibit a stronger commitment to employment than those in work. This can be seen as a means to distinguish one's self from more negative connotations about being unemployed (Becker, 1963), and in order to retain a sense of self-respect (Willott and Griffin, 2004). However, Dunn (2010) and Willott and Green (2004) report that those who are unemployed, particularly working class men, strongly desire to work in order to be able to be paid an adequate income to support themselves and any dependents. Thus the rejection of poorly paid (often low skilled) work, should be seen as evidence of the work failing to enable a 'breadwinner' role, or being inappropriate to their skills and education (Willott and Green, 2004) and not necessarily a poor work ethic.

In examining the identities of older unemployed workers including IB claimants, Riach and Loretto's (2010) focus group research with IB and JSA claimants found that non-working identity could be adopted by individuals as a result of opinions expressed by 'experts' such as doctors or Jobcentre Plus staff. Alongside this, the opinions of family members and other non-experts considered significant by the unemployed person can impact identity formation (Amundson, 1994). Therefore, the active formation of identity must be acknowledged (Giddens, 1991).

Immediately after exiting work, claimants focusing on work could adopt a disabled identity, which legitimated their non-working status, or an unemployed identity which highlighted their absence from the labour market (Riach and Loretto, 2009). On the other hand, Riach and Loretto (2009:110) found that workers could attempt to create an 'acitve' identity, as someone who was contributing to society through a variety of non-work ways. However, the researchers found that a non-working identity was felt to be 'imposed' by the benefits system that had strict rules upon what work, including voluntary work, could be performed whilst benefits were claimed (2009: 108). Accordingly, this identity may be denied to some IB claimants.

Alongside this, IB claimants could feel a tension between their previous occupational identity and the work that Jobcentre Plus Advisers were suggesting they undertake; lower pay and status work was considered undesirable (Riach and Loretto, 2009; Dunn, 2010). Furthermore, for the large cohorts of working class men who have been left unemployed in recent decades by the decline of heavy industry (Beatty, 2010), an inability to realign their (male) identity with work in the service sector and other growth areas can lead to an inability to find a place in contemporary labour markets (Nixon, 2006). Consequently, the adoption of a 'disabled/claimant' identity could be more attractive than one of a worker in a sector considered to be lower status (Dunn, 2010), or as superior to acknowledging the claimants' inability to find a place in contemporary labour markets (Nixon, 2006) and training schemes (Willott and Griffin, 2004).

Within the past four decades, those who were unemployed habitually claimed IVB, which later became IB. For claimants, there were financial benefits for doing so, and practical incentives: the benefit was paid at a higher rate without the burden of having to 'sign on'. In addition to this, Williams (2010:193) argues that there was also a 'moral...benefit'; claimants could be perceived as unable to work, as opposed to unwilling to work or

unemployable. Williams also argues that GPs can be seen as supporting those who were unlikely to gain employment by using their professional credentials to allow access to IVB and IB when many of the unemployed had long-term health problems that were unlikely to improve significantly over time.

Sick identities

The notion of the 'sick role' is classically explored by Parsons (1951) who proposed a number of stages that a sick person might progress through in order to return to being a fully functional member of (then) modern industrial society. This included a duty to obey medical advice. At this time, however, a sick, (unproductive) identity was intended to last for a short period of time, in order to keep disruption of society to a minimum. Today it is clear that long-term incapacity does not obey the same structure as Parson's sick role (Waddell and Aylward, 2004; Williams, 2010; Barnes and Mercer, 2010). Thus, whilst IB claimants may not identify as 'disabled', the literature surrounding disability identities may be more appropriate for a discussion of IB claimants' identity formation.

Crucial in the formation of a sick identity is legitimation by the medical profession, for example in the form of sick notes, medication or investigations (Stone, 1985; Williams, 2010). Thus, a strong belief in doctors' opinions as valid can be seen as crucial in creating a sick identity (Waddell and Aylward, 2004). However, the undesirability of alternative identities, such as a claimant identity, may increase the attractiveness of sick identities (Becker, 1963; Giddens, 1991).

Early approaches to the social model of disability strongly discredited the medical model of disability, arguing that with adequate societal adaptations, those with disability would be able to function adequately (Oliver, 1996). Later approaches to the sociology of illness and disability were less partisan and recognised that sickness and disability can have impacts upon

individuals regardless of the level of adaptations (Barnes and Mercer, 2010). It is clear that many IB claimants report significant health problems (see for example: Sainsbury and Davidson, 2006; Barnes and Hudson, 2006). Accordingly it is necessary to acknowledge, that long term sickness limits employment opportunities (Williams, 2010), and thus the negotiation of a 'sick' identity is not some inauthentic gambit designed to retain self-respect among IB claimants, but a reflection of their lived experience in dealing with chronic illness.

In adopting a sick identity, a feeling of loss for the non-sick self can occur, particularly where illness or disability results in an inability to complete ordinary roles (Barnes and Mercer, 2010). Thus adopting a sick role can be seen as frustrating and not desirable, although it may be essential to allow a continuity of identity as ordinary activities become impossible to complete (Giddens, 1991). The everyday realities of pain and incapacity are distinctly absent from the government literature on IB (DWP, 2002) and disability (PMSU, 2005), although this does not limit their effects on the lives of IB claimants. In fact, the division of IB claimants into a group who are viewed as sick, and another viewed as merely unemployed with minor health conditions (Welfare Reform Act, 2007) has implied that only some IB claimants are really sick. Accordingly, for IB and ESA claimants who are a long way from the labour market, as a result of their very real health conditions as well as other issues, it may be most desirable to align oneself to the 'really sick' ESA category in order to maintain a positive self-identity that legitimates the years already spent on IB.

2.5.3 Potential for discretion within Pathways to Work

Sainsbury (2008) argues that within the UK's welfare to work agenda, there is considerable room for discretion. Having studied the policy documents carefully alongside the Child Poverty Action Group's *Welfare Benefits and*

Tax Credits Handbook[15] (CPAG, 2009), it is clear that there are three potential areas in which Advisors have discretion within *Pathways to Work*. These are the requirement to attend Work Focused Interviews, the 'Choices' offered to claimants and benefit sanctions. On the other hand, it will be shown that Condition Management Programme clinical staff are subject to significantly less official guidance and therefore have the potential to use very wide discretion.

Work Focused Interviews

Whilst there is a requirement for all IB claimants to attend six WFIs, Advisors have some discretion to waive this requirement. Certain groups will automatically be exempt, including those who are terminally ill, pregnant women who would risk the health of themselves or their baby if they worked and those who would cause a risk to their, or someone else's, physical or mental health if they worked (CPAG, 2009). These categories could be interpreted very widely.

In addition to the above categories, 'a severe limitation in certain activities', such as maintaining personal hygiene, walking and continence, can be used as grounds to waive the WFI requirement (CPAG, 2009:1514). The guidance is very specific and caters for the most severely incapacitated of people. For example, if a person cannot complete both of the following they could be waived:

> 'rise to standing from sitting in an upright chair without receiving physical assistance from someone else and move between one seated position and another seated position located next to one another without receiving physical assistance from someone else' (CPAG, 2009:1514).

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[15] The CPAG Benefits Handbook is seen as the authoritative source on navigating the Benefits system, providing extremely detailed guidance on each subject. The guide is updated each year, and the information contained was correct at the time of the fieldwork.

As a result of such detailed guidelines, Advisors are constrained in whom they can exempt from *Pathways to Work*. However, Advisors have more power to defer an interview. If 'it is considered that an interview would not be of assistance or appropriate', the interview may be deferred (CPAG, 2009:1003). This could allow considerable discretion, depending upon how a lack of assistance is interpreted.

The 'Menu of choices'

One area in which Advisors have potential for significant discretion is in which 'choice(s)' they offer claimants. The DWP reports that the great strength of *Pathways* is its ability to be flexible and respond to claimants' individual circumstances (DWP, 2002). Unlike in most areas of *Pathways*, Advisors have not been given *published* guidance on how to decide which 'choices' to recommend to individual claimants (Sainsbury, 2008). To date, there is little literature available that discusses how Advisors make this decision[16].

Sanctioning Benefit Payments

If claimants do not attend a WFI without showing 'good cause' within five working days, a benefit sanction can be imposed. The guidance Advisors are given to decide if a claimant has 'good cause' is very wide, including misunderstandings, transport difficulties, attending a job interview or health issues (CPAG, 2009:1005.) As such, it would be possible for an Advisor to avoid sanctioning most claimants who do not attend compulsory WFIs. Likewise, claimants are required to 'participate' in WFIs, including answering questions and devising an action plan (CPAG, 2009:1003). The notion of participation is broad, and as such, Advisors have the power to sanction

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[16] Research relating to Advisor discretion within Pathways to Work will be discussed in more detail at the beginning of Chapter Five.

claimants who have fulfilled the requirement to attend a WFI if they perceive them to be non-compliant. As a result of the unequal nature of power relations between Advisors and claimants, this guidance could be used inappropriately. Furthermore, within the available guidance, there is no distinction between claimants who are unwilling to attend or participate and those who are unable to do so as a result of their health condition. This could result in sanctions being applied inappropriately, for example, for some claimants who are unable to attend the Jobcentre Plus office as a result of severe anxiety conditions. Whilst in previous years, Advisors visited claimants at their home if they struggled to travel, this practice is now much less common (Grant, 2011).

The Condition Management Programme

Whilst Jobcentre Plus Advisors have significant constraints placed upon them in the form of official guidance within which they must operate, CMPs have very minimal guidance. Whilst their interventions must be targeted at the three most common causes of incapacity (minor mental health conditions, musculo-skeletal conditions and cardio-respiratory conditions), without replicating existing services, CMPs were able to use any methods to support IB claimants to better manage their health condition.

There is nothing explicitly set out in policy documents as to why CMP staff were subject to such a low level of constraint compared to Advisors, but it is possible that their stronger professional identity as clinicians, who would expect to be able to exercise clinical autonomy within cases they managed (Lipsky, 1980; Bergen, 2005), was respected in the policy design stages. Alternatively, as CMPs are expected to be innovative and responsive to local conditions, it is possible that a wide range of discretion is the only way such a project could be implemented.

2.6 Conclusion

This chapter has outlined major changes to social security for unemployed and disabled people since the Poor Laws. It was shown that social security for the unemployed has always been influenced by notions of claimants as undeserving and 'less eligibility', or making benefits less attractive than work. However, until the 1990s, disabled people claiming Sickness Benefits and Invalidity Benefits were largely exempt from these discourses; benefits were paid at a higher rate and claimants were exempt from conditionality. The introduction of Incapacity Benefit in 1995 changed this. I have argued that during the New Labour Governments, the long term sick and disabled were in the process of becoming viewed as another group of unemployed people in a policy sense, with an increasing focus on distinguishing between those who were 'genuinely' ill or disabled, and consequently still deserving of help, and those whose legitimacy as a claimant was called in to question.

In addition to examining policy change, it is also necessary to acknowledge that policy is not always implemented as it is intended. This is because of the discretion of those tasked with implementing policy alongside the impossibility of full implementation of most policies. The work of Lipsky (1980) showed that the opinions and professional status of workers together with the need to limit demand for services play a crucial part in shaping policy on the ground. Having outlined the small amount of existing research, the chapter ended by showing opportunities for discretion within *Pathways to Work*. The next chapter will outline the research questions before detailing the research design adopted.

Chapter 3: Research Design

3.1 Introduction

This chapter will begin by outlining the research questions to be addressed by the research strategy. It will be argued that as little was known about the topic area, a multi-method qualitative approach was the most appropriate method in order to gain a rich understanding of how the *Pathways to Work* policy was being implemented and experienced on the ground. In addition to this, the epistemological underpinnings of adopting an interpretivist, multi-method approach will be described.

The second part of the chapter provides a detailed description of data sources, beginning with the sample selected and access arrangements. The research was carried out on four separate groups; IB claimants who engaged with voluntary work-focused activity (ten), IB claimants who were not engaged with voluntary work-focused activity (11), Jobcentre Plus Advisors who conducted compulsory Work Focused Interviews with IB claimants (eight) and CMP clinical staff who conducted voluntary clinical interventions with IB claimants (13). It will be shown that access to each of these groups had its own difficulties.

A range of qualitative data were collected, including transcripts of 42 semi-structured interviews, field notes from four days of observing Work Focused Interviews within one Jobcentre Plus office and case files from 10 CMP participants. The research thus combined interview, observational and documentary methods of data collection. Data were organised for analysis using the Miles and Huberman (1994) technique, involving data reduction, data display and conclusion drawing. The use of such a strategy enabled the wide range of data to be easily compared and contrasted. Data reduction was facilitated by the use of Atlas ti6 computer software. The chapter ends describing some of the key ethical issues within the research

including possible disempowerment of IB claimants, researcher safety and power relations.

3.2 Research Questions

In this project there was little pre-existing research in the area as a result of the policy change being relatively recent. Therefore, beyond the primary research aim, research questions were kept deliberately flexible in order to ensure that areas of interest to the topic were not excluded. New areas of interest were then able to be included when they emerged in interviews (Rubin and Rubin, 2005).

3.2.1 Primary research question

How do those participating in *Pathways to* Work experience and perceive welfare reform?

Alongside the primary question, more specific research questions were adopted based upon the limited literature available in the area.

3.2.2 Secondary research questions

- What factors result in people with a health condition leaving the labour market and becoming IB claimants?
- How do IB claimants, JCP staff, CMP staff and employers experience and perceive Work Focused Interviews?
- What happens during participation with the Condition Management Programme? What are the outcomes of participating in CMP?

- How much discretion do JCP staff and CMP staff have within *Pathways to Work* and how do they choose to use this? Why do some IB claimants engage with *Pathways to Work* more than others?
- How do the four groups of participants view each other and other people in a similar role to themselves?

3.3 An interpretivist approach to social policy research

The idea of value neutral research has been rejected within the social sciences for some time, and as such it is important to acknowledge my own theoretical position on the changing policy as having an effect on the research process (Hammersley, 2000; Fontana and Frey, 2005). An explicitly interpretative stance was adopted within the research, with the aim of attempting to describe the alternative, subjective realities experienced by different groups in the *Pathways to Work* process. The epistemology aims to discover, in detail, individuals' interpretations of experiences, including those with other groups who participated in the research, and the meanings attributed by individuals to those experiences in order to provide a greater understanding of how policy change was experienced. Thus the research enabled the narratives of participants to be documented, both as a way of recording the effects of policy change on different groups, and in order to show how the identities of groups and individuals changed throughout participation in Pathways to Work. This approach also allowed an exploration of the different power relationships each of the groups of participants had with the Department for Work and Pensions (DWP) which is likely to have affected not only their experiences but their answers given during interviews (Fontana and Frey, 2005). Whilst IB claimants are arguably the most vulnerable, relying upon a confusing and complicated system in order to claim social security, Advisors are not free from these power relations. Of the groups who participated in the research, the clinical

staff of the CMP, who were employed by the NHS, appeared to be the least affected by the DWP's requirements.

3.4 A multi-methods approach

In recognition of the limitations and drawbacks of positivist traditions, the use of multi-methods has come to be seen as an important way of building triangulation and enhancing the validity of findings (Mason, 2002). Furthermore, when researching an area about which little is known, an approach based upon ethnographic principles is advocated in order to gain a greater understanding than, for example, interview data alone (Hamersley and Atkinson, 1998). These caveats have increased relevance in complex institutional settings. Research studies adopting an ethnographic approach have attempted to create understanding of how policy is operationalised on the ground (Lipsky, 1980), and have been seen as particularly useful for undertaking research on changes to social security policy (Wright, 2003) and health policy (Murphy and Dingwall, 2003). As such, the research included some fieldwork and documentary analysis alongside interviews with a range of groups. The use of an interpretivist epistemology allows alternative realities constructed through these different data sources to be acknowledged (Meetoo and Temple, 2003). For example, when analysing interview transcripts, the primary source, in order to develop themes, the use of field notes from the observational study, and CMP case files allowed comparison. This can be seen as enhancing validity, although it will be shown in the empirical chapters that the use of multiple methods led to a more complete picture of policy change to be seen with few contradictions between different data sources. This research design was considered more suitable than an ethnography of one setting in order to examine a range of groups who were affected by the policy change, rather than investigating one of these groups more closely.

3.5 The limits of emancipatory research

Researching disability is far from a new phenomenon. Ranging from Davis's (1963) famous study of polio to Carol Thomas' research on cancer (see for example 2004, 2005), disability has been widely researched in various forms for the last 50 years. Whilst some early research adopted a medical model of disability, putting biological impairment first, this has been critiqued by the disability movement and some academics for disempowering people with disabilities (Barton, 1996; Moore et al., 1998; Barnes, 2001). Moreover, much of the work within medical sociology has taken not so much a medical as an interpretative or phenomenological approach which explores the meaning of illness from the actor's point of view (Williams, 1984; Bury, 2008). Within disability studies, there is growing acceptance of emancipatory research as a way in which disabled people can be included in the research process in order to prevent it disempowering them (Oliver, 1992; Barnes, 2001). This research did not attempt to follow an emancipatory approach. Instead, an original study was undertaken with hard to access groups in order to understand how policy change is experienced by a number of key groups.

3.6 Sample and access

3.6.1 Introduction

The research involved four different groups of respondents, which were placed in two broad categories.

- Those implementing changes to welfare: Jobcentre Plus Advisors and CMP staff.

- Those being affected by changes to welfare: IB claimants who had engaged with the CMP and IB claimants who were largely unengaged with *Pathways to Work*[17].

The first group, Jobcentre Plus Advisors was comprised entirely of front-line staff in Jobcentre Plus offices who carried out Work Focused Interviews with IB claimants. Alongside this, CMP staff included clinicians, such as occupational therapists, nurses and physiotherapists, clinical leads, who were active clinicians as well as managers, and programme managers who were not clinically trained. The clinical staff of the two CMPs interacted directly with IB claimants in order to attempt to support the claimants to better manage their condition.

Alongside the two professional groups, IB claimants participated in the research. Firstly, a group of claimants referred to as 'engaged', who had attended at least three (voluntary) CMP sessions, and were seen as engaging with the *Pathways to Work* process. Finally, a group of IB claimants referred to as 'unengaged' were recruited externally to Pathways to Work, from Housing Associations and the Citizens Advice Bureau. These claimants typically engaged less with *Pathways to Work*.

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[17] For the purpose of the research an 'engaged' IB claimant is one who has attended at least four sessions with the Condition Management Programme (CMP), a voluntary aspect of Pathways to Work. Engaged claimants were recruited via the CMP. 'Unengaged' IB claimants were recruited externally from Pathways to Work and had undertaken less of the voluntary aspects of Pathways to Work.

Table 3.1 Sources of Data

	Interviews				CMP case files	Observation, area 1
	total	area 1	area 2	alternative areas		
IB claimants - unengaged	11			11		
IB claimants engaged	10	3	7		10^{18}	
JCP interviews-observed						14
Jobcentre Plus Advisors	8	4	4			Key informant – Lydia
CMP staff	13	6	7			
TOTAL	42	17	23	12	10	14

These groups were chosen because they all had first hand experience of welfare reform. Likewise, it was felt that including several groups of respondents in the research would enable a more complete picture of multiple realities to emerge by allowing multiple perspectives to be heard (Rubin and Rubin, 2005).

3.6.2 Condition Management Programme clinical staff and managers

The first access secured was to CMP staff. Having been provided with the contact details for the managers of three of the four NHS CMPs in Wales, I had successfully arranged to meet with the managers of two projects. Furthermore, I had met with some CMP staff at a conference. Having

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[18] Whilst the CMP case files correspond to the engaged claimants who participated in CMP, the IB claimants who were observed during their compulsory Work Focused Interviews did not participate in interviews.

secured access in principle, it was necessary to apply for ethical clearance from the National Research Ethics Service (NRES, the committee for the National Health Service). Further details of this will be explored later in the chapter.

Having secured ethical approval, the manager and clinical lead of CMP 1 met with me to discuss how to take the project forward and who I would like to interview. Much of the literature on sampling (eg: Corbetta, 2003; Layder, 1998) assumes that the researcher will have a large degree of control over who is selected to participate in their research. In the case of CMP 1 this did not turn out to be a reasonable assumption, although such deviations from expected norms during research are now widely acknowledged (see for example, Coffey, 1999). During the meeting, the manager asked me who I would like to interview. I had decided that as my research looks at the implementation of policy on the ground, it would be important to include all senior members of staff; in this instance the clinical lead and the project manager were essential. Having read the small amount of available literature and using my own experience of the differing professional roles utilised by the CMP, I suggested that it would be most beneficial for the research if staff were purposively selected to reflect the full range of clinical roles employed by the CMP. This was agreed to by the management team who then decided who would be best to approach. I did not feel confident enough of my access agreement at the time to ask why, for example, one physiotherapist had been chosen over another.

Within CMP 2, I met all members of staff during a team meeting after ethical approval had been secured. During this meeting, I gave a short presentation about my research and answered questions about how I would like staff to participate by being interviewed and in recruiting the programme's participants to the research project. At the end of the meeting, I asked for those who were interested in participating either to speak to me then or email me. With the exception of an OT Technician, I was able to recruit everybody required for the purposive sample. Having discussed this

72

with the clinical lead, they spoke to the two OT technicians and one volunteered to be interviewed. It seemed that the technician was still unsure of the value of their contribution on the day that I interviewed them although the technician consented to participate. Afterwards they commented that the interview 'wasn't that bad', and that they would be interested to know the outcome of the research. All CMP staff were interviewed between June and August 2008.

Table 3.2: Clinical experience of CMP staff.

Area	Role	Clinical experience prior to CMP
Area 1	Manager (non-clinical)	n/a
	Clinical lead (O.T)	27 years. All mental health. (mental health specialist)
	Occupational Therapist 1	7 years – physical and mental health OT (mental health specialist)
	Occupational Therapist 2	Primary school teacher. Trained at OT 17 years ago. All physical OT (cardio-respiratory specialist)
	Physiotherapist	8 years (four outside of NHS)
	OT Technician	n/a; manufacturing background
Area 2	Manager (non-clinical)	n/a
	Clinical Lead (O.T.)	10 years. All learning disability or mental health (mental health specialist)
	Senior Practitioner (O.T.)	9 years. All mental health (mental health specialist)
	Occupational Therapist	18 years (with gaps raising children). All physical rehabilitation. (musculo-skeletal specialist)
	Nurse	20 years. Dual registration as Registered Mental Health Nurse and Registered General Nurse. All experience as Mental Health Nurse. (mental health specialist)
	Physiotherapist	7 years. 2 years outside NHS
	OT Technician	15 years in care work. Training to be an OT.

The high numbers of occupational therapists interviewed in area 1 reflects the fact that the Manager of CMP 1 has designed their programme to be 'largely underpinned by occupational therapists, we have 8 OTs on the team, a couple of part time physiotherapists...'. Although there was a slightly wider range of clinical staff in CMP 2, that programme also had a high level of occupational therapists, and so occupational therapists featured prominently within the sample.

Interviews with CMP staff took place at the head offices for each area. Neither of these offices were used to see patients. All interviews took place in private rooms, although it is possible that in one interview, with the OT

technician from CMP 1, that some of the interview could be overheard as it was possible to hear part of the conversation in the office next door which was being used by three members of administrative staff. Interviews varied in length from forty minutes to just over an hour.

3.6.2 Incapacity Benefit claimants – engaged

In order to be classed as having 'engaged' with CMP, that is having voluntarily participated in activity that attempted to support an individual to manage their condition, it was necessary to devise an appropriate indicator. The pragmatic decision was taken following advice from both Programme managers that attending three sessions beyond their initial assessment would serve as a good proxy for 'engagement'. As such, the population eligible to participate in the research were those who had undergone an initial assessment from April 2008 to June 2009 and then subsequently participated in at least three appointments. In practice it is unlikely that all 'engaged' claimants were offered the opportunity to participate in the research. The procedure involved when a CMP participant had reached this stage, was that their clinician was supposed to provide them with a Participant Information Sheet (see Appendicies 1 and 2), which included both my contact details, so that they could contact me directly, and a reply slip which clinicians could pass on to me. It is not known how many people in the population were not sampled, or how many people refused, but it is likely that the demands of working as a clinician may have made recruiting participants for my research a relatively low priority.

On the other hand, I believe that this approach was likely to have increased my response rate over simply posting out participant information sheets. In performing this role, the clinical staff vouched for my credibility to some extent and were able to provide some reassurance. For example, the nurse from CMP 2 related a conversation she had had to me: "Oh yeah, Aimee, she came to see us the other day... She seems OK, and it'll only take an

75

hour of your time and if you want to, you can tell her she's being nosey! (laughs) you can just say, 'I don't want to talk about that'".

Table 3.3: Data collected: Engaged Incapacity Benefit claimants.

Area	Name	Age	Time on IB	Method
Area 1	Joanne	49	4 years	Face-to-face
	Emma	41	11 months	Telephone
	Chris	58	19 months	Telephone
Area 2	Dai	41	1-2 years	Telephone
	Rachel	46	4 years	Telephone
	Paul	51	18 months	Telephone
	Jacob	26	15 months	Telephone
	Sarah	43	8 months	Telephone
	Catherine	52	2 years	Telephone
	Rebecca	50	2 years	Telephone

Within this group, all claimants took part in a semi-structured interview and allowed me to copy their entire CMP case file for analysis. Interviews took place over an extended period between July 2008 and January 2009 as a result of difficulty in accessing participants via clinical staff. I believe that the higher response rate in Area 2 may have been accounted for by the staff of CMP 2 having a stronger working relationship with me. For example, I had an open invitation to visit the office, consequently, if I was interviewing in the area, I would visit and update members of the team on my research. As such, I believe that staff either felt more confident that I would not harm their patients, or felt more desire - or obligation - to help me. The relationship in Area 1 was much more formal and I only visited the project three times, communicating by telephone or email with the Manager only outside these times. I believe that this, in part, accounts for the lower response rate from engaged claimants in Area 1.

3.6.3 Jobcentre Plus Advisors

The initial application, in December 2007, to interview Jobcentre Plus Advisors received a negative response. However, having interviewed staff and participants of the CMP and unengaged IB claimants, it became increasingly clear how much discretion Advisors had in their decision to recommend CMP to an IB claimant. Consequently, in order to understand how the Welfare Reform Act 2007 was being implemented on the ground, it would be necessary to gain access to Advisors. As such, a further attempt to secure access was made by a colleague who was known to senior members of Jobcentre Plus staff, and thus succeeded.

During the early stages of the research process, it was hoped that the role of employers in supporting people with health conditions to return to work could also be included. For this reason, Jobcentre Plus Advisors who fulfilled the Disability Employment Advisor (DEA) role alongside performing compulsory Incapacity Benefit Work Focused Interviews were sought. The DEA role is twofold: firstly, advising the most disabled people, claiming IB, other benefits or in employment, on how to retain their job or gain another job. This area of their work is fully explored within the results section of the thesis. A second part of the DEA role is to meet with employers to provide them with advice on how they could be more accessible to disabled workers, including the 'Two Ticks' scheme (which certifies employers as being disability friendly) and administering Government subsidies. Data relating to the second part of the DEA role will not be covered within the thesis to allow it to focus in more detail upon *Pathways to Work* initiatives alone.

As can be seen from the table below, the majority of the Advisors performed both (voluntarily attended) Disability Employment Interviews and Incapacity Benefit Work Focused Interviews, which are compulsory for IB claimants. What is important to note, however, is that Advisors feel that, with the exception of a referral to CMP or the Return to Work Credit, they are able to

77

offer the same interventions to all people who have health conditions and attend interviews at Jobcentre Plus.

The area boundaries that Advisors worked within were the same as the areas utilised by the CMPs. In research Area 2, access to Advisors occurred rather quickly and easily, because the cooperation of a key contact was secured. I was put in touch with a very efficient secretary who sent an email to all of the Advisors performing the DEA role within the area. Email contact continued on a weekly basis and within a month, the secretary emailed with the names and contact details of four DEAs who were prepared to be interviewed. When I telephoned to thank the secretary, she apologised for only being able to find me four DEAs rather than five. The support of the secretary undoubtedly ensured my access to DEAs proceeded in a smooth fashion, showing that secretaries and receptionists perform a crucial gatekeeping role (Lipsky, 1981), which affects those attempting to research bureaucracies, as well as those who seek the everyday services of such agencies (Campbell et al., 2006).

Gaining access within Research Area 1 was less straightforward. The area manager's secretary had sent around an email, containing my participant information sheet (see Appendix 3) to all of the DEAs who were asked to contact me directly if they would like to participate. The secretary, who was very pleasant and helpful, said that if I did not hear anything within a week, I should contact her. Having only had one positive response, I telephoned a week later. However, the original secretary was on holiday and the person who had answered my call was from the external relations department. They kindly offered to answer any questions I might have, preferably by email because: 'I can imagine that they wouldn't want to talk to you. In fact it would be very odd for them to do so (as it isn't part of their job description).' Such difficulties in maintaining access agreements within government bureaucracies is not uncommon (Wright, 2003). At this point, access agreements were retained, with some difficulty, by one of my supervisors contacting the Jobcentre Plus Director for Wales directly.

Within two weeks, I was contacted by telephone by a secretary who gave me the contact details of four Advisors who had agreed to be interviewed.

Table 3.4: Data collected: Jobcentre Plus Advisors

	Experience in role	Primary job role	Secondary job role(s) *Previous experience (italics)*
Advisor 1, area 1	35 years	Disability Employment	JSA ('signing on') IB (WFIs)
Advisor 2, area 1	18 years	Disability Employment	IB (WFIs) JSA ('signing on') *New Deal Advisor* *Advisor for private company 'Manpower'*
Advisor 3, area 1	16 years	Disability Employment	JSA ('signing on') IB (WFIs)
Advisor 5, area 1	28 years	Incapacity Benefit	Disability Employment *JSA ('singing on')* *Lone Parent Advisor*
Advisor 1, area 2	9 years	Disability Employment	IB (WFIs)
Advisor 2, area 2	21	Disability Employment	IB (WFIs) *JSA ('signing on')* *Pensions Advisor*
Advisor 3, area 2	10 years	Disability Employment	IB (WFIs) *New Deal Advisor*
Advisor 4, area 2	23 years	Disability Employment	IB (WFIs) *Industrial Injuries Benefit claims* *Income Support claims* *Appeals officer*

NB: Advisor 4, area 1 originally agreed to be interviewed but due to an extended period of sickness was unable to participate.

Table 3.4, above shows the wide range of experience and skills that Advisors had. In this way, they can be seen as experts within their role. Jobcentre Plus staff in Area 1 were interviewed in the various JCP offices where they were based. Two of the four interviews occurred in private interview rooms. The other two did not. This may have had different effects

due to the locations. For example, the interview with Advisor 2 in Area 1 took place at the Advisor's desk which was in a small and cramped office. I was very aware that there was a participant interview going on at the desk beside us and another going on just behind where I was sitting. I was able to overhear parts of their conversations and sometimes others within the office, and as such it was likely that we could be overheard. When transcribing the interview, there are times when it is very hard to hear what the Advisor had said as their voice had been lowered considerably. The other interview that took place at the interviewee's desk was with Area 1, Advisor 5. In this instance the layout of the room made the interview feel different. The JCP office was very spacious. There was one desk beside the Advisor's desk but a large partition made it more difficult to overhear conversations

3.6.4 Incapacity Benefit claimants – unengaged

From the early stages of planning the research design, I had felt that it was desirable to include a group of IB claimants who were recruited away from Jobcentre Plus and/or CMP. I believed that this would ensure my separateness from Jobcentre Plus, and hence my ability to instigate any influence on their IB claim was apparent and thus allow claimants to express their feelings about the policy change without fear of reprisal. Whilst this may seem like a drastic step, Jo's interview showed that she believed that if she was critical about CMP within evaluation forms, she would be removed from IB (see chapter 6 for more details).

Within Area 1, access to such claimants was gained through a Housing Association in a large town within the area. The manager of the Housing Association acted as the initial 'sponsor', vouching for my credentials to potential interviewees (Adler and Adler, 2001). The Housing Association (HA) has over 6,000 properties including houses, bungalows, low rise flats and sheltered accommodation. As such their head office, where tenants

could pay rent and ask for maintenance issues to be repaired, had a constant flow of people and was a suitable base for recruiting participants.

During this part of the field work, I sat behind the reception desk with two housing officers. The Housing Officers, understandably, had some reservations about my presence and what they would be required to do. One Housing Officer in particular did not want to be seen as pressurising their tenants to participate in the research and thought that it would be easier for participants to say 'No' to somebody not known to them. It was therefore negotiated that I would ask people discreetly if they claimed IB, if they did and they 'could spare me a few minutes', I would use a private interview room in which to tell them a bit more about the project and interview them if they consented. The HA's offices were pleasant – they were warm and comfortable and the Housing Officers were very polite, respectful and helpful to people, even those that they later confided were 'a right pain, she's always in here complaining...' or in significant rent arrears.

In order to ensure that participants were not embarrassed, if the reception desk was busy, I did not ask people. Thus of the 28 participants who came in, nine were asked if they claimed IB and twelve were ruled out because of things that they said showing that they were obviously not IB claimants. For example one man asked: 'can you do it quickly now? Or I'll have to pop back later – I'm in the works van and I'll be for it if the boss finds out!' Of these nine, three had experience of claiming IB recently and all took part in an interview.

Whilst this approach was successful on the first day, further visits did not result in any interviews as IB claimants who attended the Housing Association chose not to participate. As such, another Housing Association, within a city outside of both research sites, was used. Early in January 2009, I spent the morning in the reception area of the second Housing Association. In this instance, I sat in the participant area of the reception, rather than behind the desk. I noted at the time:

81

I sat on a bench in the bay window of the reception area. I think this gave me a different, lower, level of legitimacy as viewed by the participants although the reception desk was so busy that I'm not sure I would have fit in there! (Field notes: 12.01.09).

The HA had fewer people attend than the one in Area 1. However over the course of six hours 10 participants came into the office. All participants were asked with the exception of one man who did not respond when I tried to enter into a conversation with him. When a member of staff came out and started signing to him, I realised that he was deaf, I considered asking one of the Housing Officers to sign for me to ask if he would like to participate, but I had not been introduced to the Housing Officer who was signing to the customer and also felt that as they were all so busy they would prefer not to. This has implications in terms of excluding somebody who may have been an IB claimant. .].

Of the nine people I asked if they claimed IB, one woman, Michelle, was a claimant and she agreed to be interviewed. I was able to utilise one of the private interview rooms. In addition to this, I was offered the opportunity to visit one of the Housing Associations' hostels. This posed an ethical dilemma for me, as I was effectively entering part of somebody's home and then asking them to tell me personal things (Miller and Bell, 2002). When I conveyed this to the hostel staff, they did not seem to understand my reluctance. Having discussed the research with the staff, the manager used their records of tenants to identify one IB claimant, Nicola, and telephoned her to ask if she would mind coming down to see me. She agreed and we spoke in a private interview room, just off the reception area. When going through the consent process with her, I made sure several times that she understood that it was voluntary. I gave her the option to say no in several ways. In my field notes I wrote:

I told her a bit more about the research, going through the information sheet with her, but she did seem a bit 'out of it'. She claimed to be on a wide selection of drugs, some anti-psychotic. When I asked her if she was happy to participate she shrugged her shoulders and said "yes", I told her that if she didn't want to take part she didn't have to and I wouldn't mind. She said she would "like to do it", although she did not seem very convincing. I asked her if she would like me to come back at another time, in order to give her a 'get out' clause, but she said that she wasn't busy so we could do it now (Field notes, 12.01.09).

It may be that taking part in an interview was an interesting interruption to what would have otherwise been a boring day, but I did feel concerned about exploiting her. I also stressed several times that if there were any questions she did not want to answer, she did not have to. After the interview with the female tenant, the staff suggested that there were other hostels managed by the Housing Association that I could try to get participants from. However, as expressed by Miller and Bell (2002), I felt that by gaining access to vulnerable individuals in their own homes and asking for their participation, it would be difficult to ensure that their participation was truly voluntary, and not linked to a desire to please a support worker who was acting as a gatekeeper. Consequently, I asked if it would be possible to leave some participant information sheets (containing my contact details) with the staff and that they could be passed on to tenants who might be claiming IB. The staff seemed to find this a peculiar approach and said that they would be happy to take me to the next hostel that was within walking distance but I reiterated that I would prefer to do it the official way. I also took the email address of one member of staff. I did not get any positive response from the participant information sheets which may or may not have been handed out. Likewise, the member of staff did not reply to email contact. In retrospect, I still feel that this was the only ethically acceptable way to carry out the research.

The third way in which unengaged IB claimants were recruited was through one Citizens Advice Bureau (CAB) office near Area 1. In contrast to the approach adopted within the two Housing Associations, the manager of the CAB office suggested that as his advice staff would already undertake a

83

benefits check, they would be able to identify people who claimed IB and ask them if they would be willing to participate, including talking them through the participant information sheet. If the customer[19] was happy to be interviewed, the benefits advisor would then come and tell me, often giving me some background on their reason for attending the CAB that day – mostly relating to their claim for IB – and find me a private room to interview the customer. In several cases, as there was not a spare interview room, I interviewed CAB customers in a room used to store records. Interviews took place between January and May 2009.

Table 3.5: Data collected: Unengaged IB claimants

Area (recruited from)	Name	Age	Time on IB
Area 1 (Housing Association)	Brian	46	12 years
	Gwyn (mother interviewed)	22	4 years
	Mark	33	8 months (off IB now)
Alternative area 1(Housing Association)	Michelle	34	2 months*
	Nicola	27	5 years
Alternative area 2 (Citizens Advice Bureau)	James	64	14 years
	Ben	32	1 month*
	Jo	48	18 months*
	Martin	41	8 years
	Ann	42	20 years
	Rowena	57	1 year

NB: *Whilst Ben, Michelle and Jo appear to have only claimed IB for a short while, they have all had previous claims. Both Ben and Jo have previously claimed IB for their current condition and were removed after Ben failed the Personal Capability

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[19] The concept of the 'customer' has been retained when discussing the Citizens Advice Bureau, as their customers have the choice to use their services or not, unlike the IB 'customers' who were compelled to use Jobcentre Plus services as a condition of claiming benefits.

Test and Jo was removed from IB because she did not complete a form that she does not remember receiving from the DWP.

This group of interviewees was much more diverse than any of the other groups. As a result of the locations from which they were recruited this is to be expected and can be seen as an advantage in giving a voice to a wide selection of IB claimants. It is important to note, however, that over half of the sample were recruited from an advice agency, where the majority were seeking advice about their IB claim. As such, their critical views and negative experiences of IB may not be as representative of the population of IB claimants at large. On the other hand, the views of the Housing Association tenants, who were recruited in a way that was not related to their IB claim, may be more likely to represent a typical IB claimant..

Interviews ranged from five minutes (Mark) to over an hour (Jo). Some claimants seemed angry about the system, whilst others appeared to be more resigned to the perceived difficulties and injustices they found, in contrast to the engaged group. None of this group were positive about *Pathways to Work*. As such, the distinction between engaged and unengaged claimants will remain throughout the thesis.

3.6.5 Incapacity Benefit claimants – observations

Observation of Work Focused Interviews (WFIs) took place in one Jobcentre Plus office in Area 1; all of the WFIs were conducted by one Advisor, referred to here as Lydia. One of Lydia's colleagues, who also took part in the research, asked if I would like to observe one of their interviews, but on the day in question the Advisor reported that they did not have a claimant that they thought was suitable. As such, the Advisor asked Lydia if I could observe one of her claimant interviews, to which Lydia agreed, performing a gatekeeping and key informant role (Whyte, 1993). This led to me observing several interviews on that day and on three further days. I observed interviews with 12 IB claimants with two individuals being

observed twice. In addition to this, during the second visit, I officially interviewed the Advisor.

Data in this section come in the form of field notes written before, during and after Work Focused Interviews had been conducted by Lydia, the Advisor who allowed me to observe her work for four days. In some instances, Lydia was able to spend considerable time discussing an individual case, but in others, as a result of time constraints, I knew very little about the case before the interview and it was not possible to discuss the case afterwards. Field notes are organised around 19 claimants who were due to attend a WFI, however not all attended. All WFI participants were given details of the research and given the opportunity to opt out of participating in the research. None refused to participate. This might have more to do with concern over their benefit status or indifference to my presence rather than an active desire to participate.

In addition to observing WFIs, Lydia acted as a key informant discussing other claimants who did not attend an interview during the observation period. As such, in the main, general trends are extracted from field notes rather than paying specific attention to individual cases.

3.7 Methods of data collection

3.7.1 Introduction

The research adopted a mixed methods approach, utilising three qualitative methods to attempt to gain a wider understanding of policy change (Mason, 2002). Whilst traditionally the evaluation of policy has been confined to quantitative methods, the use of qualitative methods in studies of policy change has been seen as increasingly appropriate (Becker and Bryman, 2004), particularly where there are questions of social justice (House, 2005).

86

Furthermore, 'policy ethnographies' have also been employed in studying changes in health services. For example, changes to the NHS during the 1990s were researched in this manner by Strong and Robinson (1990) and Flynn et al. (1996).

The first of the three methods utilised was semi-structured interviews, with all of the groups of participants described in the previous section. Whilst the majority of these occurred face-to-face, most of the engaged IB claimant interviews occurred by telephone. Although in the past such a methodology may have been viewed as undesirable, this is now seen as an acceptable, if an under-used, method within qualitative research (Novick, 2008). The second method of data collection was non-participant observation within one Jobcentre Plus office in Area 1. During the observation period, one Advisor, referred to here as Lydia, acted as both a gatekeeper and key informant. Finally, CMP case files for each of the ten engaged IB claimants were analysed alongside their interview transcripts to gain a more complete picture of their circumstances and of the CMP process.

3.7.2 Semi-structured interviewing

The individuals from each of the aforementioned groups all participated in a semi-structured interview, which was digitally recorded. During interviews, I used a semi-structured interview schedule (see appendices 7-10) to ensure that as many of the key topics of interest as possible were covered. Topics of interest varied slightly by group. For example, IB claimants were asked about how their claim for IB began, their experiences of compulsory attendance at the 'Jobcentre' and about their health condition. On the other hand, CMP clinical staff were asked about their clinical experiences, their role within CMP and their feelings about compulsory work-focused activity.

The use of semi-structured interviews was the most appropriate form of interviewing for a number of reasons. It would not have been possible to

adopt a more structured approach to the data collection, if that was desired, as very little literature existed at the beginning of the project on the WRA 2007 and/or CMP. At the same time, however, the project had a relatively narrow focus within IB – the increasing conditionality attached to IB – and as such, an unstructured approach to interviews could have yielded much information that was not relevant to the topic under study (Warren, 2001; Mason, 2002). Furthermore, Barnes (2001) argues that a semi-structured approach allows the respondents to be as free as possible from the researcher's thoughts on an issue whilst allowing the data generated to be useful to the researcher.

Within interviews, the well known ideal of 'conversation with a purpose' (Burgess, 1984:102) was largely adhered to; for example in some of the interviews, particularly with IB claimants, I only asked three or four questions on the interview schedule, as their answers to one question touched on other areas allowing small follow up questions if more detailed was required. It should be noted, however that in the face to face interviews, the moment that the tape recorder was switched off, many respondents made quite interesting observations accompanied by statements like 'I didn't like to say it while you were recording but...' As such, the effect of recording speech, which is not common in our society, should not be underestimated (Warren, 2001). These 'off the record' comments were not included as data, unless I specifically asked if I could include an interesting comment because the interviewee's reference to not making the comment when they were recorded was assumed to mean that the interviewee did not want that particular comment to be included in the research.

Whilst the purpose of using qualitative interviews was to attempt to allow interviewees to describe their experiences, Holstein and Gubrium (1995) argue that it is important to note that there is not one objective truth that interviewees choose to give to an interviewer. As such, they argue that the interview is an "active" construction between the interviewer and the

interviewee (Holstein and Gubrium, 1995). For this reason, my status as an academic who has not claimed IB or worked administering benefits must be acknowledged as playing some part in the answers I received. For example, Advisers described processes to me in considerable detail, because I was assumed not to know anything about them. On the other hand, by not having experience of claiming IB, I was identifiable as different to the claimants, and this may have resulted in less of a rapport throughout the interview (Oakley, 1981).

At several points in many of the interviews with IB claimants, particularly with those who were not engaged, I was asked questions about technical issues relating to IB. I attempted to answer these questions, or suggested that claimants visit the Citizens Advice Bureau. Furthermore, during other interviews when a claimant mentioned something that was inaccurate about benefits, such as believing that they could only remain on IB for a certain length of time before returning to work, I made a note and gave the claimants some information at the end of the interview. Thus it is important to see the interview as 'social interaction' between two people (Mason, 2002:65) and not a neutral data collecting tool.

Telephone interviewing

The vast majority of interviews were completed face to face, however nine of the CMP participants from both of the two CMPs were interviewed over the telephone to keep costs manageable, in terms of time as well as research budgets as participants were located in a large geographical area. The vast majority of literature has focused upon the use of telephone interviews as a method within quantitative research. For example, Shuy (2001) suggests that the main advantages of telephone interviewing are those that might be required in structured interviewing such as standardisation between interviewers and less interviewer effects. Such a structured approach was not desired within the research. However, Novick (2008) argues that whilst much of the literature on the use of qualitative

89

telephone interviewing suggests that it will lead to inferior data, it can lead to greater disclosure of sensitive information and can make interviewees feel more relaxed. In addition to this, comparative research on alcohol consumption (Greenfield et al., 2000) and food intake (Casey et al., 1999) suggests that telephone interviewing is a valid alternative to face-to-face methods.

With the exception of the first telephone interview that was made up of short answers, interviews ranged from 20 minutes to an hour and included many long, well thought out responses. During some interviews, however, it was clear that I did not have the interviewee's full attention – if there were children to be looked after; a dog that wanted feeding etc, a face to face interview would have been likely to have afforded me their full attention. This is not to say that such distractions were lengthy, usually involving a brief interruption.

3.7.3 (non-participant) observation

The value of observation alongside interviews has been acknowledged for some time, as it allows the differences between talk and action to be compared (Atkinson et al., 2003). Likewise, Wright's (2003) PhD thesis shows the suitability of observation for understanding policy change in relation to social security. Furthermore, the work of Flynn et al. (1996) shows that changes to health policy are also well suited to such a methodology. For these reasons, in an area where there is very little evidence, and where the majority of that is in the form of DWP Research Reports, it seemed desirable to observe behaviour in Jobcentre Plus offices and during CMP interventions to supplement the accounts given during interviews.

Throughout the four days spent with the Advisor, I had the opportunity to ask for Lydia's views on a range of topics. On the first day, I attempted to write notes in a discrete way; holding information in my head during

interviews or direct questioning and then writing it down afterwards. By the last day, however, I sat writing what was occurring in the interview, and during the conversations between the interviews, as the interaction occurred. This change in *'jottings'* is described by Emerson (1995) who views the change in behaviour as a natural progression when conducting field work. It is not possible to estimate how much of an effect my increasingly overt note-writing had on the interaction performed in front of me, nor on the information that I was given whilst questioning Lydia. Thedecision to adopt this approach was two-fold. Firstly, I was aware that I had a finite amount of time in which Lydia would allow me to act as an observer, and as such I wanted to record as much of what was happening as possible, not relying on memory alone which would be inadequate to record all of the interviews observed (Emerson, 1995). For example, on the last day of observation, I ended up with field notes in excess of 18,000 words when they were expanded from my rough notes. Secondly, I decided that it was desirable to create a slightly artificial situation; it seemed most fair to Lydia to be reminded that she was taking part in a piece of research. I was very aware that Lydia was the only Advisor who offered me the opportunity to observe Work Focused Interviews and the vulnerable position that this put her in. I felt that in taking notes, there was a reminder of my purpose: I was there as a researcher. I hoped that this would ensure no negative consequences for Lydia. Within such a small professional community, true anonymity among colleagues would be difficult, if not impossible, to achieve; I was very aware that any comment attributed to Lydia would be known to those within her professional world as coming from her. For this reason, Lydia's thoughts in her formal interview will be described as coming from 'Advisor x, area y', whilst in her role facilitating observation, she will be referred to as Lydia.

The office in which the observation took place was a large open plan office with eight desks in my view and another four out of sight to me. There were two seating areas for customers who were awaiting their appointments. The furniture both at the desks and in the waiting areas was modern,

comfortable and clean. There was plenty of space between desks allowing more privacy than in some of the other offices where space was less available. The office had a pleasant, welcoming atmosphere. Within Area 1, Group Four security are contracted to provide security services at the reception desk of several of the JCP offices that I visited. In this office the security staff seemed more customer service orientated than at some other offices I visited, as though they were regular JCP staff than 'bouncers'. Throughout the fieldwork, the security staff were polite and respectful to customers, even those who were challenging. For example, one afternoon a man had come to the office without an appointment having had his benefits stopped. He was obviously intoxicated and became verbally aggressive when he was told that he could not see an Advisor without an appointment. When the claimant started to shout, one of the security staff said to him 'Come on, mate, this isn't going to help, is it? We can get you in first thing tomorrow morning and we'll soon get it sorted out for you...' The approach adopted calmed the man down, who left the office of his own accord.

This is a very different approach to the security staff in an alternative office in Area 1. Whilst being 'signed in' by one of the Group 4 security staff in that office, she commented that they are regularly physically attacked and that they have to 'throw customers out a couple of times a week'. I was treated very differently in this office by the security staff; they behaved much more like bouncers in a night club than the friendly, customer focused security staff in the field work site. As such, I believe that the atmosphere in the office that the field work was conducted in was not typical of offices in the area.

Coffey (1999) argues that it is important to note the geography of the context in which fieldwork occurs, as such, my fieldnotes contain diagrams of the layout of the office in which the fieldwork took place. However, during the fieldwork, approximately seven hours of each eight hour period were spent sat at Lydia's desk. As such, Lydia's desk literally was the spatial

dimension within which the majority of the fieldwork took place and the geography of the rest of the office had much less bearing on the fieldwork. The desk space was a rectangle with the Lydia on one of the long sides of the desk and the customer facing Lydia on the other side. I sat on one of the shorter edges between Lydia and the customer. During interviews Lydia referred to information contained on her computer and input new details into it. At these times, I could see the screen but the claimant could not, allowing me to see more details about their history, as written by Jobcentre Plus, than they could. This shows my acceptance by Lydia; had she chosen to, she could have averted the screen from my view. At other times, when explaining things, such as better off calculations[20], Lydia moved the screen so that the customer could also see it. During interviews, I was dressed professionally, looking more similar to an Advisor than to the majority of claimants. Likewise, my language and familiarity with the various policy documents detailing the processes involved in being an IB claimant, placed me with more affinity with Lydia than with the claimants who had little choice but to attend compulsory interviews (Coffey, 1999).

During times when Lydia did not have participants, there was plenty of paperwork for her to catch up on, showing the everyday pressures that an Advisor is under in a way that I had not fully understood from the descriptions given by Advisors during interviews (Emerson, 1995). At these times, I would take the opportunity to expand my field notes and took the conscious decision not to interrupt Lydia's work as I was aware of the pressure she was under and the precariousness of my access. However, several times Lydia would mention something that was unusual or frustrating to her. This could be about one of the interviews she had just conducted, something on her to-do list or her health and family. Once we had begun talking, we usually continued until her next appointment. Thus if

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[20] A better off calculation is designed to show benefit claimants exactly how much they will earn if they take up a job, and takes in to account finances such as council tax and rent, which would be paid for them whilst they claimed IB.

93

Lydia brought up an issue that I was interested in, she allowed me to ask her questions about that area.

On the other hand, during our lunch hour, discussion of work was almost totally absent. On each of the four days, Lydia and I had our packed lunches in the break room with various other members of staff. None of them asked who I was, although I was wearing a conspicuously large visitors' pass which had a large 'V' on it. Staff in the break room seemed friendly and discussions occurred around family, TV programmes, diet, fashion and magazines. As such, there is little detail in my field notes regarding lunch time.

Within the context of my field work, Lydia should be seen as a gatekeeper and key informant (Whyte, 1943). Whilst I learnt a lot about the day to day practices of an Advisor through observation that I did not learn through interviews, Fontana and Frey (2005) state that the researcher's views are also shared within this more natural conversational style and as such the researcher's part in the interaction must be acknowledged. Thus it is important to note that I liked Lydia; I felt that she worked hard to use all of the powers available to her to result in positive outcomes for her claimants. Furthermore, Lydia valued my research; several times she mentioned that my research was 'useful'. As such, our relationship should not be seen as neutral (Mason, 2002).

It has been suggested by Atkinson and Hammersley (1998) that there can be no such thing as non-participant observation, as just by observing, the researcher influences the interaction. Throughout the majority of the WFIs the Advisor and the customer interacted without referring to me (after the consenting process). However two customers spoke directly to me. One gentleman suggested that I should be looking at tax as he had been due a tax rebate and had not received it. The other customer who spoke to me appeared to be drunk and patted me on the arm whilst telling me that it was good that I was 'seeing it how it really is.' A further issue that Atkinson and

Hammersley (1998) raise is that some of the people being observed may know more than others. This was certainly the case with the research: Lydia had seen my participant information form and discussed my research with a colleague who was also participating in the research before we met. Lydia's claimants, however did not know that they might be asked to participate until the day, when they were then shown the participant information sheet and asked if they had any questions before the interview proceeded. I was not in control of how these interactions occurred, as I was not allowed access to confidential information, and was reluctant to ask Lydia to do anything outside of her normal job role (such as telephoning all participants before hand) there seemed to be no way around this.

Whilst the research originally planned to include observation of CMP interventions with clinical staff, and was given ethical approval for such observation, this part of the research was removed for fear of negative consequences. Through interviews with CMP staff, it became clear that CMP participants were vulnerable with the vast majority having depression or anxiety. CMP staff also describe how interventions were emotional for participants and could result in them revealing details of sensitive issues in their past that they had not told anyone about before. Furthermore, as client engagement was a source of difficulty, I did not want to be a cause of lower engagement levels if participants did not feel that they could ask for me not to be present. As such, I decided that it could be detrimental to CMP participants to have a non clinical observer present. With the added information provided by the case files, I remain convinced that this was the most appropriate approach for the CMP participants.

Field Notes

It is important to note that the data resulting from the field work are my field notes based upon my interpretation of events that unfolded in front of me (Sanjek, 1990; Emerson, 1995). As such, this data should not be seen as an objective reporting of fact, but rather my writing down a version of what

95

happened, recording the parts which appeared most important at the time, as it was not possible to record everything. This is very different to the data produced by transcribing interviews and should be treated accordingly.

Whilst in traditional ethnography, scholars have reported the difficulty of keeping their field notes up to date (Sanjek, 1990), as a result of spending four single days in the field over a period of a month, I was able fully to expand my field notes considerably. I began this process on the train after leaving the Jobcentre Plus office, and was able to spend a significant amount of time afterwards expanding field notes into fuller accounts before entering the field for the next observation session. Thus whilst I did not observe a vast quantity of Work Focused Interviews, the data that I have relating to them are highly detailed.

3.7.4 Documentary analysis

The value of documents as data for social research has been noted with detail by Scott (1990) and Prior (2003). The rationale for the inclusion of patient files, before one had been viewed, was the potential for the files to provide insights in to the working of CMP that were not available in other ways (Prior, 2003), particularly as it was decided not to undertake observation of CMP interventions. Whilst the use of documents in social research is often sidelined in favour of more 'active' data collection methods, Scott (1990) argues that documentary analysis can be used to provide a different kind of research evidence. In using documents as part of social research, however, it is important to note that all documents are a social construction, not a neutral reporting of facts (Prior, 2003; Pithouse et al., 2009).

It is the intention of this section, to focus upon the construction of documents by professionals and semi-professional SLBs in the course of

carrying out their duties. A body of social work research has utilised documentary analysis, and can be considered as suitably similar.

Key elements of case files include the referral from Jobcentre Plus (Appendix 11), and details of each intervention carried out with a participant are described in the 'clinical notes' section (Appendix 15). It was thought that such records could show elements of the CMP programme that might not be fully conveyed during interviews. At the time of securing ethical approval from the National Research Ethics Service (NRES, the National Health Service's ethical approval board), I did not know what else was contained in such files, but I knew them to be approximately an inch thick for each participant, and as such, I defended the utility of the files, in order to be able to access them, whilst having to admit that I could not tell the ethics committee how they would be useful because I had not been able to see a copy. My insistence that I thought they would be useful was related to the idea that much of what occurred within the CMP was likely to be captured, to some extent, within these files (Atkinson and Coffey, 1997). The files did not disappoint, providing detailed accounts of the participants' life histories before CMP and charting the interventions undertaken (key documents from the CMP are shown in Appendices 11-16).

All 10 engaged CMP participants who participated in an interview also gave their consent for me to have a copy of their CMP file. Files contained many documents, including the referral from the JCP, notes on every meeting with a clinician, pre and post intervention clinical measures (including the Hospital Anxiety and Depression scale, Pain scale, General Self Efficacy Scale and CMP2 outcome form, devised by the DWP) and copies of each letter sent to all parties involved; the individual, their JCP Advisor and their GP.

What was not anticipated before reading the case files was how disturbing some of the data would be. For example, Rachel had worked as a support worker for people with mental health conditions. During her interview she

stated that threats had been made to kill her by a former patient. The case file held detailed notes on a session where Rachel talks about these threats and a physical attempt to attack her. The account is written without emotion, reporting the account that Rachel had recalled , which had a strong impact on me (Fincham et al, 2007).

Whilst consent to read the case files had been given, reading accounts of highly personal life events that had resulted in the participant's depression, felt intrusive as the most personal events had not been mentioned during interviews. For example, whilst Catherine had described her son having cancer in her interview, she had mentioned that he was 'better' and had 'moved on with his life' by going to University and that she felt bad for being unable to move on. I had assumed that his cancer had gone into remission. Catherine's case file showed that her son's cancer was still likely to be terminal and that she was described as 'grieving' for him already.

Within the period of observation in Jobcentre Plus offices, I was able to view individual claimants' official records on a computer screen. As in some elements of social work practice (Pithouse et al., 2009; Wastell et al., 2009), JCP staff have a computerised database in which to input information about their claimants. Also like the social workers, fields could be left blank. However, where the practice differed was the JCP forms were never 'locked' to preserve their records; staff could update fields and remove incorrect information. Within social work, cases can be 'locked', with information reformatted, providing a different lens through which it is viewed (Broadhurst et al., 2010b). This may have resulted in Jobcentre Plus Advisors being more likely to input information of which they were unsure of the accuracy.

Within the research, it is essential to see the JCP electronic records that I was able to observe as different to the CMP records. Firstly, whilst the JCP records were entirely electronic, allowing fields to be amended over time, the CMP clinical records were all written by hand, with less opportunities to

update, for example, the initial assessment, after the event. Secondly, JCP staff completed the database infront of claimants, sometimes turning the computer screen so that claimants could also see what was being written about them, whilst CMP staff wrote notes within a session and then wrote these up into a formal record after the session. This could allow a period of reflection to occur between the session and creating the record of that session. Thus CMP staff, like social workers, spent time completing records which detracted from the amount of time that they could be actively supporting claimants (Wastell et al., 2009).

Both sets of official records contained elements of basic factual information (as reported by the claimant to the worker), much of which could be considered to be intrusive and not morally neutral (Broadhurst et al., 2010b). For example, the Jobcentre Plus claimant database held a record for the claimant's partner (or partners) and children, including their date of birth, occupation (if relevant) and address. Likewise, any child-support arrangements should also be detailed. On the other hand, the CMP initial assessment form asked questions around the claimants' diet, smoking and drinking behviour, and their support network. Within the 'risk assessment' section of the CMP initial assessment, a need to acknowledge, and attempt to manage, risk can be seen (Broadhurst, 2010b). Throughout the ten case files analysed, it can be seen that participants had few indicators of being high risk, to themselves or practitioners.

Within the clinical notes of the CMP files, it is possible to see moral undertones. The good claimant can be seen as one who engages in few health risk behaviours, keeps to a regular sleep routine, and who engages in positive activities outside of the home. Being able to ask claimants such intrusive questions is a skill, showing that the CMP staff, by necessity, have to be sensitive and diplomatic (Broadhurst, 2010b). These factors have a moral undertone which suggests that it is the claimant's duty to be as ready for work as they can possibly be within the confines of their health condition. Such a view can also be seen within the sick role (Parsons, 1951)

In addition to this, details of each Work Focused Interview, and each CMP intervention were recorded in each file, although the length of these varied considerably. This is in contrast to Broadhurst et al.'s (2010b) finding that the productive work that they carried out with their clients was not always well recorded in official notes.

Further research with social workers assessing children seen as possibly at risk found that, as a result of the need to complete the assessment within a short time scale, social workers typically only completed part of the assessment form, failing to complete the majority of the middle section of the form (Broadhurst et al., 2010a). In this research, the pressures of high caseloads and limited time had resulted in workers using the form in a way that it was not designed. Furthermore, having analysed 65 case files, the researchers stated 'Workers have become experts with the copy-and-paste function...' (2010b: 1058). In addition to this, stock phrases had become adopted by the team, when the way in which that phrase should translate into action was not fully considered (Broadhurst et al., 2010b). The Jobcentre Plus database for each claimant typically had empty fields, which can be seen as a result of Advisers failing to ask questions or record answers. On the other hand, the CMP initial assessment forms involved each field being completed, even if only to note that the information was not applicable. This may have been as a result of CMP staff being subject to higher levels of professional critique, amongst their peers and superiors, of initial assessments as part of a multi disciplinary team, or as a result of their lower case loads.

3.8 Methods of analysis and interpretation

Within the data analysis phase, it was felt that it was important to build as accurate a picture of the policy implementation as possible (Becker and Bryman, 2004). For this reason, all of the data were analysed alongside

100

each other, with any differences between sources noted. In order to ensure that all data were fully considered, Miles and Hubermans' (1994) data analysis strategy was utilised. This allowed easy comparison between different sources and groups of participants in order to enhance vailidity.

3.8.1 Searching for meaning and developing themes

Following a review of the available literature, the broad areas that were of interest were identified as:

- Becoming incapacitated
- Work Focused Interviews
- The Condition Management Programme
- Thoughts about the future - returning to work?

Alongside these experiences, key theoretical codes were used:
- The sick role
- Discretion
- The deserving/undeserving dichotomy regarding benefit claimants
- Claimant engagement with Pathways to Work
- Identity: occupational identity and claimants' identities

All interviews were transcribed; half by the researcher, and the other half professionally. The first twenty interview transcripts were analysed and coded in a line by line manner, paying particular attention to the above themes. Following the initial analysis, an expanded set of codes were developed and all transcripts and fieldnotes were entered into Atlas ti6 for coding.

3.8.2 Miles and Huberman's three stage strategy

The analysis strategy adopted within the research was that advocated by Miles and Huberman (1994). Their approach advocated seeing data analysis as three inter-related stages; data reduction, data display and conclusion drawing. The use of this approach ensured that all data were considered at the analysis stage.

Data reduction

Within this area, Miles and Huberman (1994) suggest that areas of importance should be identified within data. This allows only the most relevant information to be considered at later stages, although it is important to note that Miles and Huberman see the analysis process as cyclical, and that it may be necessary to return to this stage.

Accordingly, the use of Atlas ti6 to hold data enabled the researcher to return to data and update or amend codes as necessary.

Data display

The second stage of analysis as identified by Miles and Huberman (1994) is data display. Data should be displayed in such a way that it enables valid conclusions to be drawn, as it is not possible to ignore sections of coded data that do not fit a hypothesis. Whilst the approach shown within Miles and Huberman's (1994) guide to analysis suggests the use of tables, it was found that this approach was most useful within small subsets of the data. For example, 'time ordered displays' (p.111), simply tables that detail different areas in a chronological tale, were compiled for each of the IB claimants. This enabled a narrative to be created of their health and work histories, as well as their participation in *Pathways to Work*. Such narratives covered significant periods of the claimants' lives and showed the impact of changing work and health situations upon their identities. In addition to being able to use such tables to construct narratives, by using one cell from the table, such as 'employment history' across all IB claimants, it was possible to compare differences and similarities within the group.

A second way in which analysis utilised Miles and Huberman's (1994) approach directly was the use of 'case ordered displays' (p.190). The way in which such a strategy was adopted within the research was to create one table per CMP participant and fill in the following table based upon their case files and their interview transcript.

Table 3.6: An example of Miles and Huberman's (1994) data display technique

Aims of Pathways	Direct positive outcome	Direct negative outcome	Indirect positive outcome	Indirect negative outcome
Understand condition				
Increase confidence				
Return to work/training				

When working with larger sections of data, it was not possible to draw tables large enough to contain all of the data. For example, data from interviews with CMP staff relating to the perceived benefits of CMP participation accounted for over 20,000 words. Consequently, such large amounts of data, which could be easily printed out from Atlas ti., were further sub-coded by hand and then each new code (in this example, 'managing their condition') were identified and displayed together by creating lists with reference to each section of data, rather than neat tables. The principle of displaying similar data together, however, was retained.

Conclusion drawing

Miles and Huberman's (1994) third stage is to use such data displays to be able to draw conclusions, or to acknowledge the limitations of the existing

data or coding, and hence the need to return to earlier stages of the research process. Having completed the table shown above for each CMP participant, comparison of the ten cases enabled a way of looking at the data in order to enhance validity. For example, it could be seen that there was a very high direct positive outcome of increased understanding of conditions, as seen through participants' interviews. On the other hand, increased confidence was seen through both case files and interviews in both direct and indirect ways. Indirect increases in confidence included being able to achieve more during the day resulting in increased confidence to attempt activities that had not been undertaken for some time.

The final aim of *Pathways* to be explored was the aim of returning participants to work or training. Whilst it could be seen that some moves were being made in this direction, the use of such a strict analysis strategy showed the inability of CMP to bring about this change for most participants. This issue will be discussed in greater detail in chapter six.

3.9 Ethical Issues

3.9.1 Access

NRES Procedure

The consent of the National Research Ethics Service (NRES) had to be sought in order to carry out research within the NHS. Although this was time consuming (in total the forms amounted to more than 50 A4 pages), support from the managers of the two CMPs ensured that the research was able to proceed in a timely fashion. As already mentioned, the Committee approved observation of CMP interventions, although I decided that this would not be in the best interests of the patients so chose to rely upon interview and case file data without the use of observations.

Private CMPs

Access was sought to one of the two private CMPs in Wales, both run by Action for Employment (a4e). Despite a large number of attempts over the course of a year, by email, telephone and the 'contact us' form on the a4e website, no response was received. Katharine Weston (née Nice), the author of the only report on private CMPs (Nice and Davidson 2010), suggested at a conference that the private CMPs did not fully co-operate with their research, despite DWP backing (Davidson and Weston, 2010). This may have been as a result of a wide-scale failure of provider-led *Pathways*, including CMPs, to meet their targets (NAO, 2010). As such, my inability to secure access should be seen within the context of the privatisation of information and not as a failure of the research project. Within the context of Jo's story (contained within the prologue), it would have been interesting to see if other claimants who had participated in a private CMP had similar experiences.

3.9.2 Researcher Safety

Prior to carrying out participant interviews, both CMPs had said that they would prefer for me to interview participants outside their homes, ie: in a public place. In order to ensure that the participant was able to feel comfortable discussing sensitive information it was necessary for participants to be interviewed somewhere where we could be alone. Through a misunderstanding, I had believed that CMP 1 would be able to allow me to utilise the premises that they used to see their participants for CMP sessions, however this later turned out to be subject to paying for the venues which was not possible within the available research budget. For this reason, the first interview, with Joanne, was carried out in the participant's home.

Due to further miscommunication, the safe-call arrangements that had been put in place a week prior to the interview did not work in practice, leaving me

a little flustered on entering the participant's home. When the participant, whose condition I did not know about at the time due to consenting procedures, then locked the front door and put the key in their pocket, I did not feel safe. I believe this is at least in part due to my background. Having worked as an auxiliary nurse with people with a range of mental health conditions, many of whom were violent due to their condition, I have come to expect a very high level of safety precautions as adopted by the NHS. The interview was fine and there was no threat to my safety at any time.

As a result of the difficulties of securing safe space and other pressures on the research, including time and money, and the wide geographical distribution of CMP participants, the rest of the CMP participants were interviewed by telephone.

3.9.3 Power relations

As previously noted relating to epistemological concerns, the power balance between myself and the participants was not equal (Barnes, 2001). For CMP participants, the access strategy ensured that this was minimised as much as was practically possible. However, the use of CMP staff, with whom they did not have an equitable relationship, to introduce the research project could have resulted in some feelings of obligation. For this reason, when I made initial telephone contact with participants, I reinforced the choice to opt out. Furthermore, due to many claimants having chaotic lifestyles, as seen within their CMP files, when I was due to contact a telephone interview, these were regularly cancelled by the participant. At this point, I gave participants the option of choosing a day for me to try again or leaving the research. None of the participants withdrew their consent.

Access arrangements with CMP staff and Jobcentre Plus Advisors contained a combination of more equal power relations initially but, in some

areas, a request to participate from a manager instigated participation. Moore et al. (1998:23) warn, on the basis of their research with teachers, that if people who are in a position of power 'dictate' that others (in their research head teachers telling more junior teachers) should be involved, then it is likely that some of the participants would not have chosen to participate. This would also have been likely to have had some effect upon the answers given during interviews. As such, all staff were contacted by telephone prior to interview and given the opportunity to ask questions and/or withdraw from the research.

The final set of access arrangements was for unengaged IB claimants, who were accessed through gatekeepers in the form of either their Housing Association or a Citizens Advice Bureau office. As several people said that they did not want to be interviewed, and it was made clear to them that I was an independent researcher and their services would not differ if they took part or not, I believe that the right approach was utilised.

Disempowerment?

Having familiarised myself with the literature on disability research (eg: Oliver, 1992; Barnes, 2001), I had decided not to follow a full emancipatory approach, but to attempt to empower participants through giving their voices an audience, and attempting to bring this to the attention of policy makers. However, during the interview with Catherine, she mentioned that she believed that CMP would provide her with counselling, and that she had decided to ask me about it. As CMP is a short-term programme and it had taken over a month for the interview to take place after Catherine's first three sessions (the criteria for her to be included in the research), it is possible that she may have received different interventions if she had spoken to somebody else earlier. Furthermore, in Rebecca's interview she mentioned that she had not liked the approach taken by her clinician, whom she thought was unprofessional. Although I offered to support Rebecca to make a complaint, or to do so on her behalf, she chose not to. It is possible that both participants were disempowered by their decision to wait and ask

107

me about their CMP issues. However, it is also possible that they would not have spoken to anybody about the situation. Moreover, I believe that these risks were necessary in order to attempt to facilitate a positive policy change.

Giving to participants as well as taking

I am aware that within my research, I was taking participants' time and, especially by IB claimants, being told very personal information. For this reason, all interviewees were asked if they would like a copy of my research findings. Such practice is widely seen as important in research ethics. However, particularly among the unengaged IB claimant group, who were arguably the most disadvantaged of the interviewees, receiving such information was not seen as desirable for many of the group. One participant suggested that 'It'll just be more paperwork for me...'

On the other hand, as advocated by feminist researchers (eg: Oakley, 1981), I was able to share my understanding of *Pathways to Work*, and the benefit system more widely, to enable IB claimants to feel more aware of their rights, and hopefully less fearful of the changes introduced by *Pathways*. In addition to this, I was able to recommend to one participant, who had never been a benefit claimant before her recent spell on IB, that she might be eligible for Housing Benefit and Council Tax Benefit. If she had been able to claim such benefits, which I believed was probable due to her low level of savings and her partner's low income, this could have amounted to her being several hundred pounds a month better off.

3.9.4 Positive portrayals only?

Whilst Oliver (1992) and Barnes (2001) argue that research involving disabled people should attempt to foster positive policy change, I had to decide how I would deal with any cases where IB claimants disclosed any

108

fraudulent activity. I knew that any portrayal of IB claimants as illegitimate could be used politically to justify cuts to IB. Fortunately, in practice this did not occur. With the exception of Gwyn, who has learning disabilities, and Nicola, who has serious mental health problems, all claimants had a long history of working. As chapter five will show, the decision to exit work was often a very difficult one.

Another factor the disability studies community suggests should be avoiding in writing up research is any portrayal of 'pity' (see eg: Barnes, 2001). I believe when looking at an issue as contentious as benefits claimed on the grounds of incapacity, it is necessary to show the difficulty of claimants' lives. Whilst conducting the research, I am not ashamed to note that at times I did feel empathy for many of the claimants. For the majority, their everyday lives consist of constant pain and/or depression combined with living on the inadequate income provided by IB. Many of their stories were truly moving, particularly when more detail was provided by documentary analysis. Whilst Barnes (2001) and other disability rights scholars see such views as having the potential to make the lives of disabled people tragic, I believe that for IB claimants it is essential to describe the difficulties of their lives in comparison to non-claimants in order to remove the notion that they are simply another group of unemployed people (Compass, 2010). As such, the risk that some claimants might evoke the 'tragic' view of IB claimants can be regarded as necessary in order to show the challenges and difficulties of the lives that many IB claimants lead.

3.10 Conclusion

The chapter began by introducing the researcher's position in relation to theoretical considerations. It was stated that the researcher was not aiming to be neutral and that the research should not be seen as objective. Furthermore, the aim of facilitating positive policy change, contained within

the emancipatory research paradigm utilised within disability studies, were adopted within the research.

A detailed account of the research strategy was provided. Particular emphasis was given to access and sampling, showing the difficulty of carrying out research with hard-to-reach groups such as IB claimants, but also the difficulty in accessing professional groups unless they wish to participate. Alongside this, the use of a multi-methods approach was defined, with individual attention given to each of the three qualitative methods: semi-structured interviewing, non-participant observation, and file analysis. The analysis strategy adopted within the research was also discussed. It can be seen that by adopting Miles and Huberman's (1994) three stage strategy, particularly the use of 'data display', it was not possible to exclude parts of the data from conclusion drawing once they had been coded. Thus conclusions can be seen as robust within the limitations of the data. The chapter concluded by describing key ethical considerations. The next section of the thesis will contain three empirical chapters, following the path that a new IB claimant would take. The first chapter will outline the IB claimants' education and work histories before examining their decision to exit the labour market and claim IB.

Chapter 4: Becoming Incapacitated

4.1 Introduction

This chapter is the first of a trio of chapters which take the reader on the journey from becoming incapacitate, to compulsory interaction with Jobcentre Plus before ending with participation in one *Pathways to Work* scheme, the Condition Management Programme (CMP). This first chapter will provide an overview of selected literature in two area beginning with the increasing uptake of Incapacity Benefits over time. Considerable academic attention has been focused upon attempting to provide an explanation for such an increase. Yeandle and Macmillan (2003) argue that there are several factors that can account for the rise and their thesis forms the structure for an exploration of the literature in this area. Factors to be considered include changes in health, changes in the governance of benefits, fraudulent use and inappropriate use. In addition to this, a wide body of evidence exists in relation to the impact that labour markets have on receipt of disability related benefits; key texts will be included such as the works of Beatty and Fothergill (1996; 2003; 2005).

The second area the literature review focuses upon is the journeys that people with health conditions take from work (or non-work) to IB. There is a much smaller body of evidence in this area. A figure created by the author will provide a visual representation of the complex interaction at play between many factors, including health conditions, employment type and security, and knowledge of the benefit system. The relationship between these factors has a large effect upon when (or if) a person who might be eligible for IB attempts to claim it.

The chapter continues by presenting empirical findings, specifically detailing the 21 IB claimants' journeys from work to IB. Work and employment histories are examined alongside the explanations for the rise in IB, before

moving on to describe the onset of ill health and its deterioration into worklessness. However, it should be noted that nearly half of the IB claimants experienced a sudden onset of illness (or injury) resulting in a swift exit from the labour market. Conclusions will be drawn by linking data to the existing literature.

4.2 Literature

4.2.1 Trends in receipt of disability related benefits overtime

The rise in receipt of social security on the grounds of sickness or disability since the 1980s came to the fore of political and media attention in the mid 1990s, and has been a contentious subject ever since. The graph below shows the extent of long term (more than 6 months) Incapacity claims for Great Britain. It is evident that policies that have aimed to decrease the numbers claiming sickness benefits during and since the 1990s have had little success, although a small reduction has occurred since the peak of claiming in 2004.

Figure 4.1: Long term Incapacity Benefit claimants, excluding Severe Disablement Allowance: Great Britain 1963-2009.
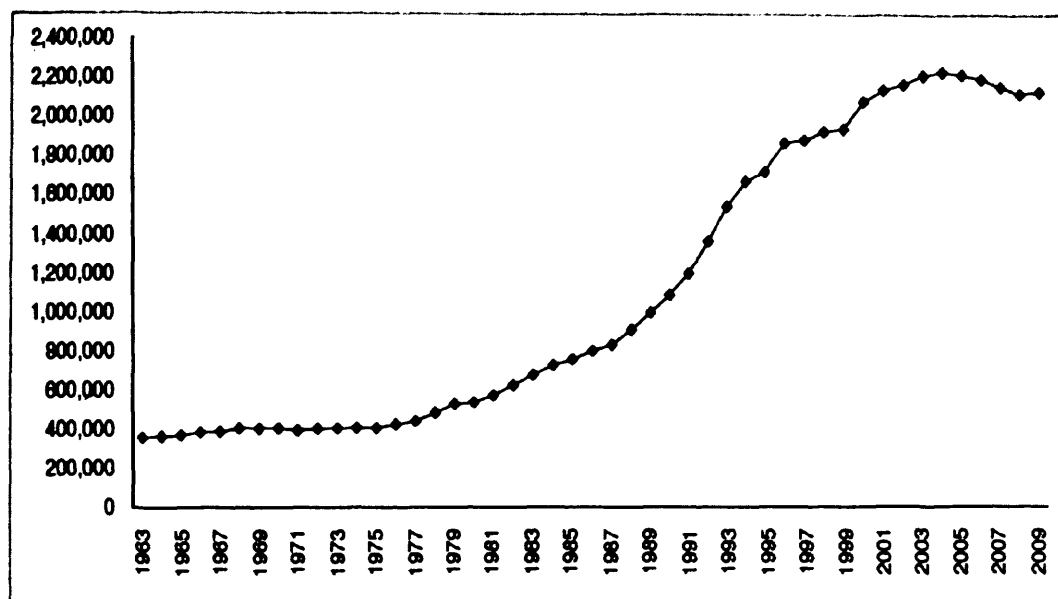
Source: Beatty (2010) from Webster (2004) and author's updates based upon DWP data.

What Figure 4.1 does not show, however, is that whilst the numbers on IB are rising, this is not explained by the number of new claimants. It has not been possible to find up to date data, although Figure 4.2, below shows that the rate of new claims onto IB and Severe Disablement Allowance from 1990-2002 fell by a quarter.

113

Figure 4.2: Inflows to Severe Disablement Allowance, Invalidity Benefit and Incapacity Benefit 1990-2002.
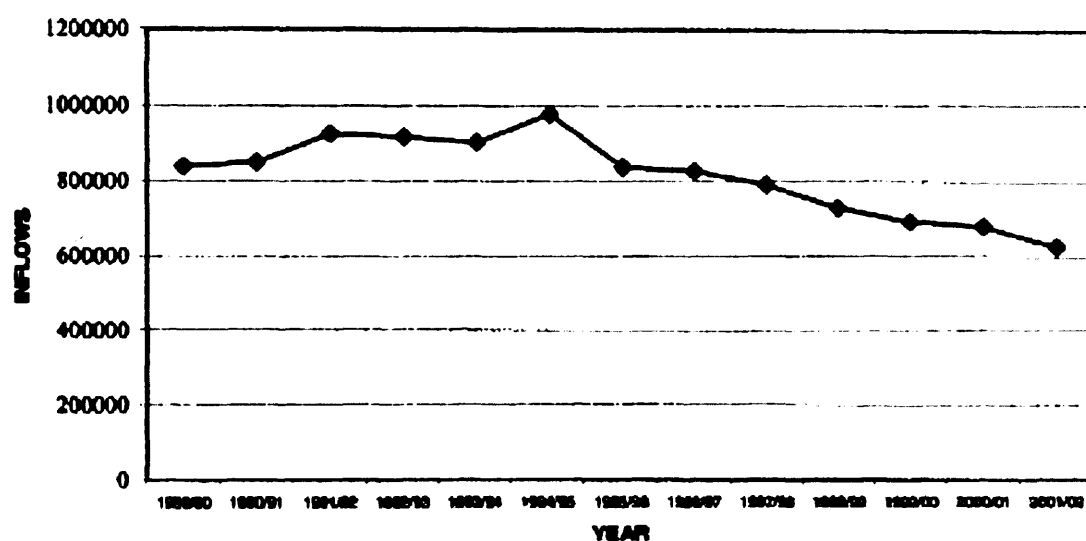
Source: Select Committee on Work and Pensions Fourth Report (Parliament, 2002)

It is also possible to see disparity in the rate of IB uptake in different areas. Whilst Figure 4.3, below, shows that parts of Wales and the North of England have over 10% of their working population claiming IB, the graph does not show that in some areas, such as Merthyr Tydfil, in the Welsh Valleys, over one quarter of people of working age claimed IB in 2002[21] (Parliament, 2002). This is contested by Buck and colleagues who found that between 1999 and 2005, between 11 and 13% of working age people in Merthyr Tydfil claimed IB (Buck et al., 2006:13). What is apparent from Figure 4.3 is that the areas that have the highest rate of IB claimants in 2009, are mainly ex-industrial areas.

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[21] For a more complete account of challenges with health Welsh health policy see NHS Cymru (2001)

114

Figure 4.3: IB Claimant rate February 2009, England and Wales
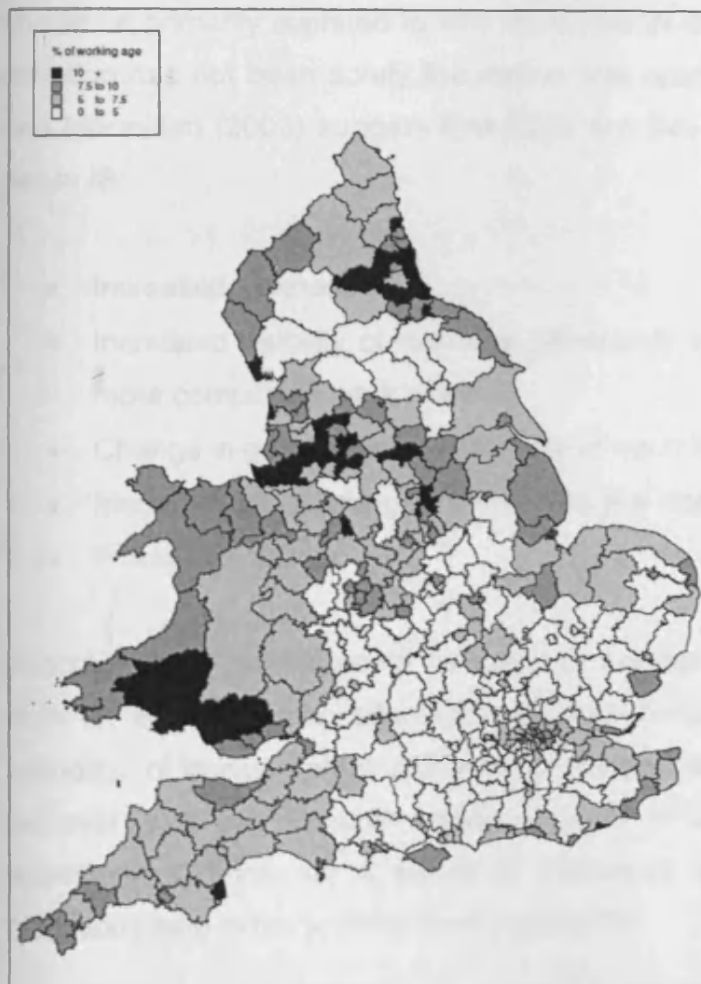
Source: Beatty (2010) based upon DWP and ONS data.

The rise in receipt of IB over time is an accepted phenomenon, although,
some DWP research reports have suggested that there has been little
attempt to explain the trend (Sainsbury and Davidson, 2006; Kemp and
Davidson, 2007). What is clear, is that the number of people beginning a
claim for IB has not risen dramatically and has actually fallen in recent

115

years[22], but the numbers leaving IB has fallen dramatically (Waddell and Aylward, 2005)

Whilst the data relating to 'stocks and flows' suggest that explanations should be primarily confined to why IB claimants do not leave IB, academic attention has not been solely focused in this area. For example, Yeandle and Macmillan (2003) suggest that there are five possible reasons for the rise in IB:

- Increased sickness
- Increased visibility of sickness, previously concealed by claimants or
  - more compatible work roles
- Change in governance or eligibility of such benefits
- Inappropriate claiming by those who are unemployed
- Fraudulent claims

Although these factors could be used to explain the decline in 'off flows' from IB, little academic attention has been focused in this area with the exception of labour market and governance explanations. The chapter will, however, examine research based upon all of these explanations before attempting to compose a series of *Pathways* which people with health conditions take in the journey from work to IB.

4.2.2 Explanations for the rise in IB claimants

Health explanations

Two differing explanations that fall in to the broad camp of health explanations are proposed by Yeandle and Macmillan (2003). Firstly, the

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[22] Unfortunately, the Government do not publish details of how many new claimants there are in their quarterly Incapacity Benefit statistics (see www.neighbourhoodstatistics.gov.uk), although it is likely that the trend of reduced applications for IB has continued since 2005.

notion that there has been an actual rise in ill health. This explanation has been widely discredited as trends regarding mortality have improved over the time of the increase in claimants (see for example: Bell and Smith, 2004; Waddell and Aylward, 2005; Beatty and Fothergill, 2003, 2005). However, when Limiting Long-term Illness is used as an indicator, more support can be seen for rising ill health accompanying increased use of IB. Research by Bartley and colleagues (2006), using 2001 Census data support this argument. Furthermore, within Wales, it is possible to map a rise in LLI alongside a rise in IB claims (Jewell, 2009). However, this thesis has not been widely adopted by those researching Incapacity.

The second way in which Yeandle and Macmillan (2003) use health explanations to account for increased incapacity benefit use is as a result of increased visibility of sickness. Thus differing attitudes towards illness and/or a reduction in sympathetic employers may partially explain the rise in IB claimants. Beatty and Fothergill (2003) reject the first part of the assumption; that people are now more willing to admit to ill health but accept that the labour market can have an effect on the use of benefits.

Whilst Yeandle and Macmillan (2003) did not approach the topic in this way, Waddell and Aylward (2005) state that there has been a change in the way that disability benefits have been used since their inception. It is argued that disability benefits were originally intended for those who had 'severe medical conditions' which could be verified through the claimant having a recognisable impairment or disease (p.34). Since the 1970s, however, IB is claimed in the main by people who have long-standing, non-specific symptoms such as back pain or depression, with only a quarter having disease or impairment for which IB was originally intended (p.34). Accordingly, Waddell and Aylward (2005) state that the rise in claimants of IB is as a result of people becoming trapped on IB because their non-specific conditions will not necessarily improve so they do not exit the benefit. This explanation fits with official statistics that show that the numbers of people leaving IB are in decline. However, the literature does

117

not account for the reduction of musculoskeletal conditions and the accompanying rise in mental health conditions (Neighbourhood statistics, 2010).

In some cases, it is suggested, GPs reinforce the notion that people with health conditions should not be working (Waddell and Aylward, 2005[23]) or are unable to say no to requests for a sick note (Pickering, 2008). Furthermore, delays in treatment for health conditions sometimes leave sick workers outside the labour market for longer than is necessary (Hedges and Sykes, 2001; Sainsbury and Davidson, 2006). The extent of such a delay is not fully known, but in Kemp and Davidson's (2007:60) survey of 1,800 new IB claimants, six months after beginning their claim, 40 per cent were still awaiting medical treatment. Thus it can be seen that whilst actual levels of sickness, as evidenced by mortality and morbidity figures, are in decline, health factors can still account for some of the decline in 'off flow' from IB.

The second part of Yeandle and Macmillan's (2003) explanation focused upon changes to employment that meant that people with health conditions could no longer be accommodated. Labour market explanations suggest that the decline in traditional industry accompanied by changes to increasingly insecure, low paid work has forced those with health conditions out of the labour market, although there is geographical variation within this pattern (Green, 1997; Davidson, 2006). However, it could be argued that Figure 4.3 looks very similar to charts based on Limiting Long-term Illness as evidenced by the General Lifestyle Survey (Compass, 2010) and the 2001 Census (Bartley et al., 2006) This explanation will be explored further, alongside other labour market approaches, later in the chapter.

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[23] It has not been possible to find reports of this phenomenon post 2005, although the Independent (2010) argued that work by Whittaker et al. (2010) had identified this trend, I believe that the research did not support this phenomenon.

Governance and eligibility of Incapacity Benefits

The suggestion that the Conservative Governments of the 1980s onwards allowed an increase in IB claimants as a way to reduce the claimant count has been supported by Adams' (1999) research in Scotland. However, Beatty and Fothergill (2003) and Waddell and Aylward (2005) argue that it is difficult to draw a strict line between sickness and unemployment. Whilst the introduction of IB, replacing Invalidity Benefit, in 1995 introduced increased conditionality, the numbers claiming IB continued to grow. What is clear is that the increased governance of IB seen within *Pathways to Work*, in the form of earlier medical exams and compulsory attendance at JobCentre Plus interviews has resulted in more people exiting IB earlier (National Audit Office, 2010), although this is not to imply that they do not have a health condition that limits their activities. Consequently, it is perhaps telling that the largest increase in conditionality was introduced in a period of low unemployment, when the Government wanted to increase employment further. The issue of further reforms and increased governance in this area post-May 2010 will be returned to in the conclusion.

Research for the Bank of England by Bell and Smith (2004) suggests that during periods of high unemployment, the relative generosity of disability benefits, as compared to unemployment benefits, encouraged older unskilled male workers to take up IB. Green and Shuttleworth (2010) came to similar conclusions in their more recent study of Northern Ireland. However, it is important to note that Bell and Smith (2004) and Green and Shuttleworth (2010) see unemployed workers who have a health condition as rational actors, choosing the most attractive benefit available to them. During their analysis of the General Household Survey and the Labour Force Survey, Bell and Smith (2004) found that if a person had multiple disadvantage in the form of no qualifications and a longstanding limiting health condition, they were much less likely to be in work, and were 'accommodated' by IB (p.27).

119

As IB is now rebranded as ESA for new claimants since 2007 and paid at the same rate as JSA unless return to work activity is undertaken, Bell and Smith's explanation suggests that there should be a reduction in new claims for sickness benefits because the benefit is less attractive. Alongside this, governance of ESA has become increasingly strict. Eligibility for ESA is based upon the 'Work Capability Assessment', introduced in 2009, it is more stringent than the previous 'All Work Test' (Compass, 2010), leading to concern about the number of people who 'fail' the test (Citizens Advice Bureau, 2010).

Whilst there is considerable anecdotal support for the rise in IB claims during the 1980s and 1990s, there is limited research evidence to support such a theory. However, if the explanation is correct, it is likely that another such increase in IB claimants would not occur in the future as a response to the increased governance of sickness related benefits. The decreased generosity of IB in its rebranded form of Employment and Support Allowance, and increased governance of IB claimants shows that, at least to some extent, these explanations for the rise in IB claimants were seen as plausible to the New Labour Governments.

Inappropriate and Fraudulent Claims

Yeandle and Macmillan (2003) suggest that both inappropriate and fraudulent claims could account for some of the rise in IB claimants. The notion of widespread IB fraud has been largely discounted. For example, Waddell and Aylward (2005:37) state that despite many IB claimants being capable of some work this 'does not mean that these people are **all** malingerers or scroungers' (my emphasis), as 'true malingering' accounts for less than 1% of IB claimants. The figure of less than 1% is accepted by many disability rights groups, as well as government experts such as Waddell and Aylward (2005), so may be taken to have some validity.

What is more contentious is the idea of 'inappropriate' claims. These have already been covered to some extent by the use of IB by people who Waddell and Aylward (2005) believe do not have serious enough conditions to warrant claiming IB. Likewise, both Adams' (1999) argument that Governments diverted unemployed workers to IB and Bell and Smith's (2004) suggestion that unemployed workers, as rational actors, took up IB because of its generosity suggest that IB has been used inappropriately. In addition to this, there is a significant body of literature that argues that labour market variation can be used to explain the rise in IB claimants.

Labour Market Explanations

The strongest proponents of this explanation are Beatty and Fothergill who discovered 'hidden unemployment' in their 1996 study of UK coalfields. The authors noted that whilst at the time of wide-scale pit closures, the unemployment count did not rise, the sickness count did. Beatty and Fothergill have produced a compelling account of this phenomenon throughout the past 14 years. It is argued that this has also occurred in rural areas (2005), ex-industrial areas (2003; 2005; Webster et al., 2010) and can still be seen to account for the regional variation in levels of IB claiming. However, whilst Beatty and Fothergill suggest, somewhat persuasively, that changes in the labour market have caused an increase in IB, the authors refute that claims are fraudulent; put simply, while a person with a health condition may be coping with that job, they may be disadvantaged when it comes to finding another job and thus choose to claim IB (2005). Evidence to support this can be seen in their 2003 research of 2,000 men who were not working which found that compared to JSA claimants, IB claimants were four times as likely to report a health limitation (2003:119). As such, Beatty and Fothergill's (2005) simulation showed that approximately 10% of the male working age population are diverted from unemployment to IB, although there are massive regional variations (p845). Thus if full employment were to occur, 40% of IB

121

claimants within the UK and 49% of the Welsh IB claimants could expect to return to work (p.845).

The largest scale survey of IB claimants regarding routes from work to IB, undertaken by Kemp and Davidson's (2007:41) found that for all claimants their previous wages were likely to be low, with three quarters of those who had worked in the last two years earning under £15,000 per annum, with only 7 per cent earning above the national average. In addition to this, it was found that IB claimants were more likely to have come from insecure employment. Whilst 40% of respondents stated that the 'main reason' their previous job had ended was due to their ill health, 31% identified that their previous job role had been terminated for a variety of reasons including the end of seasonal work or redundancy (p.33). Furthermore, for those who were in permanent employment, the likelihood of leaving work because of ill health was 49% compared to 32% of those in temporary employment (p33). Similar levels were found by Beatty and Fothergill (2003) regarding ex-industrial areas in the UK; 48% had ended their last job because of health but 31% had lost their job because of the end of a contract or such like (p.121).

These figures are a contrast to Green and Shuttleworth's (2010:231) finding from a survey of 800 IB claimants that 75% had left their job because of illness and 84% felt that their health was the major barrier to re-entering employment. It is important to see these as subjective, self-reported data. For example, the authors found that IB claimants felt that their local labour market was both low paid and insecure and also noted the increase in IB claimants in areas where unemployment was highest. Thus perhaps the answers given by Green and Shuttleworth's respondents can be seen more in terms of attempting to regain respectability as part of the 'deserving' group of IB claimants, rather than totally reflecting their lived experience. Looking specifically into the routes people take in and out of work when experiencing a mental health condition, Sainsbury et al. (2008) found that whilst two out of three stated that they left work because of their mental

health condition, 20% had left work as a result of their contract ending, thus showing that labour market forces are highly significant for one fifth of this group. Furthermore, some workers had lost their jobs before the onset of their mental health condition, further underlining the relationship between work and mental health.

In addition to their previous labour market disadvantage, many interviewees in the Kemp and Davidson (2007) survey felt that they would be unable to compete in the labour market. In particular 34% had no qualifications (p.19) and 21% had difficulties with either numeracy, literacy or both (p.5). Furthermore, a study of GP sick notes by Shiels et al. (2004) found that the more deprived the area an individual lived in, as measured by the Townsend Deprivation Score, the more likely the patients would remain 'off sick' for longer than six months. As such, Beatty and Fothergill (2005) conclude that withdrawing from the labour market to IB is a functional solution for those who experience health conditions in addition to wide-scale labour market disadvantage.

Thus the evidence provided shows the labour market to be a strong shaping factor that interacts with an individual's health and other factors to create the necessary circumstances to turn a worker with a health condition into an IB claimant.

4.2.3 Conclusion

The literature shows a number of convincing explanations for the growth in IB claimants during the past three decades. It can be concluded that labour market explanations, which focus upon both wide-scale redundancies in the 1980s and the growth of insecure employment provide evidence for the growth in IB claimants among those with the most labour market disadvantage. However, it is also important to note that if the Governments of the 1980s onwards had been committed to increased governance of IB, as the New Labour Governments were, they could have decreased the numbers claiming through increasingly harsh eligibility criteria. Thus whilst

unemployed sick people facing labour market disadvantage were able to claim the more attractive IB, they chose to do so, as rational actors. It will be shown more clearly in the next empirical chapter that this approach was no longer tolerated, let alone encouraged, by the New Labour Governments, who moved the line of demarcation between unemployed and sick to allow less out of work people to be seen as truly sick enough not to work.

4.2.4 What Pathways do IB claimants take from work to IB?

The literature has demonstrated the complexity of factors involved in increasing the number of IB claimants since the 1980s. The chapter will now outline the routes that people take today to enter IB which should be seen as part of the explanation for why people claim IB. It will be possible to identify points at which people with health conditions could be given increased support from their employers or other agencies in order to prevent labour market detachment.

The evidence available shows a diverse range of journeys onto IB (Nice and Thornton, 2004; Sainsbury and Davidson, 2006; Davidson, 2006; Kemp and Davidson, 2007). This does not seem to be linked to particular health conditions, although it is important to note that when a worker suddenly becomes unwell, there is less (and sometimes no) time in which employers could attempt to make adaptations to attempt to retain the worker. Furthermore, differences relating to jobs can also determine whether sick workers are entitled to any sick pay or support from an occupational health department. Both sick pay and occupational support can be seen as buying a sick worker some time in order to attempt a return to their job in the future. Sick workers who do not have such security become detached from the labour force much more quickly and often need to find an immediate alternative source of income. If they are unable to find alternative work, many sick workers will have little choice in satisfying their need for income but to claim some form of social security benefit. However, a complicated

124

and confusing benefits system does not mean that they will always end up claiming IB as soon as they would be eligible (Sainsbury and Davidson, 2006).

Amongst those who go on to claim IB, work, external factors or a combination of both factors can be seen as the causes of ill health (Sainsbury et al., 2008). The chart below attempts to summarise this complicated process, showing that the type of employment a sick worker has can have a large impact on their likelihood of claiming IB whilst sick. A factor that it has not been possible to show within the chart is that health conditions are also variable and can influence decisions about making accommodations within secure employment. In addition to the typology utilised by the DWP which looks exclusively at the aetiology of a condition (eg: musculo-skeletal and minor mental health), Hedges and Sykes (2001) propose that conditions can be:

- Complex, including multiple conditions
- Fluctuating or degenerative
- Acute, requiring long term treatment
- Short term, with an expectation for a quick return to good health

Furthermore, within secure employment, the type of work an employee undertakes, and has the potential to undertake, will influence how desirable it is for an employer to retain them. This is particularly relevant where employees have a physical health condition and there is not a 'light' job available for them to undertake, or they do not have the skills to undertake such a job.

An alternative journey to IB is from a previous IB claim via an unsuccessful return to work, and a return to IB under the linking rules. Within Sainsbury and Davidson's (2006) research of the 36 new claimants coming from work, this situation applied to two claimants who had experienced deteriorating health since returning to work. Furthermore, Davidson (2006) notes that for

125

some people moves between insecure and low paid work and IB are common because of their labour market disadvantage. In such instances, it is sometimes the frugality of benefit levels, as opposed to feeling well enough to work, that prompts the end of a claim for IB and a return to the labour market. These moves are not always sustainable in the context of health conditions and labour market demands, prompting a cycle of unsuitable work and benefit receipt.

Whilst not all IB claimants were working prior to claiming IB in their study of 1,800 new claimants, the distinction between sudden onset and gradual worsening is also used by Kemp and Davidson (2007). The face-to-face survey found that 56% of new claimants experienced a gradual worsening of their condition and 44% of new claimants had a sudden acute episode.

Figure 4.4: Pathways from work to IB (neglecting severity of health conditions)

1. Health condition doesn't affect work (K&D – 55% of cases)
2. Condition deteriorates 'warning signs' (S&D:p26)
3. 'Struggle on' (S&D:p14) decreased performance [may be viewed as deviant by employer (Nice and Thornton, 2004)] OR accommodations (K&Dp5 – 17% recent IB claimants had accommodations made for them)

Sudden onset of ill health (K&D – 44% of new IB claims)

No limiting health condition

Work impractical/undesirable with health condition
Decision to 'go off sick' (S&D)

Job ends - Claim JSA/IS/ no income

ATTACHED TO LABOUR MARKET   DETACHED FROM LABOUR MARKET

Secure job – sick pay

Secure job – mutual decision to end (retirement/ redundancy) OR dismissal

Insecure job eg: agency work, self employed – no sick pay

Onset/ deterioration of health condition [or pregnancy]

Occupational support? – Return to work?

End of sick pay: Claim IB while still employed or choose/ forced to end contract

SOURCES OF INCOME

No Income

Claim other benefits

Claim IB

Find alternative work

Claim IB from non-work (K&D p.88 26% new IB claimants from work ->

Sources/key: Sainsbury and Davidson (2006) – S&D; Davidson (2006); Kemp and Davidson (2007) – K&D; Sainsbury et al. (2008); Irvine (2010)

Whilst the majority of the literature above has focused upon the journey, Sainsbury et al.'s (2008) research suggested that in cases where a mental health condition was the primary reason for claiming IB, work, external factors or a combination of both work and external factors could be the trigger for the mental health condition. This can be seen as a result of the more complex aetiology, and can lead to more complicated consequences. What was of particular interest, however, was whether work was a trigger or not, many IB claimants felt 'relief' (p.95) when their jobs ended, particularly if they had been working with their condition for some time. This is of particular relevance if the labour market explanation of hidden unemployment for claiming IB is to be adopted as the primary discourse; some people simply are not well enough to work and this should be acknowledged within policy.

4.2.5 Why do some IB claimants come from non-work?

A figure cited within the literature is that approximately half of new IB claimants have not claimed IB directly after leaving work (Sainsbury and Davidson, 2006:19; Kemp and Davidson, 2007:5; Irvine, 2010). The first DWP funded research to examine this trend was Hedges and Sykes (2001) which interviewed 40 people who moved from JSA to IB or vice versa within the previous two years. The report does not contain details of how many claimants moved from JSA to IB only. The study also interviewed Benefits Agency staff[24]. Hedges and Sykes (2001) found that Benefits Agency staff believed that such moves were often inappropriate. However, the authors concluded that the reason for such moves was twofold: confusion about the benefit system led sick workers to apply for the wrong benefit or after rightly having claimed JSA, workers' health deteriorated. As such, Hedges and

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[24] The Benefits Agency and the Job Centre were replaced by JobCentre Plus following Pathways to Work (2002). The equivalent staff today would be the Personal Advisors.

128

Sykes stated that such moves 'mostly seem to have been appropriate' and that there was no evidence of improper moving (2001:2).

Whilst Hedges and Sykes (2001) focused exclusively upon moves from alternative benefits to IB, Sainsbury and Davidson (2006) identify two *Pathways* from non-work to IB. Firstly 'work to non-work to IB' (p49), this group had been in work relatively recently, but had not moved straight on to IB when their deteriorating health resulted in their labour market exit. This group then either claimed alternative benefits (eg: JSA) or had no income before applying for IB. Sainsbury and Davidson's (2006) second pathway is 'non-work to IB' (p41) which applied to the majority of new claimants who moved from non-work to IB. Within this group there was a wide range of 'non-work' activities prior to claiming IB including claiming alternative benefits either because their health was not preventing job searching or as a result of 'failing' the Personal Capability Assessment (PCA)[25]; being financially supported by family or living off redundancy payments or savings; and engaging in full time studies. Whilst it was found that GPs could facilitate a claim for IB by asking if a patient needed a sick note, it was very rare for GPs to suggest patients should attempt to claim IB.

The most comprehensive survey in this area, completed by Kemp and Davidson (2007) found that 44% of new IB claimants had come from 'non-work'. Of these, two thirds had claimed JSA or IS beforehand, however, almost half of the 44% had worked in the previous year whilst 11% had not worked for 10 or more years (p.5) showing the complexity in the lives of those who claim IB.

It can therefore be seen that journeys from work to IB are far from straightforward. However, the cause of a gap between labour market exit and claiming IB is unlikely to be as a result of fraudulent claiming with confusion leading to genuine mistakes playing a much more important role.

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[25] The PCA is the medical test that determines eligibility for IB

Furthermore, other factors such as living off savings or being in full time education should not be discounted.

4.2.6 Conclusion

The literature in this area shows that levels of IB receipt are increasing, primarily as a result of a failure of IB claimants to leave the benefit. Several explanations have been put forward to attempt to account for such a phenomenon. These include factors relating to health conditions, the governance of IB over time, fraudulent or inappropriate use, and labour market factors. The area in which the most conclusive evidence lies is labour market factors, although this is as a result of a dearth of evidence in other areas.

However, even where a person's health condition dictates that they are likely to need a period of sick absence from work, there are a number of alternatives to IB. As such, there are a number of *Pathways* that sick workers can take, not all of which end with IB. This further shows the impact of labour market factors on benefit receipt. The next section of the chapter will follow the IB claimants' journeys from either the beginning of their health condition or their labour market entry, showing a diverse range of trajectories.

4.3 Results

4.3.1 Introduction

Within this section, empirical findings will be presented alongside the literature already discussed in four key areas. A chronological approach will be adopted, initially describing claimants' journeys from school and early

years of work. The chapter will then move to outline the onset of ill health among claimants, showing that many continued to work for several years alongside their health condition. Labour market exits and the factors instrumental in such decisions will be shown, before briefly describing interviewees' health at the time of interview. The chapter concludes by drawing together the literature and results.

4.3.2 Education and work history

Education and early years in work

Interviewees were only asked about their last job, however, many chose to discuss their education and work histories. Of the 21 interviewees, the education level of 16 is known, comprising all 11 unengaged claimants and half of the engaged group. The vast majority left school at the age of 16, with five (four unengaged, one engaged) stating explicitly that they left with 'no qualifications, nothing!' (Jo). The most clearly disadvantaged in terms of skills was Rowena who left school unable to read or write. This continues to have a considerable impact upon her day to day life; for example, during the consent process Rowena was unable to read the form or sign her name.

Five engaged interviewees who left formal education at the age of 16 found 'good jobs' (Catherine) with opportunities for training and progression. Whilst two interviewees learnt skills in a similar fashion to apprentices, they distinguished themselves from them as they did not officially learn a trade. Furthermore, Joanne began work as an auxiliary nurse shortly after leaving school and Catherine began to work for her local council. Both maintained these jobs for over twenty years. Finally Paul started work as a gardener, but was taught how to restore old buildings using traditional methods. It is clear to see that although the five engaged interviewees who discussed their education showed the same educational trajectory as the most disadvantaged of the unengaged group, their employment trajectories have

131

resulted in training to increase their skills and hence their employability should their employment end. The literature shows that this is likely to have an impact upon their labour market attachment in cases of sickness or injury (Sainsbury and Davidson, 2006; Kemp and Davidson, 2007).

Three interviewees from the unengaged group took part in post-16 education. Firstly, Brian began a YTS scheme in the 1980s but found it to be 'slave labour' so left before completing the scheme having found a similar job that was significantly better paid. Ben, on the other hand, started an apprenticeship when he left school as a mechanical technician which he successfully completed resulting in Ben being 'very well paid' when at work. The interviewee with the highest qualification was Michelle. Michelle completed A' levels when she left school and then almost completed a teacher training course, however she then became pregnant and did not finish the course. Over a decade later, Michelle returned to higher education and completed a Bachelor of Nursing degree although an injury during one of her practical placements has left Michelle believing that she will never be able to work as a nurse. As such, Michelle felt that completing her degree – and living on a very low income for three years - was a 'waste of time'.

Recent employment

It may be assumed that the differing educational trajectories noted above would map the employment successes and failures of the group, however, Michelle, the most educationally qualified, worked as a pharmacy assistant paid at the National Minimum Wage for a year after completing her degree before claiming IB. It could be argued that Ben or Catherine were the most successful in their chosen career; both Ben and Catherine had worked themselves into a position where they were well paid and often received promotions before both leaving their jobs through ill health.

Interviewees' descriptions of their most recent employment were often tangled within discourses regarding 'struggling on' (Sainsbury and Davidson, 2006:14; a phrase also utilised by Chris) or 'battling' (Joanne), showing the impact of their physical health conditions upon the activity that could be performed.   Whilst Chris injured his back by slipping on some steps at work, Joanne was diagnosed with arthritis prior to beginning work. The difficulty of working with musculo-skeletal conditions was noted by Joanne:

> You've battled with (arthritis) for so long, and carried on working when there wasn't any help. There wasn't any support then, and what aggravated my condition was that we were taught back then we were taught to lift without the equipment, just get in there and get on with it.

However, it appears that in both Joanne and Chris's case, the adequacy of company sick pay alongside such determination to remain in work prevented both from claiming IB at a much earlier stage in their ill health. Chris stated:

> I've been struggling on. I had periods on the sick, during my four years (since the accident) with the company. But we had a full payments scheme, where if you were injured and you were on the sick, you got your full payment. So I carried on working with light work.

A brief overview of their employments shows that the majority of the 21 interviewees were concentrated among manual and service sector jobs, as would be expected in a cohort of IB claimants (Kemp and Davidson, 2007). The exceptions to this were Catherine's high-level administration work for the council, Sarah working as a 999 operator for her local ambulance trust and Ben's work as an engineer.

In the main, interviewees largely stayed within one type of work for their careers, although Brian, Emma and Michelle had worked for many companies. However, Jo and Rebecca did not follow this pattern, adapting

their skills to different job roles when their insecure employment ended. For example, like many of the other IB claimants, Jo left school 'as soon as I could' at the age of 15 without qualifications, and worked in a shop. She then worked in a factory for several years, becoming a supervisor. When Jo's partner became unemployed, she accompanied him in a venture to run a public house, however, this resulted in a spell of unemployment when the business went bankrupt. At this time, Jo reports, the 'only jobs going' were as sewing machinists, when she asked in the Job Centre about getting training, she was told that she was ineligible as she had not been unemployed for long enough, which she found exasperating. This is a factor which remains contentious today. Jo described a lengthy argument with Job Centre staff, showing her fierce determination to work, which resulted in her completing the training and working in a sewing factory for a year. Following a spell of working abroad, Jo returned to the factory, although her new role required a lot of heavy lifting. When she was laid off, Jo found work in a factory producing detonators she states 'It'd blow your finger off. But (the job) was enjoyable because there was no heavy lifting. It was just that you had to be careful...' The wide range of roles that Jo adapted herself to shows considerable determination to work, although her claim for IB has lasted for longer than a decade.

The education and employment trajectories mapped above show that the IB claimants largely had few formal qualifications and were heavily concentrated within manual and service sector jobs. Whilst the majority remained within one area of work with spells of unemployment at times, a minority were more tenacious and sought any kind of work available rather than be unemployed. The next section will explore the onset of ill health before section 4.3.4 describes the way changing health affected the claimants' work trajectories.

4.3.3 The onset of ill health

Introduction

This section will focus upon participants' health trajectories, showing that the onset of health conditions could occur at three points in the life course: before entering the labour market; gradually, usually whilst working; or suddenly, usually whilst working. In addition to this, pregnancy was used by two interviewees as a proxy for ill health in claiming IB. Furthermore, work, external factors or a combination of both could be seen as causing ill health. The chapter begins with a table, which should be used as a point of reference when reading the rest of the chapter.

Physical/Mental Health ⟶ Trigger ↓	Physical	Mostly Physical, some mental health	About half and half	Mostly Mental health, some physical	Mental health
Condition present while still in full time education but entered work	*Brian Martin*		*Michelle*		[*Nicola*]
Condition present while still in full time education: Never worked					**Gwyn** (learning disabilities)
Came to IB from other benefit	[Ann]				
Last work caused illness	Jo Rebecca Chris * Sarah* Emma Dai Paul				
Last work and external trigger caused illness					*Rachel Catherine*
External trigger caused illness	**Rowena** **James*** **Ben** *		*Joanne*†		**Mark** *Jacob*

Key: **bold** – unengaged group; non-bold – engaged group.
Italics – remained in work with condition; non-italics – suddenly had to leave work.
* denotes interviewee described a supportive employer or secure employment
[name] denotes pregnancy was also instrumental in the decision to leave employment

Physical conditions – musculo-skeletal; cardio-respiratory; both; other

136

Ill health during education

The literature on routes to IB noted that sometimes people had health conditions present whilst in work that were not a hindrance to performing their work role (see for example Irvine, 2010). However, the literature failed to note that sometimes 'struggling on' (Sainsbury and Davidson, 2006:14), or performing at less than optimal levels in work, is the every day reality for some people who later went on to claim IB. It is noteworthy that five of the 11 unengaged IB claimants had had health conditions whilst still in full time education; four of these entered work and one, Gwyn, did not. None of the engaged claimants experienced ill health whilst in education. Of the four with pre-existing health limitations who entered work, Brian and Martin had remarkably similar circumstances. Brian injured his knees playing rugby at school and Martin's back injury, later diagnosed as arthritis of the spine, both occurred in the last years of secondary schooling. Whilst Brian chose, from his limited options, to work in building jobs, Martin tried to remain out of the labour market because of his health condition. Showing a not unusual lack of knowledge of the benefits system (Sainsbury and Davidson, 2006), Martin spent a short period 'on the dole' whilst the pain in his back 'got worse and worse'. However, when Martin's entitlement to unemployment benefits ended, he also became a builder; one of the few sources of employment available to him as a result of his lack of qualifications and the local labour market. Although both men experienced considerable physical pain from their already present health conditions being aggravated by the heavy work they were doing, Brian worked for 12 years and Martin for 15 years, showing a significant period of 'struggling on' in employment sectors that were not ideally suited to their health conditions.

In addition to this, Nicola and Michelle have had mental health conditions since they were in education. Nicola has a background of depression and self harm since she was 12, whilst Michelle has suffered with an eating disorder since her undergraduate studies. In more recent years, Michelle has also become depressed and, following unrelated surgery and a physical

attack at work, has developed a back injury. Whilst it can be clearly seen that for the other four IB claimants their original condition is the source of their current incapacity, Michelle's newer conditions have contributed significantly from her withdrawal from the labour market.

Work as a cause of ill health

It can be seen from figure 4.5 (above) that seven of the 16 claimants who had not been experiencing ill health before starting work attributed their health condition to their job. These were exclusively musculo-skeletal conditions and in several instances an accident at work occurred. As such two interviewees, Chris and Dai, were pursuing personal injury claims against their employers. Alternatively, work stress can be accompanied by external factors to result in a labour market exit: in two cases (Rachel and Catherine), where mental health conditions were experienced, stressful jobs had resulted in anxiety, although difficulties in their personal lives ended their period of work. A third way in which ill health could be caused is by external triggers alone. In three instances, these resulted in mental health problems; panic attacks and depression; and three in physical health problems: diabetes, Crohns' disease and asthma. This reflects the full range of factors as identified by Sainsbury et al. (2008) and Irvine (2010).

Pregnancy as a route onto IB

In two instances a pregnancy was instrumental in the decision to claim IB. This phenomenon was not discussed in the literature, although the next chapter will show that, in the experience of Jobcentre Plus Advisors, these are far from isolated cases. Both ladies were out of work when they became pregnant. Whilst Nicola was already ill with depression but not claiming benefits, Ann was not unwell and claiming unemployment benefits. When Ann became pregnant, she was transferred to IB and subsequently,

after the birth of her son, developed musculo-skeletal problems. Ann's son is now 19. Although her pregnancy was the route onto IB, the inadequacy of social security benefits for single mothers resulted in Ann's decision to stay on the benefit. Likewise, Nicola now has a second child and has claimed IB for five years. These stories show the different factors involved in the onset of health conditions and the complexity of claimants' lives.

Ill health whilst at work: 'struggling on'

Of the remaining 16 IB claimants, eight remained in work whilst experiencing ill health. The common factor among this group was that their health was affecting their work, and their work also had a negative effect on their health in most cases (Sainsbury and Davidson, 2006). However, the IB claimants continued to work for a period of up to 28 years. All of the interviewees described difficulties in attempting to either perform their job role satisfactorily, or had to limit their activities outside work in order to keep up with the demands of work.

For example, Joanne was diagnosed with arthritis and ankylosing spondylitis, a type of arthritis of the bones, muscles and ligaments of the spine, whilst she was in her twenties. She stated:

> Prior to (claiming IB), I was nursing for 28 years...And even though the arthritis, the spondylitis... I kept on working with it. But years ago they said, well I just enjoyed my job, I really enjoyed it. But the other thing was, as they said years ago if you had a bad back you were malingering, so I just got on with it, I worked with it, I coped with it.

Whilst it can be seen that part of Joanne's rationale for remaining in work was to combat the scrounger discourses prominent in the 1980s (Moore, 1981), it does not detract from the determination required to continue in such a physically demanding job role for many years. Later in the interview, Joanne described how she 'battled' with her health conditions to carry on working and that it 'aggravated' her arthritis, as at the time nursing involved

a lot of lifting patients without the aid of a hoist. In addition to her physical problems, Joanne began to suffer from depression towards the end of her employment; she was the primary carer for her husband and another relative and felt unable to say 'no' to friends and family asking for her help. However, Joanne's depression increased following the death of her husband after she had finished working. This example shows the complexity of interviewees' circumstances that cannot be seen from less detailed accounts.

Whilst Nice and Thornton (2004) found that employers could view reduced performance as a deviant act, sometimes resulting in official warnings, this was not the case for any of the interviewees, although Joanne stated that she was viewed as a 'health and safety risk' by the NHS resulting in her being pushed to take 'voluntary' redundancy against her wishes.

Accommodations by employers

The literature showed that accommodations of any type were made in only 17% of cases (Kemp and Davidson, 2007). As such the results presented below are in line with expectations. Only four interviewees described any accommodations made for them by their employers. Time off for medical appointments was the most common (James, Joanne, Chris). Furthermore, James, who was diagnosed with Crohn's disease aged 38 for which he has 'had numerous operations...re-sections of the bowel, colostomy...' had been working in a factory. Whilst the role did not require heavy lifting, 'it was busy work like, you had to be pretty, well more or less healthy like to do the type of work...' During the twelve years that James remained working, his employer was sympathetic, and where possible gave him a job where he could be sitting down and close to a toilet. James was very clear that this approach enabled him to continue working for as long as he had.

In addition to this, Chris's story shows the importance of having stable, secure employment when periods of sick leave are needed (Kemp and Davidson, 2007). Having worked at his local colliery since leaving school

aged 16, when Chris had an accident at work and injured his back, he was eligible for 'very good sick leave'. As such, Chris was able to remain on full pay whilst not working and return to work when his pain was more manageable without having to access the official benefits system. Furthermore, like James, Chris's employer found him 'light duties' wherever possible. This allowed Chris to remain in work for four years after his accident, which was clearly financially advantageous as ordinarily sick pay would only last for a maximum of one year (Sainsbury and Davidson, 2006).

Finally, Catherine, who worked for her local council, received both sick pay and occupational health support, with a phased return to work attempt. It would be expected that an organisation the size of a council would be able to provide occupational health support. However, Catherine was the only worker to be offered such support, which is lower than was found in Kemp and Davidson's (2007) research which used a larger sample. In particular, it was surprising that Sarah, a 999 telephone operator for her local ambulance trust, who suffered a back injury from a damaged chair, did not recall being offered occupational health support. She described in her interview how she was not able to sit for long periods of time, but that the current set up in her office, where she needed access to a keyboard and telephone headset, required her to sit for extended periods. Whilst she was very keen to return to her role, she was frustrated by the lack of input from her employer about how they were going to accommodate her.

These experiences show the difference an accommodating employer can make to enabling sick workers to remain in work and to return to work after a period of absence. As such, the labour market explanation (eg: Beatty and Fothergill, 1996) for increasing levels of IB is supported by these findings.

4.3.4 Leaving the Labour Force

Introduction

Within this section, factors instrumental in the decision to leave the labour market will be discussed. With reference to figure 4.6 (below), the chapter will show that for some IB claimants, their gradually deteriorating health arrived at the point where they were not able to work. For other claimants, however, a sudden, acute illness resulted in swift withdrawal from work. It is at these times that the security of employment held could be instrumental in keeping sick workers attached to the labour market. However, for those who are fortunate enough to have secure employment, after some time, negotiated exits from their job may occur.

Physical/Mental Health → Factors influencing ↓ decision to leave work	Physical	Mostly Physical, some mental health	About half and half	Mostly Mental health, some physical	Mental health
Health	**Brian** **Martin** *James** **Jo** **Rowena** Emma *Rebecca*				[*Nicola*] *Jacob*
Employment Issues	Chris * Dai **Ben** [Ann]				
Personal Issues					**Mark**
Health and Personal Issues					*Rachel* *Catherine*
Health and Employment Issues					
Health, Employment and Personal Issues			*Joanne** *Michelle*		
Still have a contract of employment	Paul* Sarah*				
Never Worked					**Gwyn** (learning disabilities)

Key: **bold** – unengaged group; non-bold – engaged group.
Italics – remained in work with condition; non-italics – suddenly had to leave work.
* denotes interviewee described a supportive employer or secure employment
[name] denotes pregnancy was also instrumental in the decision to leave employment
Physical conditions – musculo-skeletal; cardio-respiratory; ▓▓; other

143

Chronic ill health: a gradual realisation

As described in the previous section, exits from the labour market could be either sudden or gradual. Those who had long standing health conditions gradually reached a point where they did not think work was achievable or that it was desirable to remain in employment. This trend is supported by the literature in relation to all IB claimants (Sainsbury and Davidson, 2006; Davidson, 2006) and also, specifically, to those with mental health conditions (Sainsbury et al, 2008; Irvine, 2010).

In the majority of cases, those with both physical or mental health conditions experienced increasing symptoms, including pain, fatigue and panic attacks, which made it increasingly more difficult to do their jobs, leading to their decision to leave the labour market:

> So do you think that there was any chance that you could have gone part time and maybe carried on or?
> Well I didn't give that a thought at the moment, when they gave me this colostomy, I thought it was the end of the world you know, but I did realise after that perhaps I could have done a little job you know, maybe um... sitting down job or something, nothing too strenuous, like lifting.[26]
> Do you think that they would have had jobs like that?
> No, they wouldn't have had, not in that industry no, unless that I was in an office or something, but no. They didn't have that... (James)

The quotation above from James's interview shows that deteriorating health was sometimes accompanied by feelings of stress or depression. Furthermore, these feelings were increased where workers were concerned about letting their employer down when there was a positive relationship and accommodations had been made (James, Chris, Paul, Jacob).

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[26] By the time of James's interview, he had undergone a hip replacement operation which has made him more mobile and he describes himself as in better physical health. This may account in part for James's answer.

In other cases, factors external to their health condition could combine to make work unmanageable (Rachel, Catherine, Michelle, Joanne). For example, Michelle had been coping in work with depression, anxiety, a skin condition similar to eczema and back pain, until debt and personal problems *combined* with her health condition resulted in her decision to leave the labour market. Michelle's last job was as a pharmacy assistant, and was paid the minimum wage. Consequently, Michelle's financial situation was often difficult. She stated: 'I think that was what killed me, the council tax, the rent, gas bills, the electric bills. Having two children, it was hell trying to get money together...'. In addition, when the father of her children stopped paying maintenance and her car was vandalised, costing £600 to fix, Michelle was unable to pay all of her rent and bills. This situation caused her stress, which, in turn, affected her skin condition. Michelle notes how the deterioration of her performance at work and the stresses in her home life combined, resulting in her decision to leave employment:

> I think eventually, I was going to work as well, on (strong prescription painkillers). I was making loads of mistakes, and working in a pharmacy that's no good. So I thought I was being a risk as well... I didn't see much of my kids, and the bloke next door living to me is on the sex offenders' register, and his son has just moved back in. He's being investigated and the police don't tell me anything. Nobody tells me anything. I just had a breakdown really. And then I phoned up (Jobcentre Plus) and they sent me the relevant forms, when I told them what the doctor said...

In the cases of chronic ill health, as illustrated by Michelle's case, it is possible to see how the interaction between deteriorating health conditions and other factors can combine. At this point, performance at work suffers and employees question the desirability of remaining in employment.

Sudden Acute Illness

After having been in relatively good health, eight of the 21 interviewees experienced a sudden, acute illness, which necessitated their swift exit from the labour market. With the exception of Mark, these were entirely physical

conditions. Mark was undergoing a 'difficult divorce', when, one day, he had a 'breakdown' into depression and 'just couldn't face going to work basically...'. Consequently he went to his GP to get signed off from the permanent building job that he was doing at the time and was later made redundant.

Of the physical health cases, the most extreme is that of Ben. Having felt slightly unwell for a while, Ben was found to be diabetic. He slipped into a coma and was given two weeks to live. For the next eighteen months, until the time of interview, Ben's health continued to be poor with extended spells in hospital. However, cases like Ben's were not the norm. The most common reason for a sudden exit was an injury, which had often occurred at work (Sarah, Jo, Paul, Dai, Emma, Ann). For example, at work one day, Jo lifted a heavy box and 'done my back in'. At this time, her GP advised her to 'rest, lay down.' Such an approach is in line with Waddell and Aylward's (2005) theory that GPs can have a considerable impact upon their patients' decision to work.

The impact of labour market factors

In six cases, labour market factors were cited as contributing towards the decision to exit the labour market. Compared to the large-scale survey of new IB claimants, this is to be expected (Kemp and Davidson, 2007). Labour market factors could be explicit, such as a job ending through redundancy when a company closed down (Chris) or forced 'voluntary' redundancy against the wishes of the employee because of their health condition (Joanne). Joanne is still aggrieved about this situation several years after the end of her time working for the NHS, particularly as she felt that it tarnished her reputation in terms of gaining further work:

> I was advised to take redundancy because of the spondylitis... never mind the fact that I had done the job for 28 years. I was seen as a health and safety risk, right, all

146

of a sudden I was a health risk, right...When it's on your work record that you're a liability, who the hell, when they see that, is going to want to employ you?

In other cases, labour market factors contributed to leaving the labour market in an indirect way. Such a trend is not noted explicitly in the literature, although poor employment conditions were noted by Green and Shuttleworth (2010) as a factor in increased reliance on IB. This could have been a result of a lack of sick pay (Michelle[27]) or sick pay ending (Ben). Other factors included not being able to find 'light duties' for employers with physical injuries (Dai) or having been made redundant *before* the onset of health conditions and then being unable to find suitable work (Ann). Such journeys are to be expected in an increasingly insecure labour market (Beatty and Fothergill, 2005).

Whilst it can be seen in figure 4.5 that many participants attributed their health condition alone as the factor that influenced them leaving work, it is possible that further probing during interviews may have turned up additional factors. For example, Brian, Martin and Jacob were all working in the building trade prior to their IB claim. As such, it is quite likely that they were self-employed, and therefore would not have had access to occupational sick pay.

Negotiated exits from work

The literature noted that if a sick worker was in secure employment, negotiated exits could occur, where the employer and employee mutually decide to terminate the employment (Sainsbury and Davidson, 2006; Davidson, 2006; Sainsbury et al., 2008; Irvine, 2010). This occurred in two cases (Ben, Catherine). For example, Ben's sudden onset of diabetes

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[27] In this instance, Michelle stated that she was given wrong information by her employer; she was told she was eligible for only one week of SSP when she was entitled to 26 weeks of SSP, resulting in her resignation to claim IB.

resulted in him being considered 'physically unfit' for his job. Having received full sick pay for six months, his employer gave him two options; claiming SSP or redundancy. Ben chose the redundancy option, and the company arranged a 'generous' package of £16,000 for him, with the condition that if he were to become well again soon, he should let them know and they would do their best to find him a suitable job. It was clear from both Ben and Catherine's accounts that they were content with the employment circumstances resulting in their exit from work: Ben, and his mother[28], stated that the employer was 'brilliant...they were marvellous.'

Pregnancy and caring responsibilities

A relatively neglected trend in the literature is the instrumental role a pregnancy can play in the decision to begin claiming IB. Whilst both Nicola and Ann were already out of work when they became pregnant (Nicola with a health condition, Ann without), their original reason for claiming IB was pregnancy. Both had deteriorations in their health conditions resulting in remaining upon IB. It is noteworthy that IB was used as a safety net for pregnant women in insecure employment or unemployment, which was unanticipated within the policy design of IB. Furthermore, such use can result in lengthy stays on IB beyond the original pregnancy.

During the observation period within Jobcentre Plus offices, it became clear that Lydia thought of pregnancy as a 'really common' route onto IB. Although she did not personally approve of the use of the benefit in this way, she knew that pregnant women had few other options in an area of increasing unemployment. However, during one Interview I observed with a pregnant woman, who was suffering with morning sickness, Lydia asked: 'your health condition will go away after your pregnancy, won't it?' The claimant agreed. At the end of the interview, Lydia introduced the claimant to her colleague who was a Lone Parent Advisor, and described how the

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[28] Who was also present during the interview and contributed sometimes.

claimant would be transferred on to 'more appropriate benefits' once her pregnancy was over. The use of compulsory Work Focused Interviews, as introduced by *Pathways to Work,* can be seen as an attempt to prevent the new cohort of pregnant women disadvantaged in the labour market, like Ann and Nicola, from remaining on IB long-term.

Furthermore, increased caring responsibilities for Rachel and Catherine following illness in teenage children were instrumental in increasing their stress, making remaining in work impractical and undesirable. Whilst Rachel's daughter suffered a lengthy stay in hospital after being involved in an accident, Catherine's son developed leukaemia. Both children required considerable care during their rehabilitation, which was particularly stressful for Rachel and Catherine. Whilst caring is not exclusively carried out by women, it is more likely to be undertaken by women. As such, discourses that describe a decline in traditional heavy industry, largely undertaken by men, are less relevant.

Conclusion

It is possible to see that the reasons for leaving the labour market were complicated and did not relate to health conditions alone, with caring responsibilities and quality of life also featuring highly. However, it is important to note the relative ease in accommodating a gradually worsening condition in comparison to one that appears suddenly. The data show that labour market conditions can have an effect on whether workers with health conditions can remain in work, and for how long (Beatty and Fothergill, 1996). Thus, two people with similar conditions can spend vastly different times employed with a health condition as a result of the support offered by their employer. The provision of alternative choices, or not, obviously impacts the person's decision to claim IB or not. The research also highlighted the focus of previous research in the area upon unemployment resulting from the decline in heavy industry, which largely excluded women. Thus it is important to note that the research found that for some women

pregnancy and caring issues were instrumental in their decision to exit the labour market and to remain claiming IB.

4.3.5 Ill health now

· Getting better

Of all of the 21 IB claimants, only one had undergone what he considered a full recovery. Two interviewees described ways in which their health had improved (prior to CMP intervention). On the other hand, two interviewees became increasingly frustrated by a lack of treatment provided by the NHS and sought private treatment to attempt to improve their conditions.

The one success story came from Mark. Mark's depression was reported to be entirely related to the breakdown of his marriage and at the time of the interview, almost a year afterwards, he was 'feeling OK, yeah, fine' and had returned to work (without the support of *Pathways to Work*, although he was collecting the Return to Work Credit). Such a situation would be viewed positively by Waddell and Aylward (2005); the claimant had completed all parts of the sick role, in order to get better and return to the labour market. However, the lack of support from Pathways to Work shows that the policy was not supporting all of those who might have benefitted from it.

Whilst two interviewees (James and Rowena) described how they felt better, they were by no means well. For example, James considered that his condition had improved; having suffered with Chron's disease for many years, having a colostomy has improved his condition. However, James was by no means cured. For the previous six years, James had used 'Total Parental Nutrition', an artificial feeding device, which transfuses users over night, taking at least twelve hours four times a week. Furthermore, James had to have infusions of magnesium which he had been trained to do himself, and took ten hours at a time. In order to determine how much magnesium James should be given, he drove for nearly an hour to a

hospital each week for blood tests that could not be carried out by his GP. He described a further cocktail of drugs that he was taking, however stated that 'I'm better now than I was (when I 'retired' from work)...'. It is also interesting to note that James, who was a long way from the state retirement age when his claim for IB began, saw himself as 'medically retired', a status that implies a permanent labour market exit.

In addition to his bowel problems, over the years, James's mobility had decreased significantly as a result of arthritis in his hips, caused by one leg being three inches shorter than the other. Two years prior to the interview, James had a hip replacement, which 'caused me a lot of trouble, you know, I've spent thirty-two weeks in hospital...' During this time, James's wife was 'sent for twice because I was going to die...'.

It is clear that several claimants felt so desperate to find the cause of their ill health that they sought private treatment, at considerable cost, in order to speed up the investigations their GPs believed to be necessary, or to provide treatment (Doyle and Bull, 2000). Whilst Emma's family paid for her to have weekly chiropractor sessions, Sarah took out several loans in order to privately visit consultants, because she was: 'at the end of my tether'. Emma considered her treatment to be successful, although she was left in considerable pain after each session. However, Sarah's trips to see consultants left her with more questions than answers, and she was awaiting further investigations.

Continued incapacitation

The vast majority of IB claimants still classed themselves as incapacitated by their condition(s), although in some cases, the condition that incapacitated them the most was not the one for which IB was originally claimed. Ann described how she originally claimed IB because of a pregnancy, 'as everyone did at the time', but about a year later, she was diagnosed with arthritis of the spine, although an accident later in her life caused further musculo-skeletal problems:

151

> After they found out I had arthritis of the spine then uh... some years later I broke my ankle, dislocated my ankle, broke the tibia and the fibea. Um.. they said I would always have problems with it and now I've got arthritis of the hips because of moving from your gate, walking different and everything. So I've got arthritis of the hips now as well

Jo was in a similar position. Whilst she originally claimed IB because of musculo-skeletal problems, five years ago she had a heart attack and subsequently considered her cardio-vascular health condition, alongside her depression to be most incapacitating.

These cases of multiple conditions form a contrast to Hedges and Sykes's (2001) neat typology of incapacity, where conditions are either complex, fluctuating, acute or short-term. Within the research, it was clear that most IB claimants had more than one condition, and that these conditions were far from static andoverlap could occur between, for example, complex and fluctuating conditions. Therefore, Hedges and Sykes's (2001) typology can be seen, in the context of this research, to be overly-simplistic in describing the complicated reality of ill health. For example, Paul suddenly became incapacitated 18 months prior to the research. Having snapped his Achilles tendon by simply turning around too quickly, Paul's acute condition required a plaster-cast. It was anticipated that the condition would heal enough for him not to be incapacitated for long. However, Paul stated that as a result of this injury, he developed a blood clot on his lung. This acute condition was treated in hospital, but subsequently turned into an infection which has left him with a chronic condition:

> (The clot on my lung) put me in hospital for a week and everything, was really painful. (Whilst) getting over that, a month later, I got an infection in the lungs, I got fluid on the lungs and an infection as well on the lungs... That one was a killer, I spent a month in hospital. The first week was um... they told me after I was coming out, the first week was touch and go, I didn't know how bad I was because I was dosed up on painkillers and having drips morning, afternoon and evening...I'm fortunate though because they stick a tube into your back, right into my lungs. To get the fluid out... So they drained me lungs first and made me have an operation

afterwards...But it just made me so ill and everything. That's why I've got no energy, no stamina at the moment (seventeen months on). So... that's basically what happened from my leg to that in a week and then a month in hospital with my lungs.

For some participants, their condition has deteriorated further over time, or as mentioned above, they have developed other incapacitating conditions alongside the condition for which they claimed IB. Very few of the claimants felt that their health had improved. In returning to work after eight months off for depression, Mark is very much the exception in the work and health trajectories, as opposed to the rule.

For all of the interviewees with musculo-skeletal conditions, Hedges and Sykes' (2001) concept of a 'fluctuating' condition is accurate, resulting in 'good days and bad days' (Jo). However, the overwhelming majority of these claimants were now exhibiting some symptoms of anxiety or depression; and as such they did not only fit into one category. Consequently, it is important to note that in general the IB claimants:

- Often had more than one health condition, as such an improvement in one condition did not result in a return to good health
- Were often being treated for at least one of their conditions
- Did not feel well enough to work

It can be seen that long-term, chronic ill health is complex and fluctuating, and therefore, it prevents people from performing every day activities in many different ways. These factors are largely neglected by labour market approaches to incapacity (Compass, 2010).

4.3.6 Identity and Becoming Incapacitated

As can be seen throughout the chapter, claimants' identities undergo significant change throughout their transition from work to IB. This section will focus firstly upon claimants' identities as sick people, before moving on to focus upon their identification with a claimant identity, if any. It will be shown that adopting a sick identity was more common than identifying as an IB claimant. Reasons for this will be discussed in light of Giddens' (1991) work on stigma. The section will close by focusing on other 'active' identities adopted by some IB claimants, which allowed a positive sense of contributing to society to continue.

Sick Identities among IB claimants

Throughout the interviews, it was clear that claimants were identifying strongly as 'sick'. For claimants, this sickness can have been present for some time, or have onset suddenly. The common factor, however, is that shortly prior to beginning their claim, work became unmanageable or undesirable because of the severity of the condition. For example, Martin described how his back pain became 'worse and worse', until he had no option to stop working. Claimants described the escalation of sickness, and their 'need' to leave work (Michelle), sometimes in significant detail. This can be seen as attempting to legitimise their claim of being disabled (Stone, 1984). In order to distinguish themselves more fully from those who are fraudulently presenting themselves as sick, some claimants identified groups who were eligible for IB, but who were not seen as being truly in need of state support. The most aggressive proponent of such othering was Jacob, who mentioned how alcoholics and drug addicts were taking up valuable NHS mental health resources when they 'weren't really sick'. This may have been in order to fully distinguish his invisible health conditions from the invisible health conditions of other patients.

Parson's concept of the sick role (1951) argues that sickness should be a short term phenomenon. Within interviews, claimants used their interaction with the medical profession to show their identification as legitimately sick (Williams, 2010). The majority of claimants were awaiting investigative tests, operations or appointments with consultants. At the most extreme end, Ben was told by his Consultant, which was reinforced strongly by his GP, that if he were to return to full time work, he would be likely to die. Accordingly, it can be argued that claimants had not breached the sick role; they were still following medical advice. On the other hand, Martin and Brian 'knew' that there was little left that medicine could offer them, but were incapacitated by their chronic health problems.

In other cases, the label that claimants invoked for themselves can reveal something of their identification with a sick role, as opposed to a claimant role. Having also been incapacitated for some time, James left work, aged 50, after more than a decade of ill health. Upon leaving work, James claimed IB rather uneventfully throughout the late 1990s until turning 64 in 2008. During this time, he believed himself to be 'medically retired' and he referred to himself as having taken 'early retirement' a number of times throughout the interview. This is not surprising, as James was confused as to what benefits he was claiming, and believed that he had been claiming a 'disability pension'. This may have been as a result of the way the Benefit was 'sold' to James during a time when it was desirable to increase the numbers of IB claimants in order to reduce the number of registered unemployed (Waddell and Aylward, 2005). Many of the other claimants used the term 'on the sick' as a shorthand for 'claiming Incapacity Benefit', accordingly, the language used in claimants' narratives showed their belief in their sickness.

This is an interesting contrast to the social model of disability. Oliver (1990) and colleagues have argued forcibly that society disables people who have impairments. These discourses have been widely adopted, although somewhat watered down (Barnes and Mercer, 2007), and are thought to

155

empower those with impairments. In several interviews, claimants were asked if they were disabled. Most rejected the label of disabled, listing their health conditions as problems instead. However, claimants, in the main, subscribed closely to the medical model of disability. Their opinions may have varied more strongly if they were fortunate enough to be able to be employed by a company that was able to make adaptations for them.

Claimant Identities among IB claimants

Whilst claimants acknowledged their receipt of benefits, none appeared to view this as separate to their role as sick. Furthermore, throughout the interviews, claimants discussed the undesirability of claiming IB: bureaucratic processes, low incomes and a feeling of insecurity. Alongside this, without prompting, the majority of claimants described 'other', undeserving, IB claimants, who they believed fitted the media image of the 'scrounger'. Accordingly, it is not surprising that in order to develop a positive sense of self, claimants chose to self-identify in ways separate to their IB claim (Giddens, 1991).

Alternative Productive Identities among IB claimants

Whilst the majority of claimants identified as being 'sick', productive, non-employment roles were also present in the formation of their identities. This reflected both positively and negatively for some claimants. Rebecca was able to engage in some voluntary work, supporting local young people to learn to play musical instruments. This 'kept me busy' and provided a source of productivity and usefulness that Paul was unable to find. As a result of severe health complications following an ankle injury, Paul had suffered a loss of stamina. He was struggling to come to terms with being unable to performing traditionally masculine roles such as carrying shopping and performing DIY tasks. The absence of these productive functions, identified by Paul as part of being masculine, left him feeling like "less of a

156

man". This was something that Paul described himself as struggling significantly with, resulting in an acute feeling of loss, which his CMP clinician was concerned would turn into depression.

Furthermore, Joanne, a confident outspoken woman, described at length how she had been stigmatised by people she did not know at a family barbecue when they found out that she was 'on the sick'. Joanne felt that 'they turned their noses up' at her until they found out that she had previously had a respectable, or 'good', job as an auxiliary nurse. Throughout the interview, Joanne referred to herself as 'working as a nurse...all of my life', despite having claimed IB for four years. Joanne chose to continue to identify as a nurse, despite not actively working in this area. However, Joanne was a member of several websites for 'carers', where she contributed actively to discussion boards, and was able to continue to act as a professional with valid expertise. Consequently, Joanne was able to create a sense of continuity from her participation in online communities (Giddens, 1991).

Statements that identified claimants as hard workers were common among interviewees. In fact, many had been involved in heavy, laborious work with only two of the (female) claimants previously involved in office-based work. As such, it was a matter of pride to be a 'grafter', and office jobs, which did not involve physical work, were viewed negatively by many claimants (Brian). Whilst this may have resulted in the labour market becoming increasingly inaccessible to the claimants, the desire to do a 'decent days work', which many unemployed people may find unattractive, was viewed positively by the claimants (Michelle).

4.4 Conclusion

. This chapter opened with an exploration of literature in several key areas. It was shown that rates of claiming IB have risen since the 1970s, although this can be primarily explained in terms of a steady number of new claimants, with fewer people exiting the benefit. Reasons for the decrease in 'off flows' have been offered in various guises. The typology offered by Yeandle and Macmillan (2003) was adopted as a framework to explore relevant literature. It can be seen that traditional approaches that state that the health of the general population has got worse have been largely discredited, although health related factors, such as waiting times for treatment can act as a factor (Waddell and Aylward, 2005). In addition, it can be argued that lack of governance of IB during the previous Conservative Governments (1979-1997) may have accounted for a decrease in exiting IB. Whilst there is no convincing evidence of this thesis to date, the increased regulation of IB from 2002 onwards, as part of *Pathways to Work*, was intended to increase off flow levels from IB.

The third reason proposed for increased use of IB is that of fraudulent or inappropriate use. Whilst it has been agreed that fraudulent use is low, the labour market thesis argues that inappropriate use is common as a result of an insecure, fragmented labour market. Wide ranging support can be seen for this thesis from Beatty and Fothergill (1996 onwards). This thesis is also supported by DWP research reports describing IB on-flows, which show a strong link between poor job security and labour market attachment, and IB claims in times of ill health (eg: Sainsbury and Davidson, 2006; Davidson and Kemp, 2007).

The data presented here also show strong support for labour market factors. It can be seen that most of the claimants were concentrated in low paid, insecure employment. However, whilst the literature (eg: Sainsbury and

Davidson, 2006) suggests that a decline in health may lead to decreased performance at work, one quarter of the 21 participants in this study had begun their working lives with a health condition that made their working lives more difficult from the outset. This finding was not found in the literature relating to IB receipt. As such, periods of 'struggling on' may begin as soon a person with a health condition enters the labour market.. In these difficult economic times, this effort should not be understated.

For other claimants, when their health began to deteriorate, some were fortunate enough to have supportive employers who made adaptations. Others were not so fortunate, or experienced a sudden onset of their condition, making the chance of adaptations being made less likely. Many of these claimants experienced musculo-skeletal problems, primarily as a result of an injury at work. For this group, the decision to leave work was fairly simple. For those who had chronic ill health that deteriorated over time, the choice was more difficult, but often involved factors other than their health alone. This was more common among the women in the sample who tended to juggle caring responsibilities. The data also show that pregnancy, either alongside a health condition or without a health condition, can form a route onto IB which is something that previous research on IB has not highlighted, possibly because of the traditional focus being on labour market disadvantage in ex-industrial areas with a focus on men.

Discussing their health conditions at the time of the research, it is clear that all of the claimants still felt incapacitated to some extent (with the exception of Mark who returned to work). However, among some of the longer-term claimants, the condition that was affecting them the most may not have been the one for which they originally claimed IB. As such, whilst the labour market explanation argues that almost half of the people claiming IB in Wales are hidden unemployed (Beatty and Fothergill, 2005) and could expect to be employed in a fully functioning economy, it does not seem likely that half of the 21 claimants interviewed would have been capable of returning to work.

159

This chapter has examined the first part of IB claimants' journeys, the next chapter moves on to discuss IB claimants' interaction with Jobcentre Plus. This focuses upon Work Focused Interviews with Personal Advisors.

Chapter 5: Compulsory Work Focused Interviews

5.1 Introduction

Having described the journeys that resulted in an IB claim in the last chapter, this chapter will explore IB claimants' and Jobcentre Plus Advisors' experiences of compulsory Work Focused Interviews that are part of *Pathways to Work*. The chapter also draws upon the fieldwork which was undertaken, where 14 Work Focused Interviews were observed.

The chapter will begin with a review of existing literature, specifically regarding Work Focused Interviews for IB claimants. Whilst there are only a handful of DWP Research Reports, these reports are highly detailed, often spanning at least 100 pages. The literature review will be divided into a section relating to Advisors, followed by one relating to claimants. It will be shown that researching *Pathways to Work* is far from straightforward.

The second part of the chapter will present the data collected alongside a comparison with the literature. Exploration of the data will occur in a broadly chronological pattern, beginning with claimants' early contact with Jobcentre Plus whilst attempting to claim IB. The chapter will then describe what occurs within WFIs from the Advisors' perspective and the claimants' experiences with reference made to the observation period where relevant. It will be shown that Advisors more clearly differentiate between individual WFIs, whilst claimants remember their interviews much less distinctly. Advisors' experiences of attempting to refer claimants to work focused activity, including their relationship with targets will be discussed. Furthermore, claimants' decisions to participate in work focused activity will be described in some detail, before looking at sanctions imposed by Advisors. The chapter ends by outlining Advisors' views of claimants and claimants' views of Advisors.

161

5.2 Review of the literature

5.2.1 Introduction

The literature review will consider selected material, relating mostly to attendance at compulsory Work Focused Interviews (WFIs) for IB claimants, although where there are gaps in the literature, other material will be presented. The review will begin by revisiting the policy context in order to remind the reader of what *should* occur during WFIs, including the 'menu of choices' available to be used at Advisors' discretion. The section will continue by looking, firstly, at Advisors' experiences of WFIs, including how they conduct such interviews, their experiences of being subjected to targets, levels of claimant engagement and their own job satisfaction. The review will then consider claimants' views of attending compulsory WFIs, primarily with reference to three reports commissioned by the DWP. Experiences relating to attending the interview, uptake of work-focused activity from the 'menu of choices' and leaving IB, because of work or being removed from the Benefit, will be discussed. Finally, literature that has specifically attempted to evaluate the worth of *Pathways to Work* will be discussed.

5.2.2 A note of caution

Within the majority of the policy documents and DWP research reports, IB claimants are referred to as 'customers'. The concept of the 'customer' within Social Security, however, is disputed, as benefit claimants do not have many of the rights associated with being a customer (Rosenthal and Peccei, 2006; Rosenthal and Peccei, 2007). As such, throughout the thesis, IB claimants will be referred to as 'claimants', as opposed to 'customers',

although the term 'customer' is widely utilised in the official DWP Research Report series.

5.2.3 The policy background revisited

Whilst the use of compulsion was dealt with in considerable detail in chapter 2 , a recap of the *Pathways to Work* policy (2002-2010) will be given in order to contextualise the specific findings from the literature and the research.

Pathways to Work

As part of the *Pathways to Work* pilots (DWP, 2002), new IB claimants were required to take part in six compulsory Work Focused Interviews to be scheduled at approximately monthly intervals. Within these interviews, conducted by Incapacity Benefit Personal Advisors (referred to as 'Advisors' throughout the thesis), claimants were supposed to agree an action plan based upon the 'menu of choices'.

The 'menu of choices' comprised a variety of initiatives, although Blyth's (2007) analysis of official statistics show that the New Deal for Disabled People (which already existed prior to *Pathways to Work*) and the Condition Management Programme were the two main choices, accounting for three quarters of all 'choices' undertaken in 2006. Programmes that are available include:

- New Deal for Disabled People – Aim: job searching, work related activity, increased confidence
- Condition Management Programme – Delivered by the NHS in some areas, private providers in other areas. Aim: help participants to manage their health conditions better within a work environment.

- Work Preparation – Aim: place people who have been out of work for a long time because of disability into work for up to six weeks.

- Work trials – Aim: enable benefit claimants to try a job for up to 30 days without changing their benefit status

- Work step – Aim: help disabled people to find and retain a job.

- Programme Centres – Providers can include Jobcentre Plus or other providers. Aim: provide support in job searching and skills such as CV writing. Sometimes know as 'job clubs'

- Work Based Learning for Adults (Wales only) – Available to groups at risk of long-term unemployment including those with disabilities. Aim: provide individual support which can include work experience and training.

With the exception of CMP, all of these programmes were available before *Pathways to Work* was introduced. As such, it is fair to say that there is very little new support available within *Pathways to Work*. In addition to the continuity in the programmes offered, Lindsay et al. (2007) argue that, like most activation policies, the choices aim specifically to change the claimant, rather than the labour market. However, unlike some earlier programmes, Lindsay et al. (2007) suggest that *Pathways* can be seen, to some extent, as an attempt to move away from a policy exclusively focused upon the quick wins of any job entry to promoting longer term development among claimants with the most significant barriers.

In addition to the 'menu of choices', Advisors can provide up to £300 of discretionary funding from the Advisor Discretion Fund, and a Return to Work Credit of £40 a week for the first year of a 'full time'[29] job is also available. The *Pathways* pilots were extended twice after their inception, before being rolled out nationally by the 2007 Welfare Reform Act. In 2010, a National Audit Office Report (NAO, 2010) stated that *Pathways* was poor value for money. As such, it is likely to be disbanded by the new coalition

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[29] 'Full time' was considered to be more than 16 hours per week at the time of the research.

Government. Therefore, the thesis performs as an analysis of a completed policy which can be seen as the embodiment of the New Labour welfare to work programme.

5.2.4 The role of Personal Advisors

Conducting Work Focused Interviews

Building a rapport with claimants was seen as a key part of the interview process (Dickens et al., 2004; Knight et al., 2005). Within the first three *Pathways* pilot areas, Advisors reported that they used their discretion in deciding whether to discuss work in the initial interview or not and how to respond to a claimant's circumstances (Dickens et al., 2004). The need to build up a relationship was also seen as crucial in later pilots (Knight et al., 2005).

'Menu of Choices'

Within the 'menu of choices', there was considerable staff discretion in the use of different choices. For example, within Dickens et al.'s (2004) qualitative research, consisting of two focus groups and 14 interviews, some Advisors referred nearly all of their claimants to the CMP, whilst others had referred none at all. Levels of referral to Job Brokers also varied considerably. Research on the second wave of *Pathways to Work* pilots found that Advisors felt more able to 'sign post' to support available from the 'menu of choices', although some Advisors were still not using all of the choices available to them as a result of lack of knowledge (Knight et al., 2005:1).

Targets

Whilst, initially, JCP Advisors did not have specific targets to meet in relation to IB claimants, there was still some pressure to contribute towards office

targets. As such, Advisors felt under pressure to focus their efforts on people closer to work, in order to meet 'job entry targets' (Dickens et al., 2004; NAO, 2004; Knight et al., 2005; Pendleton, 2006; Barnes and Hudson, 2006). This was felt by some Advisors to be going against the rationale for *Pathways* (Knight et al., 2005; Barnes and Hudson, 2006). Research on all Jobcentre Plus Advisors found that when Advisors have to meet targets in order to gain an incentive, they will aim specifically to meet that target and no further (Burgess et al., 2003), which can also have a negative effect.

Targets relating to *Pathways* increased in the second round of pilots, including targets for referring claimants to avenues of support from the 'menu of choices'. Advisors expressed concern that this may result in inappropriate referrals, although administrative data suggest that practice has not been influenced since the introduction of the targets (Knight et al., 2005). Likewise, focus group research with Advisors found that some Advisors felt that their managers did not always understand how much effort needed to be utilised to secure meeting targets (Barnes and Hudson, 2006). Furthermore, at the time of the research undertaken by Dickens et al. (2004), Advisors had the power to defer or waive interviews, and they were using this power. By the time of the PhD research, the power to waive interviews had been revoked to a great extent, which made meeting targets more difficult.

Claimant Engagement

Many claimants were reported by Advisors to be anxious, negative or hostile about having to attend an interview, although this was countered, to some extent, by staff attempting to telephone claimants beforehand (Dickens et al., 2004; Knight et al., 2005, Barnes and Hudson, 2006). Hostility could be increased by insensitive materials about returning to work being sent to claimants who felt that they were too ill to work (Pendleton, 2006).

Advisors described how some groups of claimants were more likely to 'fail to attend' a compulsory *Pathways* interview (Dickens et al 2004). When this occurred, Advisors often stated that they tried to contact claimants more than was required. In a survey of Jobcentre Plus Advisors, claimants failing to attend interviews was seen as a key obstacle to enabling Advisors to carry out their jobs, with 75% of Advisors experiencing this at least once a day (NAO, 2006). As such, within the context of pressure to reach targets, 'Fail to Attends' can be seen as frustrating for Advisors. Overall, Advisors reported greater engagement from voluntary customers, who were seen as more motivated and easier to help. This increased job satisfaction (Dickens et al., 2004). As such, it is crucial to note that many of *Pathways'* successes were from voluntary customers (NAO, 2010). Consequently, the rationale for introducing compulsory activity is undermined.

Sanctioning

Whilst *Pathways* allows for claimants who do not engage to have their benefits sanctioned, Advisors did not always follow this course. In part, this was as a result of some Advisors feeling 'very uncomfortable' with sanctioning claimants (Dickens et al, 2004:ii; Knight et al., 2005). As reported above, Advisors sometimes made extra effort to contact claimants who did not attend an interview, as opposed to sanctioning them (Dickens et al., 2004). This was because Advisors acknowledged that to sanction a claimant could have a negative effect on both the claimant's health (Dickens et al., 2004; Knight et al., 2005) and the relationship between the claimant and the Advisor (Dickens et al., 2004). Furthermore, by the second wave of pilots, some Advisors did not feel that they had the capacity to follow up and sanction those who did not attend a compulsory interview due to increasing workloads (Knight et al., 2005).

Job satisfaction

Whilst it can be seen that levels of job dissatisfaction among all Jobcentre Plus Personal Advisors (not just those working with IB) were low (NAO, 2006), job stresses can be high (Webster, 2008). Focus group research relating specifically to *Pathways* by Dickens et al. (2004) and Knight et al. (2005) found that Advisors could feel unsupported and out of their depth. Furthermore, training given to Advisors in the pilot areas was not seen as fully preparing them for all aspects of the role, and case load increases were common, resulting in them carrying out more interviews each day than was recommended (Knight et al., 2005). As such, Webster (2008) argues that to avoid burnout, Advisors de-personalised their customers, acting in a detached way, although this was not a long-term solution and burn out is often a long-term problem. In addition, some Advisors felt a tension in their role between attempting to support people and, at the same time, controlling their behaviour (through benefit sanctions, if necessary). This may in part explain the feeling that Advisors found it easier to progress 'voluntary customers'.

Whilst official targets might not recognise small steps on the path to work-readiness, Dickens et al.'s (2004) Advisors took satisfaction from enabling claimants to remove barriers to work. However, it was acknowledged that for some claimants, particularly 'mandatory customers', there were significant barriers, and some claimants did not move closer to the labour market.

5.2.5 Claimants' Experiences

Attending WFIs

The DWP commissioned three longitudinal pieces of qualitative research to explore the claimant experience of *Pathways*. Follow up interviews were conducted at three and nine months in order to attempt to provide a comparison as engagement levels changed (Corden and Nice, 2007). The research comprised three reports, sampling 105 claimants from three different cohorts, from the Social Policy Research Unit at the University of York (Corden et al., 2005; Corden and Nice, 2006a; Corden and Nice, 2006b). It is important to note, however, that the research team acknowledged that changes arising as a result of *Pathways* participation may occur beyond the end of the research project (Corden and Nice, 2007).

The majority of claimants were not expecting to have to attend a WFI, and when notified by telephone or letter, could feel threatened by it, believing that its purpose was to remove their benefit eligibility (Corden et al., 2005; Corden and Nice, 2006a; 2006b). As such, reluctance to attend interviews was common. Patmore (2008) argues that such lack of engagement can be seen as a response to the claimant's belief that they should not have to take part in such activity as it has not been previously expected of them; and so it is viewed as a breach of the contract between Government and citizen. Therefore, Patmore (2008) suggests non-engagement should be expected.

As a consequence of such negative feelings, the first WFI tended to be the most clearly recalled event, unless specific referrals were made at subsequent WFIs. For many of the anxious claimants, the research found that the first WFI was an opportunity to reassure them that they would not be pushed into pursuing unsuitable work (Corden et al., 2005; Corden and Nice, 2006a).

The DWP research evidence found that most claimants did not have all six interviews and that the pattern of monthly interviews was not subscribed to with time-scales altered to fit claimant needs. For example, some claimants made informal contact outside scheduled WFIs with their Advisor, particularly if they were highly motivated to find work (Corden et al., 2005). Further evidence of less than a full quota of interviews can be seen from administrative data on the early pilots; for those who were correctly screened[30] (two thirds of all new claimants), one third only had to attend the initial WFI (Blyth, 2006). For some interviewees this was seen as positive as they did not feel that they were capable of work or had already returned to work, negating the need for further input from *Pathways*. For others, however, further contact would have been desirable (Corden et al., 2005). Among those claimants who had more than one interview, it could seem that information was repeated and that subsequent interviews held little value, particularly if none of the 'choices' available seemed relevant (Corden and Nice, 2006b).

As part of the further roll out of *Pathways to Work*, some existing customers who had been claiming IB for less than two years were mandated to take part in existing *Pathways* areas. Focus Group research by Barnes and Hudson (2006) found that responses to being asked to take part in compulsory interviews were similar to that of other groups from research on new IB claimants.

It is clear that claimants' experiences of the interviews as useful and positive or disappointing and negative were directly related to how ready for work claimants felt, which was closely related to life events as well as health conditions, and how much support was offered (Corden et al., 2005; Corden and Nice, 2006a; Corden and Nice, 2006b; Corden and Nice, 2007). For

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[30] The 'screening out' process involved Advisors completing a web-based questionnaire for each new claimant. If a claimant's answers show they are unlikely to still be claiming IB in 12 months, they are 'screened out' of mandatory Pathways in order to concentrate support on those most in need.

those who did not feel ready to return to work, a sense of powerless compliance can be seen (Corden and Nice, 2006a; Corden and Nice, 2007).

Despite negative feelings towards how the policy change was affecting them, claimants generally viewed Advisors positively, and the concept of conditional entitlement to benefit was accepted by most claimants interviewed (Corden et al., 2005; Corden and Nice, 2006b). A national survey, sampled from all Jobcentre Plus 'customers', showed a similar view: claimants were generally positive about Advisors' behaviour, although claimants were less positive about technical issues, such as telephone services, or policies (Johnson and Fidler, 2008). On the other hand, some *Pathways* participants felt that Advisors did not fully understand barriers they faced to finding suitable employment, including the local labour market, leading claimants to adopt a sense of cynicism (Barnes and Hudson, 2006).

Uptake of the 'Menu of Choices'

In general, claimants appreciated the individually tailored nature of support offered to them, although work focused activity was mainly undertaken by those who felt ready to return to work or wanted to be able to return to work in the future. Those who undertook some activity from the menu of choices were less critical of the *Pathways to Work* process (Corden et al., 2005; Corden and Nice, 2006a). However, whilst part of the *Pathways* process involves completing an action plan within the WFI, many interviewees could not remember completing one or thought it was an exercise in bureaucracy, detailing activities that they were already doing (Corden et al., 2005).

Using administrative statistics, the initial pilots showed the take up of at least one choice in around one fifth of those who attended an initial compulsory interview within the following year (Blyth, 2006). The decision to participate in work focused activity was primarily based upon its perceived usefulness in returning to work by claimants, although encouragement from Advisors could be influential. As such, confusion or

171

mis-information could lead to claimants who may have engaged with choices deciding not to participate (Corden and Nice, 2007). Furthermore, claimants stressed the importance of correct timing in their decision to take up support that was offered (Corden and Nice, 2006b), showing the importance of external factors in the decision to participate, despite conditionality.

An alternative approach was found regarding participation in CMP. For some participants, who did not feel ready to return to work, CMP was seen as useful because it could potentially improve their health condition (Corden et al., 2005). However, later research also found that claimants sometimes participated in parts of Pathways, in spite of reservations, to show willing or as a result of (perceived) pressure. This was particularly prevalent among those whose health conditions were worsening (Corden and Nice, 2006a). Fundamentally, the introduction of Pathways to Work had little impact upon participation in activities that were previously available, despite the increased knowledge of choices available through the compulsory interview process (Adam et al., 2008).

On the other hand, lack of participation was primarily related to not wanting or feeling able to work and feeling that the activities offered the claimant very little. The level of perceived usefulness could be influenced by misunderstandings or previous negative experiences with Jobcentre Plus (Corden et al., 2005; Corden and Nice, 2006b). Furthermore, if information about choices did not seem relevant or appropriate at the time it was given, it was forgotten within nine months (Corden and Nice, 2007). In terms of recall, financial support offered as part of Pathways was more likely to be remembered than other aspects of Pathways, however, in both cohorts of research, there was a group who could not recall any aspects of support offered (Corden et al., 2005; Corden and Nice, 2006a).

In contrast to the first cohort, some respondents in the second piece of longitudinal research felt that their access to some of the menu of choices

was restricted when they showed a desire to take up support (Corden and Nice, 2006a). This was not found in the earlier study (Corden et al., 2005) and may be related to increased demand upon scarce resources.

Returning to Work and/or leaving IB

Research undertaken for the DWP found that of those who had enquired about claiming IB (not those who had actually gone on to claim IB), participation in *Pathways* increased their likelihood of working 10 months later from 22.5 per cent to 33 per cent. Likewise, there was a reduction in those who were claiming IB at this point of over 8 percentage points. For the sample, income also increased, regardless of whether they had returned to work, when compared to a non-pilot area with similar characteristics (Adam et al., 2006). However, the sampling method, including some people who enquired about claiming IB, but did not go on to claim IB, can be seen as seriously flawed when trying to generalise to IB claimants. Furthermore, those who did not become IB claimants would not ordinarily be eligible to take part in *Pathways* and may have already been closer to the labour market. Accordingly, it is not possible to generalise these results, where some participants were IB claimants, but some were not, to a population made up entirely of IB claimants. .

Based on internal DWP administrative data available until August 2005, Blyth's (2006:1) DWP research suggested that the 'evidence on the performance of the *Pathways to Work* Pilots is very encouraging.' Furthermore, Blyth (2006:9) reports: 'there is an increasingly clear indication that *Pathways* is having an impact on IB off-flows.' This in turn was reducing the number of people claiming IB in *Pathways* pilot districts.

Of those who did return to work, qualitative retrospective research suggests that they did not attribute their success to *Pathways*, although it may have been a catalyst (Corden and Nice, 2006b). On the other hand, some longer-term IB claimants (less than two years), who were mandated to

173

participate in *Pathways*, felt disappointed after having participated in *Pathways* when they were unable to find work quickly afterwards (Barnes and Hudson, 2006). This illustrates the need for Government policy to influence the labour market, as well as the claimants it seeks to activate, in order to have an effect on IB off flows.

Whilst those who returned to work valued the financial support offered through the Return to Work Credit and Advisor Discretion Fund and information relating to permitted work rules, such assistance did not influence those who were not already considering a return to work. This was at least in part related to the low quality of work available locally (Corden et al., 2005). Among those who did return to work, some claimants who were eligible for the Return to Work Credit (RTWC), of £40 a week for 52 weeks, did not take up this support. This was possibly as a result of a lack of understanding of available support (Corden and Nice, 2006a; 2006b), although earlier research found mixed views of the appropriateness and necessity for the RTWC (Corden et al., 2005). On the other hand, for those who did return to work, financial problems could quickly develop when the RTWC and other forms of assistance, such as tax credits, were not paid in a timely fashion (Corden and Nice, 2006a).

For others who had been out of work for relatively short periods of time, the intensive support of an Advisor could enable them to return to their original role or consider alternative options, which was considered valuable (Corden et al., 2005). However, not everyone who returned to work was able to sustain this (Corden and Nice, 2006a). This provides further evidence against the labour market explanation for rising IB claims, which was discussed in the previous chapter (see, for example Beatty and Fothergill, 2005). For those claimants who did return to work, health problems may still prove difficult to manage within the context of work, leading to reduced performance and sometimes to the conclusion that their current work is not sustainable and/or desirable.

Sanctions

During the *Pathways* pilots, it was clear from administrative data that sanctions were not common, with 0.4% of claimants taking part in *Pathways* sanctioned (Blyth, 2006:13). However, qualitative research has shown that - the fear of sanctions was enough to secure compliance from those who were not interested in participating in *Pathways* for other reasons (Corden and Nice, 2006b).

Being removed from IB

Within Corden and Nice's (2006a) research, a group of IB claimants who had 'failed' the Personal Capability Assessment, and as such were removed from IB and *Pathways*, felt that the abrupt ending of contact with their Advisor was disadvantageous. However, this group was reluctant to renew contact with their Advisor, who was seen as being specifically for IB claimants. In addition, some of this group had agreed to participate in the CMP before being removed from IB. For those whose benefit was subsequently reinstated, they did not get re-referred to CMP.

5.2.6 Claimants' experiences: Post-pilot, interaction with Employment and Support Allowance (2007-2010)

Whilst many of the findings cited above retained their relevance after the national roll out of *Pathways* in 2007, more critical evidence emerged after this point. However, it is not possible to distinguish the effects of the privatisation of many parts of *Pathways* from the introduction of Employment and Support Allowance and its greater conditionality.

For example, in response to the 2010 *Pathways* consultation, the Citizens Advice Bureau (2010b) found that their customers[31] felt that *Pathways* was not taking into account their individual circumstances and giving poor benefits advice. The bespoke nature of *Pathways* was one of the key positive findings from the early research (Corden et al., 2005), although this was not noted by later research reports (Corden and Nice, 2006a, 2006b). Furthermore, some customers felt that *Pathways* Advisors were pressuring them to do tasks beyond their capabilities. It is not known how many of these were private *Pathways* Advisors (who receive bonuses for meeting targets) and how many were Jobcentre Plus *Pathways* Advisors.

5.2.7 Evaluating the effect of Pathways

Research with *Pathways* participants found that those who were already motivated to return to work gained the most from *Pathways* (Corden et al., 2005; Corden and Nice, 2006a). In addition, research with Jobcentre Plus Advisors found that staff found this group easier, and more rewarding, to work with (Dickens et al., 2004; Knight et al., 2005). Furthermore, Blyth's (2006:16) analysis of administrative data found that voluntary *Pathways* participants made a 'significant contribution' to job entries resulting from *Pathways*. Moreover, research with a group of mandatory claimants who had difficult health and personal circumstances found that the *Pathways* pilots made little difference to their desire to return to work. However, for the minority who felt able to return to work, the support could speed up the return to work process (Corden and Nice, 2006a).

In February 2006, as part of a welfare reform Green Paper, the Government announced its intention to reduce the numbers claiming IB from 2.7 million

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[31] The term 'customer' is retained in relation to the Citizen's Advice Bureau (CAB), as unlike being a 'customer' of Jobcentre Plus, claimants have some choice over whether to engage with the CAB's services.

to 1.7 million within a decade. The tool to enable such dramatic change was to be *Pathways to Work*. However, independent research carried out for Scope, a disability rights charity, and subsequently peer reviewed argued that the effect of *Pathways* within a decade would only have half of that effect unless specific attention was diverted to increasing employment opportunities in ex-industrial areas (Fothergill and Wilson, 2007).

In 2008, research to estimate the effectiveness of *Pathways* in the non-pilot areas was published by the DWP. It found that there was more off flow from IB in the early months following an initial claim, although this reduced over time, with no positive effect beyond ten months. In such cases, claimants were typically moved to Jobseekers' Allowance rather than returning to work (Bewley et al, 2008).

Research carried out by the Institute of Fiscal Studies for the DWP attempted to estimate the effect of the menu of choices two years after the initial *Pathways* interview, although there was some conflict between administrative data and claimants' accounts as to whether they had participated in a 'choice' and if so which 'choice' (Adam et al., 2009). It is possible that the already discussed pressure for staff to tick boxes may have resulted in some inaccurate official statistics. Furthermore, the complexity of *Pathways* and claimants' difficulties in understanding the scheme (Corden and Nice, 2006a) may result in inaccurate self-reporting. In addition, the authors acknowledge the impossibility of knowing if participating in a choice caused the change, or if that person was somehow different to those who did not participate in a way that cannot be seen through the available data. However, the research found that participating in one or more of the 'choices' activities increased the likelihood of subsequent employment by at least 6.4% in a matched pairs design (Adam et al., 2005:25). Furthermore, those who participated in a 'choices' programme, and subsequently went into work, earned on average an extra £14.80 gross per week. However, those who participated in choices were 5 percentage points *less* likely to leave IB within six months (p27), although

more likely to leave IB after 15 months. This research shows a tension between those who participate in *Pathways* being more likely to work, with higher incomes but also being more likely to remain on IB in the short term. Furthermore, the contradiction between the Adam et al. (2009) research and the Bewley et al. (2008) research shows the difficulty of knowing the impact of *Pathways* with any certainty.

Based upon a systematic review, Clayton et al. (2010) stated that *Pathways to Work*, like many other similar schemes aiming to increase the employability of benefit claimants, did have some positive effects. However, these are as a result of focusing upon claimants who are closest to returning to work, as influenced by high case loads and the need to meet targets.

5.2.8 Conclusion

The literature presented has shown a wide range of opinions from both Advisors and claimants who have participated in *Pathways to Work*. It can be seen that Advisors are able to use discretion in what 'choices' to recommend to claimants, although they are under pressure to meet targets. Claimants who chose to participate in any of the voluntary 'choices' were mainly those who wanted to move back into work. This group also tended to have more positive feelings about *Pathways*, which can be related to its perceived usefulness. The evaluations of *Pathways* show that claimants did not attribute any return to work successes to the scheme (Corden and Nice, 2006b), and that uptake of 'choices' that were available before IB claimants were subject to compulsory Jobcentre Plus interviews did not increase (Adam et al., 2008).

5.3 Results

5.3.1 Introduction

Within the second part of the chapter, data collected during interviews with Jobcentre Plus Advisors and IB claimants will be presented alongside data from observing compulsory WFIs. Data are presented from the claimants' initial experiences of trying to negotiate a complicated bureaucracy, through to experiences of WFIs. It will be shown that Advisors have considerable discretion within compulsory interviews, but this is constrained by the need to meet targets. The decision claimants make, regarding whether to participate in the voluntary aspects of *Pathways* will also be discussed in detail. The chapter will end by describing Advisors' views of claimants and claimants' views of Advisors.

A note of caution

When reading this chapter, it is essential to note that Rachel, who was highly engaged with *Pathways to Work*, was a voluntary participant who had chosen to participate in Work Focused Interviews as a result of it being timely for her to do so (Blyth, 2006, Corden and Nice, 2006b). As such, her views, which were quite different to the views of other, compulsory, participants, should be seen within this context.

5.3.2 First contact with JCP and 'medical boards'

Whilst interviewees were not asked to discuss the procedure surrounding their claim for benefits, six of the 21 claimants did so. These experiences were unanimously negative and left the interviewees feeling 'frustrated' (Sarah) and confused, as this extract from Paul's interview shows:

all I can say is that the benefit people I find irritating, on the phone, I pull my hair out with them, the benefit people, because they couldn't understand where I was coming from and when I'd fill a form in, they'd send it back because something minor, any common sense person would understand, they'd send it back...

Consequently, this time was fraught with anxiety, sometimes exacerbating health conditions.

In addition, difficulties with bureaucracy associated with claiming benefits led to problems. Rebecca was awarded £400 in tax credits to which she was not eligible and was left in the difficult position of trying to pay back the £400 from her IB. On the other hand, having claimed IB uneventfully for 13 years, one day Jo's IB stopped for reasons she did not understand. Having spoken to Jobcentre Plus, it appeared that Jo had not completed a form that she had not received. This resulted in Jo having to start a new claim for ESA (the successor to IB), causing considerable stress.

Regarding claiming other benefits, Brian had applied for a job driving buses for the local bus company. However, when he discussed this with 'the incapacity people', he was told that if he took the job, he would lose his entitlement to the mobility component of DLA. Brian lived in a rural area with poor public transport links and was only able to walk short distances. He stated: '(it) made me feel down in the dumps...It's very frustrating. If somebody said to me, I've got a job for you, nothing is going to happen with your Disability (Living Allowance), I'd be back (working).' As losing his car would make Brian virtually housebound, he decided to stop searching for work.

Furthermore, interviewees were not asked to give their experiences of the 'Personal Capability Assessment' (PCA), the way in which eligibility for IB was decided at the time of the research, although several chose to do so. In general, attending what was universally referred to as a 'medical board' or 'board', was seen as unpleasant, stripping claimants of their dignity. The

most harrowing story was that from Ben who suffered from diabetes and had been in and out of hospital, including stays in intensive care, over the previous year. Ben had 'failed' the PCA and was told to claim Jobseeker's Allowance instead. However, when Ben tried to do so, he was viewed as too ill to work, as he needed almost constant rest and had been told by his consultant that working could result in his death. As such, Ben spent nearly all of his redundancy pay from his previous job on living costs and, at the time of the interview, was concerned that he could lose his home as he was unable to pay the mortgage. Whilst Ben was too ill to fight the initial decision, another claimant Jacob, who was incapacitated by anxiety and panic attacks, failed the PCA and successfully appealed the decision. He explained that he was 'baffled' by the decision and sent a letter to the DWP explaining how he felt on a day to day basis. Consequently, Jacob was awarded 'extra points, whatever that means' and awarded IB. On the other hand, when Martin 'failed' his PCA after 10 years on IB, he did not appeal the decision, but started a new claim for ESA. He had not realised that keeping his original claim could have been advantageous, not only financially, but also in exempting him from compulsory work focused activity or a benefit sanction.

It is likely that these early negative experiences of administrative procedures and medical boards at least in part, resulted in the negative view that many claimants had of Jobcentre Plus. Whilst the Advisors saw themselves as separate from those who work on the phone lines, for claimants 'the Jobcentre' constitutes everything to do with their IB claim.

5.3.3 First Compulsory Work Focused Interview: the Advisors' perspectives

Whilst for staff the first compulsory interview was seen as distinct, in terms of completing a number of databases, claimants did not tend to distinguish between interviews, so their views will be presented in the next section.

Among all Advisors there was considerable consensus that the initial WFI was more about information gathering than anything else. The Advisors found it important to '(find) out a bit more about them, what they've done in the past, what are their plans for the future, or even do they have any plans for the future, some of them?' (Advisor 1, Area 2). In addition, it was seen as important to determine exactly what health conditions claimants had and their effects. Information gathering was facilitated by the Jobcentre Plus database. For those who had previously attended Jobcentre Plus, a record which was accessible by National Insurance number or date of birth, was held on the database. This included an enormous amount of information, including work history, benefits claimed and even information on the ages of any dependents. Throughout the observation period, claimants' electronic records were updated each time they attended a WFI.

For some Advisors, information gathering was the 'whole purpose' of the initial interview (Advisor 1, Area 1), and information about what support could be given was restricted to later interviews. Several Advisors consciously adopted this approach in order to ease the anxiety and nervousness of claimants. It was suggested that:

> The majority of people think: "Well I'm on the sick; the doctor has given me medical certificates. So why have I got to come into the job centre?" "What are they going to do for me?" So an awful lot of that time is spent with the Advisors to (say) "Actually, well, yes we do understand that"... and, yes, you do have to have a little understanding of the health condition, but the whole purpose of it is to get to know that customer and to see how you can move them on. (Advisor 2, area 2).

In addition to gathering information about the claimant, some Advisors spent considerable portions of early interviews dealing with benefit queries: 'I know it's not part of the (Advisor) role to check benefits or to discuss benefits but, at the end of the day, if that's the main concern of the customer... I feel you've got to get that out of the way before the customer can relax and give you more information.' (Advisor 1, area 1). It was agreed

by all interviewees that it was important to try to build some kind of rapport, or professional relationship with claimants during early interviews, and as such supporting claimants who were having difficulty claiming benefits was a necessary part of the Advisor's role.

The vast majority of Advisors had an hour to complete the initial interview, with the only exception being Advisor 1, area 1, who had recently had their interview times decreased to 40 minutes to cope with additional demand. In most cases, an hour was seen as an adequate amount of time for the interview. Furthermore, it was suggested that for some customers, an hour was too long for them to concentrate and/or feel comfortable. All interviewees suggested that as there were future occasions in which more information could be gathered, the initial interview could be 'relaxed' and 'informal' (Advisor 4, area 2) in order to put claimants at ease.

Whilst Advisors were clear that information gathering in the first interview was good practice, views were more divided other whether it was a good idea to give claimants information about what services and/or support might be available to them. Advisor 4, area 2 stated that 'really (the first interview is) for me to give them information and try to establish, you know, and try and understand where they are coming from as well.' The approach of not providing information about services was also considered most appropriate by the majority of the other interviewees with Advisor 1, area 1 stating that this helped to stop claimants feeling 'overwhelmed'.

On the other hand, three Advisors said that they gave information in the first session (Advisor 2 area 1, Advisor 1 area 2, Advisor 4 area 2), although a cautious approach was utilised:

> But I wouldn't push anything in the first session... unless (they) wanted to. If (the claimant) had something specific in mind, "right I want to do this", "I want to do that", then that would be fine... I try not to bombard them, because there are a lot of things out there that can help them (Advisor 2, area 1).

It can be seen that the Advisors were sensitive to the possibility of claimants feeling anxious or stressed about their mandatory interview. As such, Advisors attempted to make the interview as relaxed as possible. There was some debate about whether the first interview should only aim to gather information, or if it should also provide claimants with information. However, those who gave information in the initial interview were wary of not scaring claimants and used a careful approach, trying not to intimidate claimants.

5.3.4 Subsequent Compulsory Work Focused Interviews

Claimants' initial thoughts on attending WFIs

With the exception of Rachel, all attendees were mandatory. However, it is important to note that several of the unengaged group had not had to participate in *Pathways*, although they had been summoned to attend interviews at the Jobcentre with Incapacity Benefit Personal Advisors (IBPAs, referred to here as 'Advisors'). As such, the views of Gwyn, Martin, James and Ann, who did not take part in *Pathways* will still be included as their experiences did not appear to be different to those who were taking part in *Pathways*, and Advisors did not see *Pathways* interviews to be particularly different to other interviews they conducted.

Prior to attending a WFI, the vast majority of claimants were anxious, as the literature predicted (Corden et al., 2005; Corden and Nice, 2006a, 2006b). However, it is important to note here that those who were in the unengaged group were generally more anxious about having to attend. The unengaged group seemed more suspicious of the possible motivations for Work Focused Interviews, with Martin believing that Advisors will 'tell' him what work he is able to do. Furthermore, the unengaged group described more negative previous experiences with the Jobcentre in its various guises over their lifetimes. As already mentioned, unlike Advisors, claimants did not distinctly recall their first interview as opposed to subsequent interviews.

This is a contrast to the first two official evaluation studies (Cordent et al., 2005; Corden and Nice, 2006a).

Advisors' use of the 'menu of choices'

Advisors were asked which activity on the 'menu of choices' they preferred or used most often. Throughout the interviews, it was clear that Advisors knew the menu of choices well, unlike in early research (Knight et al., 2005). Their knowledge may have been as a result of the Advisors having extensive experience of working in administering benefits. Furthermore, it was clear that Advisors were aware that, despite Government's claim that IB claimants are now inundated by choice, as evidenced by policy documents and leaflets targeted at claimants, little had changed in practice. This acknowledges the presence of schemes like work preparation that were previously available (Blyth, 2006). Moreover, Advisor 1, area 1, pointed out that when Advisors are conducting JSA interviews, they are able to offer everything apart from the Return to Work Credit to claimants, thus *Pathways* cannot be seen to be a specialist approach tailored for IB claimants.

In addition to failing to see *Pathways* as radical and innovative, two of the Advisors in particular also described courses which they access that are not part of *Pathways*. Advisor 3, area 2 accessed many courses that were specific to an individual's disability, such as the Royal National Institute for the Blind's residential courses in Hereford. Alternatively, Advisor 5 area 1 used more local courses, including a two week introductory IT, care or retail course. However, the Advisor no longer had a confidence building course or a building course to offer claimants. Other Advisors would refer claimants to specialist support groups of which they were aware that may deal with, for example, 'mental health issues or drug addiction' (Advisor 2, area 1). The use of non-*Pathways* services cannot always be made to count towards an Advisor's targets. Alternative approaches were used by

185

Lydia[32] widely during the fieldwork, including referrals to a local Further Education college and a referral to a local charity that supported women with depression. However, during these interviews, Lydia had to report 'no positive action' on the claimant's official record which contributed to her targets, as they were not part of *Pathways*.

When Advisors described their approach to giving claimants the menu of choices, Advisor 1, area 2, stated:

> what I would say is I do have the choices package and what I do is say look this is what we've got and actually go through them but if there was a trigger that I had from the individual I would highlight the one that seemed to be the most appropriate for that person...

The other Advisors, however, tended to adopt a more pragmatic approach straightaway. For example claimants who were seen as anxious, depressed or in pain were told about CMP; those who wanted to change career were given information about work preparation. This may be seen as disempowering claimant choice, however, throughout the observation period, several claimants remarked about the high levels of 'paper work' that had been given to them and how that was overwhelming. Furthermore, as it is well known that many benefit claimants are confused by the complexity of the benefit system and anxious about attending interviews, Advisors rationalised that it may be easier for some claimants not to have to understand each part of *Pathways* but to choose the most appropriate 'choice', if any, for them within the 40 minute interview. In addition, the official evaluation of *Pathways* found that claimants were positive about the bespoke nature of the support they were offered (Corden et al., 2005; Corden and Nice, 2006a).

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[32] It should be noted that Lydia is the pseudonym of the Advisor who was observed carrying out Work Focused Interviews.

Whatever approach was utilised in discussing *Pathways*, all Advisors stated that claimants were given time to decide if they would like to participate in the proposed scheme. Advisor 1 area 2 stated that they would provide claimants with information, both in terms of discussing their options during the interview and then, wherever possible, providing literature for claimants to take away with them. The Advisor would then 'follow up' in the next interview, once the claimant had had time to think about the proposed plan of action. This practice should alleviate some of the possible feelings of pressure to participate that have been reported by some claimants (Corden and Nice, 2006a).

Having discussed the 'menu of choices', all Advisors stated that a plan of action would then be written, as indicated by the *Pathways to Work* policy. Previous research showed that many claimants did not recall this, and this finding was mirrored during interviews with claimants (Corden et al., 2005). However, what became clear during the observation of one Advisor was that when the Action Plan was being composed on the computer, it was agreed to by claimants, and sometimes largely composed through them dictating, but the Advisor did not refer to it as an 'Action Plan' at any time. Furthermore, in four of the ten CMP case files, there was a copy of the Action Plan (although this is not part of the referral process and was not included by all Advisors when referring a claimant), showing that they were more common than claimants recalled.

According to the official documents, by attending the interview and agreeing to an Action Plan, claimants have fulfilled their duties as far as *Pathways* is concerned. However, there is an inherent tension as Advisors have targets to meet in terms of participation in parts of Work Focused Support offered by *Pathways*. In addition, some Advisors felt that if claimants were going to reject Work Focused Support, it should be an active choice:

> I do my best not to actually let somebody do nothing. I feel would that it doesn't matter if it's voluntary work, if it's the fact they read the leaflets and it's their choice

not to do it, I don't mind as long as their actually being pro-active and actually thinking about the best way to move themselves forward... (Advisor 1, Area 1).

Aside from the need to have six WFIs, to compose an Action Plan and to be 'productive' in the majority of those, Advisors had a considerable amount of flexibility. Such discretion was viewed positively and seen as essential to provide claimants with a service that would benefit them. Advisor 2, area 1, stated: 'you can't use just one particular ('choice')... There's a lot more (that can be) done and we're sure to bring what's best for the customer.'

Although all of the Advisors thought that it was necessary to have full discretion, the question, 'In terms of the interventions and things that you might offer to people, is there any one that you tend to use most often or one that is most successful?' was asked of all interviewees. One of the Advisors did not suggest a preferred option (Advisor 2, area 1). Of the others, CMP was the most used by Advisor 1, area 2, and was highly praised several times throughout the interview by Advisor 5, area 1. For example:

> I love CMP. I love the programme, if it was open to staff, I would be the first one there. I absolutely love CMP, I think it is the best thing ever been thought of, whoever thought of that programme deserves a pat on the back.

Furthermore, Advisor 5, area 1, also described herself as a 'big fan' of Work Preparation, which was also described as one of the most used of the services by: Advisor 3, area 1; Advisor 3, area 2; Advisor 4, area 2; Advisor 2, area 2:

> The Work Preparation Programme is excellent, providing that you have got the employers that are willing to give the work placement... it's very gentle; it's whatever the customer thinks they are able to do. It might even start off as just two hours a week and then hopefully build up on that. That is a very good programme, I feel because they are not pressurised.

Advisor 1, area 1, was torn between Work Preparation and CMP as their favourite programme. However, whilst work preparation was the most used service by four of the Advisors, three described difficulties in the current system of finding placements. This task was outsourced to a variety of private and third sector job brokers, although in some areas there was limited choice so for a claimant who was suffering from, for example depression, there may not be any choice of broker. Advisor 4, area 2, suggested that it was necessary to 'try and keep a tight control over' the placement the broker was going to find in order to ensure 'the placement is found quickly... but it also has to be the right type of placement...'. In addition, Advisor 2, area 2, suggests that claimants can get 'lost' in a broker's heavy workload. A more critical account is given by Advisor 5, area 1, in relation to the type of placement found:

> The issues have mainly been that providers will try and change the work placement that we have asked for because we have asked them for a factory placement, and this has happened to me recently, but they know they can get this person into a care home, well, I'm sorry, that's not going along the lines of what the customer has asked for and I have had customers who have been influenced to change their options, I particularly don't like that.

The Advisor also stated that sometimes brokers do not address the specific goals that they have asked for within a placement:

> I have had a provider recently where (the goals) were not addressed. I asked him to address the length of, the ideal length of time that it would be ideal for this lady to work because she has got a spinal problem. She used to do care work, we are trying to look at clerical work, but I need really to have guidance about how many hours she could work because this is not an area she has worked in before, but he just totally didn't answer that one. I have asked for them to do CVs and they have not done the CVs, you know that type of thing? ...I think we don't do enough to complain actually... When they are good, they can be very, very good, but when they are bad, they are not so good.

The variation in quality was seen as difficult to address, as, often, claimants do not feel confident to complain, as such, Advisor 2, area 1, stated that

they inform their claimants that they should keep in touch during the placement, particularly if there are any difficulties.

Advisor 2, area 2, was concerned that claimants were 'spoon fed a lot', as a result they stated that they gave 'homework' to their claimants as 'they are capable adults, most of them'. It was hoped that this approach would help claimants to build their confidence as the Advisor thought that most of the claimants had simply got 'out of the habit of doing things' for themselves.

Targets

Within their day to day roles, targets have become a normal part of all of the Advisors' jobs. After each interview, the details of that interview are recorded using the 'Advisor tool', a computer programme with a database for each claimant. During the observation period, Lydia showed me how to use the tool, and described it as simple to use. The tool consists of a selection of 'positive outcomes' that can be ticked by the Advisor. These can include 'job submissions, there has got to be a certain percentage of job submissions, there has got to be a certain percentage of back to work calculations' (Advisor 2, area 2) or 'I can tell them about *Want to Work* in one, then it's up to them if they self refer. I could do a benefit calculation in another, but then I've got four more interviews to try and fill' (Advisor 5, area 1). In addition to these, all Advisors are monitored on their 'Failure to Attend' rate, which tends to be higher with IB claimants than JSA claimants, and the 'Job Outcome Target', that is somebody entering work for more than 16 hours a week and paying income tax. The office in which Advisor 3, area 1, primarily works has been set the job outcome target of '40 claimants with disabilities' for the year, which was seen as achievable: 'there is never a problem normally with the figures going into work.'

Although Advisor 3, area 1, found this target achievable, two of the other Advisors felt pressured by the targets. Advisor 1, area 2, described how the 'job has really changed, it does seem to be a lot more target driven'. On the

other hand, Advisor 5, area 1, often felt 'worried' about achieving targets and tried to 'catch up' if she had had an unproductive interview: 'I constantly check (the Advisor tool). And that's what they want, daft buggers like me to worry my socks off about it!' On the other hand, Advisor 2, area 2, had a somewhat defiant stance towards the targets:

> I am not going to sub to a job (submission) just because I know I am two or three down, I don't even know, I don't mean that, I don't know how many I'm supposed to be doing, but I don't get hung up on the fact that I had better do a few more back to work calculations, because if it is not relevant to the person I have got in front of me at that time, I just don't do it, if it is relevant, I'll do it.

Advisor 1, area 2, agreed with the idea that it was not always 'appropriate' to do something productive within an interview, and particularly in a first interview when it was seen that 'the person can't even think at the moment what they're going to do, let alone think of having to get this much money when I get back to work, if it's not appropriate I don't do it.' Furthermore, Advisor 4, area 2, found it frustrating that the Advisor tool mainly takes in to account 'contracting provision' and, as such, does not consider local knowledge and searching for self help provision. However, the Advisor stated that their manager was aware of the difficulty of being 'productive', and, to an extent, was supportive if they had not managed to meet their targets.

Three of the other Advisors suggested that as long as they could justify why they had not been productive, their managers would support them so that they would not experience negative consequences if targets were not met (Advisor 5, area 1; Advisors 2 and 3, area 2). Furthermore Advisor 2, area 1 and Advisor 2, area 2 stated that there were no negative consequences unless targets were consistently missed. However, it should not be assumed that such managerial support happened automatically (Barnes and Hudson, 2006), and as such the experiences reported here should not be seen as generalisable. It was suggested by Advisor 3, area 1, that the consequence of consistently missing targets was likely to be e-learning and

that the Advisor was aware of some colleagues who had already been subjected to this 'punishment'.

Whilst Advisors were asked about their own behaviour, several chose to describe the practices of other Advisors; some Advisors, not known personally to the Advisors, were described as 'just play(ing) the system as it's supposed to be, they do what is required whether they think it's right or wrong. They'll tick the boxes, perhaps they'll tick the boxes and not have done exactly what their supposed to do' by Advisor 1, area 1, who saw this as not being in the best interest of the claimants. On the other hand, Advisor 2, area 2, stated that they did not know any Advisors personally who performed in that way but believed that some people did. Whilst these comments described the negative practices of some other Advisors, Advisor 4, area 2, pointed out that some Advisors do not have supportive managers and may be under more pressure to achieve targets. Finally, Advisor 5, area 1, described the contrast between the approach adopted by themselves and several other Advisors in the area, who did not take part in the research:

> (Advisor A) in (small office) doesn't worry about them, but I do, me and (Lone Parent Advisor), we're constantly checking the Personal Advisor tool. (Advisor B) won't look at it, she says she won't be ruled by targets, but we just can't help it, I constantly check it...

The Advisor continued to describe Advisor A's behaviour: Advisor A was consistently the worst performer regarding targets, however Advisor 5, area 1, described the Advisor as 'a bloody good Advisor'. However, because of the poor performance regarding the Advisor tool, Advisor A's manager was 'being told off about it and having to come up with action plans to try to make (the Advisor) perform better.' This caused Advisor 5, area 1, to be worried that they 'might cause hassle for my boss' and that 'an action plan' would be put in place if targets were missed to 'improve my performance'.

192

However, whilst interviewees discussed their targets, three Advisors also mentioned targets that they were not subjected to. Advisors 2 and 5, from area 1, described occasions where they felt that their claimants had developed considerably in confidence, but:

> There's no tape measure if you want to say well you started here and going on these indicators this is where you are now. It's personal recognition from the Advisor to the customer and see how well they've moved on. (Advisor 2 area 1).

Furthermore, Advisor 2, area 2, stated

> In the 'first interview, I might not refer them anywhere, it's just an information session which I do have to tick then 'no positive outcome', yet that person has walked out of an hour's interview feeling great. They go away and think about it and then they come back. Yet, my first interview, one of that five in my day there's no positive outcome...

It can be seen that the use of targets within Jobcentre Plus was considered controversial by Advisors. Whilst some Advisors were concerned about meeting targets, others reported that they make a conscious decision not to be influenced by the targets imposed upon them. Furthermore, it is clear that all Advisors held the belief that meeting targets was not a clear indicator of being a 'good Advisor'. Being a 'good Advisor' required acting in the best interests of the claimant and could sometimes contrast with a behaviour that should be carried out to meet a target.

Claimants' participation in Work Focused Activity

All of the engaged claimants had agreed to participate in the CMP during their Work Focused Interviews. Of the ten IB claimants, only Dai and Rebecca did not talk about how they were referred to CMP during their interview. Of the remaining eight, two interviewees were reluctant to participate. Joanne thought that she did not need the support of CMP and Catherine was unsure, so sought guidance from her GP, who suggested

193

that anything that could boost her confidence would be worth trying. Neither felt pressured to participate, which Catherine saw as instrumental in her decision to 'try' CMP.

At the opposite end of the spectrum, Rachel and Jacob were very keen to try anything in order to hasten their return to work. This is consistent with other research on uptake of 'choices' (Corden et al., 2005; Corden and Nice, 2006a). When Rachel voluntarily attended a WFI, four years after beginning to claim IB, she was thinking to herself "now come on, you've got to get yourself out of this", and decided to take up any opportunity offered. Likewise, after Jacob's failed return to work, his Advisor decided that Jacob did not need to attend a further five compulsory WFIs. At this point, Jacob asked "'Is there anyone that I could see here or do you do anything...?" And (the Advisor) said "oh, we do...there's an NHS thing now", she said, so she explained it to me, she said it's up to you, you don't have to go for it...' Jacob, by asking for further support to try to foster a return to work when he had the option of being exempt from *Pathways* showed his determination to return to work (Corden et al., 2005).

It would be easy to criticise Jacob's Advisor for deciding to waive his requirement for further interviews, which would not have been an easy decision for the Advisor. During the initial pilots, Advisors had the discretion to waive interviews based upon their own decision, but this was much more difficult at the time of the research, and required a manger's agreement. Furthermore, as a result of the severity of Jacob's anxiety, resulting in frequent panic attacks, it can be seen as an empathetic decision aimed at making his life easier.

The way in which claimants remembered Advisors conveying CMP appeared to differ, although it cannot be known if this is due to differences in Advisors or in claimants. Unfortunately, Emma and Joanne, who had recently both had close family members die, left the Jobcentre Plus office believing that they would have some form of bereavement counselling from

194

the CMP. Although Joanne found it useful to have the grieving process explained to her, both felt disappointed with the service that they had received as it was not what they had expected. On the other hand, both Joanne and Paul appreciated that their Advisor 'realised there was something wrong with me' (Paul) and suggested CMP to them, which they viewed as a valuable resource. Thus, whilst Joanne and Paul did not see themselves as close to the labour market, they both thought CMP could benefit them, which was also found by large-scale quantitative research conducted by Blyth (2006).

Of the unengaged group, only three took up any support included within the *Pathways* umbrella, including Jo, who participated in CMP[33]. Mark, who had been off work for a short time with depression decided, in a similar fashion to Rachel, that it was time to go back to work, which shows the importance of timing in IB off flows (Corden and Nice, 2006b). Mark found a job using his own contacts, one of whom told him about the Return to Work Credit. In order to be eligible, Mark had to make an appointment with his Advisor who referred him to a job broker, a situation which Mark found 'ridiculous' as he had already found a job. Although he was pleased to be in receipt of the additional money, Mark did not know about the Credit before deciding to return to work and would not have received it if a friend had not told him about the scheme. This situation is not unique to Mark, reducing any effectiveness the Credit has in promoting a return to work (Corden and Nice, 2006a; 2006b).

The other unengaged claimant to undertake some Work Focused Activity was Rowena, who worked part time under 'permitted work rules'. Being unable to read and write, Rowena was given considerable support by her Advisor to find a part time cleaning job. In addition, support was also given in terms of completing paperwork related to claiming IB. However, Rowena was subsequently removed from IB. She stated 'I don't know what's gone

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[33] Jo's experiences were covered in the prologue to the thesis.

wrong' and had been unable to contact her Advisor. Rowena had only been working for nine months, so should not have come to the end of her permitted work period (which is up to 12 months). As a result of such confusion, Rowena decided to immediately resign from her job, which she described as 'a shame' as she had liked her employer and was able to cope with the job. She then instigated an appeal against the decision with the help of the Citizens Advice Bureau.

Sanctions

When a claimant 'Failed to Attend' an interview without contacting the Jobcentre Plus Office, the Advisor often attempted to contact the claimant by telephone where a number has been provided (Dickens et al., 2004). If the claimant had an answer-phone facility, the Advisor may leave a message similar to the one below:

> Hi there, this is Lydia from the Job Centre. You were due to pop in to see me today at two, I'm sorry that you couldn't make it. It's really important that you do come in for these interviews because if you don't, your benefits can be stopped. Could you please give me a ring to arrange a more convenient time for you to come in. My direct line is (phone number). Thanks again. (Failure to attend first WFI)

If telephone contact could not be established, a 'five day letter' (Advisor 5, area 1) would be sent out, these were 'to the point' (Advisor 2, area 1), advising claimants that they have to attend interviews or their benefit 'will' (Advisor 2, area 1) be sanctioned and asking claimants to contact the JC within five days to prevent a sanction occurring. Advisor 5, area 1, stated that 'the majority' of claimants got in touch once they received such a letter. However, some claimants did not respond and their details were sent to a central sanctioning unit to begin the process of cutting benefits. The centralisation of sanctioning can be seen as the removal of a layer of Advisor discretion. This may, to some extent, shelter Advisors from the reality of a sanction.

Among interviewees, a considerable range in the amount of sanctioning was described. Of the five Advisors who quantified their use, Advisors 1 and 3, area 2, had only ever completed one sanction. On the other hand, Advisors 2 and 5, in area 1, tended on average to use one sanction a month and Advisor 1, area 1, used around 'one or two each week'. Such usage was seen as 'unavoidable sometimes' (Advisor 1 area 1) by all Advisors in area 1 in order to ensure claimants attended interviews. Furthermore, Advisor A (who was mentioned earlier), who worked in an office in area 1 that was not included in the research, was reported by two interviewees to use more sanctions than other Advisors in the area because otherwise customers would not attend interviews. This situation was reported to be particular to the office rather than to the Advisor as when Advisor 3, area 1, had covered that office in the past, they had also increased their use of sanctions. Such differential behaviour between offices cannot be accounted for with reference to the guidance Advisors have to follow. Consequently, it can be seen that where there is room for decisions to be made at a local managerial level, as described by Hunter (2007) in relation to the NHS, this can account for intra-office variation.

When interviewees were asked if their level of sanctioning was similar to their colleagues, it became clear that there was a higher rate of sanctioning reported in area 1 than in area 2. Advisor 2, area 2, stated that other Advisors were reluctant to use sanctions. In addition, the other Advisors in area 2 were described as 'sympathetic' by Advisor 4, area 2. On the other hand, within area 1, some Advisors were perceived to be sanctioning more than Advisor 5, area 1, who sanctioned on average once a month. On the other hand, Advisor 1, area 1, the highest self-reported user of sanctions, stated that their use was 'similar' to other Advisors.

Although there was a difference in the amount of sanctions used between the two research areas, all interviewees were in agreement that sanctions

were sometimes necessary to persuade people to attend interviews, where they would be given support.

None of the 21 IB claimants who took part in interviews were aware that their benefits had been sanctioned at any point, although research shows that sometimes claimants are not aware that their benefits have been sanctioned due to the complexity of the system (Barnes and Hudson, 2006).

Whilst the literature did not discuss the introduction of 'partner interviews', one was observed. Also, it was noted that several partners 'failed to attend' during the observation period. Lydia explained to me that many families within her area have two adults, one of whom will claim a benefit, such as IB, whilst the other is economically inactive and not claiming any benefits. An extension of compulsory interviews for claimants means that a claimant's benefit could be sanctioned if their partner fails to attend a Work Focused Interview. Lydia showed me the computer record of the partner who was due to attend a WFI but did not attend. He had previously claimed both IB and Job Seekers Allowance (JSA), having been made redundant from a local factory where he was a forklift driver some years previously. His partner, who Lydia had also interviewed, had begun her claim for IB when her partner's JSA was stopped. Lydia reported that this situation was common and that she thought the Government was hoping to 'stamp it out' by introducing such compulsory interviews.

5.3.5 Discretion and Advisors' identities

As can be seen in the above sections relating to Advisors' reported behaviour during semi-structured interviews and their behaviour during the observation period, Advisors were able to exercise discretion in many ways, despite the considerable amount of guidance and procedures they were required to follow. This use of discretion can be seen in relation to their use of the menu of choices, targets and sanctions.

Whilst it was noted in chapter two that Advisors were less likely to be provided with the label of being 'professionals', as a result of their lack of formal training and a specific body to represent their interests, it can be seen that the Advisors in this research considered themselves to be experts, whose embedded knowledge, experience and skills would not make them some easily interchangeable administrative unit. For example, a wide range of training initiatives open to claimants as part of Pathways to Work and outside the programme, and the loop holes required to provide funding for such training, were confidently described. This may be as a result of the longevity in post for the Advisors in this research, as previous research has shown Advisors were not always so confident in negotiating the plethora of Pathways to Work options available (Nice and Davidson, 2007), let alone additional provision for claimants with specialist needs. In light of such claims to being experts in their field, some Advisors felt that they were able to reject guidance that went against their concept of how they should be performing their role within the setting in question. For example, Advisor 3, Area 2 felt strongly that they would not 'tick boxes' in order to meet targets. The stated rationale behind such behaviour was the desire to provide claimants with the most suitable advice or intervention (see Broadhurst et al., 2010b). This could include a very gentle touch approach with claimants who appeared very nervous about the aims behind Pathways to Work. It was suggested that this would enable claimants to understand that the Advisors were not going to force claimants into work. However, such behaviour also conferred the advantage of keeping claimants engaged with Pathways to Work, which was also in Advisors long-term best interests, in order to meet targets in the future.

In relation to their policing function, imposing sanctions on claimants, Advisors discussed a variety of strategies. In some areas, the use of sanctions was very rare, and applied only to those who were impossible to reach through other means. On the other hand, in other areas, the use of sanctions was more usual with approximately one a week reported.

Advisors were keen to relate their sanctioning behaviour to that of their colleagues, normalising their level of sanctioning, regardless of the level of sanctions applied. Throughout interviews, Advisors rarely reported any negative feelings towards claimants, showing that they were uncomfortable with the moral dimension involved within their work, despite previous research showing that those performing a similar role had negative opinions of claimants (Foster and Hoggett, 1999; Kingfisher, 1998). This will be discussed further in section 5.3.7.

Within previous research, the caring function of Advisors was largely neglected (Wright, 2003). However, it can be seen from this research that Advisors felt that they had good relationships with the majority of their claimants and were able to support many in a way that Advisors felt improved their lives. For example, Advisor 3, Area 2 reported how a young deaf claimant who had previously felt isolated and had been led to believe that she would be unable to work by her family was able to access a residential course for young deaf people that had enabled her to start considering undertaking further studies with a view to seeking employment. Likewise, it was seen within the observation period that Lydia had an excellent relationship with many of her claimants. This was expressed through claimants telephoning her for advice on a range of employment or benefit related issues, and claimants 'popping in' outside of their mandated appointments to provide Lydia with information, such as when they had been selected to attend an interview or if they had gained employment. These examples of when Advisors felt that they had been able to make a positive difference in the lives of claimants were felt to be highly rewarding, and can be seen as contributing to high levels of job satisfaction among Advisors (Johnson and Fidler, 2008).

Whilst the social workers in Broadhurst et al.'s (2010a) study felt that the ICT system available to them was a hindrance to carrying out their duties, there was no such disquiet among Advisors. This may have been as a

result of their differing job roles: Advisors were desk-based at all times and completed computerised records during interviews, rather than after interviews. Furthermore, the need to keep detailed records has always existed within the previous incarnations of Jobcentre Plus, and the use of computerised systems was seen as preferable to the paper based system, where records could be lost. Accordingly, Advisors barely acknowledged their use of ICT, and did not view the use of ICT per se as enabling managers to keep their work under surveillance. However, the use of a computerised system which linked (paper based) referrals to Pathways to Work interventions did minimise opportunities for 'workarounds' (Pithouse et al, 2009): if a form was not completed to refer a claimant to an intervention, Advisors could not claim to have referred a claimant. On the other hand, as a few of the 'positive actions' did not require Advisor to complete a form, it was possible that Advisors could say that they had undertaken the positive action without having done so, in order to perform a 'workaround' to meet targets, although none said that they did so. This may have been as a result of some Advisors stating, somewhat defiantly, that they would miss their targets if it was in the best interests of the claimants. Furthermore, among Advisors who were worried about missing targets, all reported supportive managers who would defend Advisors against any negative recriminations of missing targets. However, if Advisors are to be subject to further targeting in the future, as is likely in the climate of increasing regulation of public sector workers, it is possible that, in order to meet workloads with limited resources, workaounds may increase (Lipsky, 1981).

5.3.6 Claimants' views of Advisors

Claimants were not specifically asked about their views of staff but, as part of anecdotal accounts, over half described their Advisor in some way. As may be expected, the engaged group of claimants had more positive feelings towards their Advisors than the unengaged group. When discussing their experiences of WFIs, five of the engaged claimants

discussed their views, with three being overwhelmingly positive and two conflicted. Emma, who attended the Jobcentre Plus in area 1, stated, 'I'm really pleased with the woman in the Jobcentre, she's really lovely and really helpful...', however this conflicts with Emma's feeling that she was misled about the content of CMP by her Advisor. Likewise, Paul (area 2) states 'the woman who I seen, I like her a lot...she was lovely, but she was just going through the criteria, you know...'. Later in the interview, Paul showed his 'frustration' as he felt that his Advisor did not listen to him: he felt that he constantly has to reiterate that he has a job to go back to and felt that he would be fit to return one day. However, towards the end of the interview Paul sums up '(the Advisor) was fantastic, she saw something wrong and then got me involved with (CMP). She's been great, so I can't fault her in the job centre, she was good.'

On the other hand, the unengaged group gave a much more conflicted picture of their Advisors, describing 'nice' people, carrying out a role that was not always seen as claimant-centred. Mark, who had returned to work of his own accord, suggested that his Advisor was 'fine, just a job centre bod...'. This was the most positive statement made by any of the unengaged group. Of the other four people to describe their Advisor, three had conflicting opinions, with the remaining being entirely negative.

Jo, Rowena and Nicola all described their Advisor positively 'a very nice girl...no complaints about her' (Jo). However, when they were describing their experiences more fully, conflicting statements can be seen; Jo felt that she was 'pressured' into attending CMP as the alternative was to lose her entitlement to IB. Likewise, Rowena was removed from IB for possibly breaching the permitted work rules but did not understand that this would happen and felt let down by her Advisor. Finally, Nicola was offered support by her Advisor to find child care when she was offered a part time job in a nursing home. However, her Advisor did not help her and she felt unable to look for suitable child care herself so rejected the job offer. Regarding her

Advisor, Nicola remarked, 'They say that they do all of this, they say that they'll help you do this, but they don't. It's quite crap really.'

Whilst these conflicting views show that the Advisor was viewed positively as a person, for being friendly and appearing helpful, it shows that the claimants were still confused and frightened by the benefit system. In addition, it could be argued that as Nicola was not psychologically able to arrange for child care, she was not ready to return to work. An alternative, more hostile, view of Jobcentre Plus Advisors came from Michelle. Michelle had not had her first WFI for her current claim for ESA, although she had claimed IB within the last year. For Michelle, a typical member of Jobcentre Plus staff is described as 'somebody who probably hasn't even got a flipping GCSE in English...some jobs worth who hasn't got a clue probably what even, you know, depression is, or schizophrenia... or having a bad back is like...'.

It appears that whilst some of the engaged group held loosely positive views of Jobcentre Plus Advisors, the same was not true for the unengaged group. This is in contrast to previous research conducted on behalf of the DWP which found mainly positive accounts of Advisors (Corden et al., 2005; Corden and Nice, 2006b).

5.3.7 Advisors' views of claimants

The Advisors spent very little time discussing their view of claimants; anecdotes were given, but with little description of claimants beyond their health condition(s) or work histories. Occasionally, levels of engagement were described; turning up for interviews on time and being prepared to engage with Advisors' suggestions was seen as very positive (although by no means to be expected). Claimants who were seen as 'good', in some way, were also described positively. For example, a young man with hearing difficulties was described as, 'A brilliant young chap...' (Advisor 3, area 1), because of his determination. Likewise, Lydia went out of her way

to ensure that claimants who were naive regarding the benefits system were not disadvantaged. An interview with a young woman with many different health conditions, who was moving into work was observed. It was clear that the Advisor obviously had a good relationship with the claimant. Afterwards the Advisor remarked 'She never asks for anything'. During another day's observation, the same young lady attended a voluntary appointment and the Advisor offered her travelling expenses, paid for by the Advisor Discretion Fund, for a training course she had to attend in order to begin her new job.

Thus, it can be seen that Advisors can and do identify claimants who are 'a pleasure to work with' (Advisor 5, area 1), even though Advisors are much less comfortable describing those who are not. This concept of good claimants, who are then offered additional support, can be related to the concept of deservingness, which is not necessarily related to the severity of a claimant's health condition.

On the other hand, sometimes claimants were seen as difficult to help. For example, many claimants with drug and alcohol problems were seen as being unable to make progress towards returning to work whilst their addiction was still out of their control (Advisor 5, area 1; Advisor 3, area 2) and as such were seen as 'a waste of my time' by Advisor 3, area 2. Furthermore, such claimants could be regarded as unreliable even if they did agree to attempt to participate in *Pathways*. For example, one of Advisor 5, area 1's claimants had agreed to participate in a Work Preparation placement with a recovering alcoholic who had a successful gardening business. The employer was seen as attempting to 'give something back by employing people who are struggling' to give them a chance. When meeting the employer, the claimant was rude and drunk and said that 'he didn't want the fucking job.' The Advisor was obviously annoyed when recounting the anecdote. However, Advisor 5, area 1, described one claimant, an alcoholic, who was 'really trying' who always insisted on seeing her as early in the day as possible because 'I haven't had

a drink'. The Advisor commented that he comes in a complete mess; shaking and sweat pouring off him but he always turns up on time, usually early. These cases, and the lack of provision to refer them to ('well, you couldn't send them to CMP, could you?') really frustrated the Advisor.

An alternative claimant group who were regarded as harder to help were those with communication difficulties. The half hour time slot was insufficient time for interviewing claimants with speech difficulties or those who needed the services of a translator (Advisor 3, area 2). This was not mentioned by any of the other Advisors or by the literature.

A final group who were identified as difficult to help were pregnant women, due to their temporary condition, it was felt that they were not worth the investment of effort. Throughout the course of the observation period, two pregnant women attended WFIs. When carrying out an initial WFI with one of them, Lydia asked if her health condition was only related to her pregnancy. When she replied that it was, Lydia stated 'Then of course once you've had the baby, you'll be going on to Income Support, and then you'll see (Lone Parent Advisor).' After the interview, Lydia described how, in area 1 as a whole, pregnancy is a route on to IB for women who do not have secure employment. Lydia felt uneasy about the situation, but accepted it as necessary within the local economy: 'we both know they're not really sick, but she's too early for her maternity pay and who on earth is going to employ someone who's five months pregnant? '

Considering the evidence from the previous chapter where a pregnancy had led to Ann spending two decades on IB, Lydia's approach of attempting to prepare claimants to move on to a more appropriate benefit after the birth can be seen as appropriate. However, it is not known in practice if this would occur once a claimant has given birth if she had already passed her medical assessment and attended all of her compulsory WFIs before the birth. The failure of the social security system to protect pregnant women who are working in insecure jobs or are unemployed has resulted in IB

being used for a purpose that it was not designed for. It is not known if the situation was similar within area 2, as interviews with the Advisors in the area took place before the observation period.

The Advisors made few explicitly moral judgements about claimants. Sometimes, when a claimant could not see that the Advisor was attempting to help them, they experienced frustration (all Advisors except Advisor 3 area 1), but many claimants were seen as motivated, which balanced these cases. Ultimately, Advisors seemed to believe, 'Some people want as much help as we can possibly give them and other people, no matter what their circumstances are, don't want any help from us at all, they are quite happy to stay on their benefits' (Advisor 5, area 1).

This reluctance to make moral judgements can be seen as more telling than making a negative comment about the claimant. I believe that in not making these judgements, Advisors were trying to show their objectivity, when it was highly unlikely that they are able to perform the Advisor role in an objective way. In practice, the discretion required to perform their role appropriately requires judgements to be made about claimants on a frequent basis. This, however, does not mean that Advisors feel comfortable openly discussing this difficult area of their work.

5.4 Conclusion

The chapter has reviewed the literature relating to participation in compulsory Work Focused Interviews, which mostly comprised of DWP Research Reports. It can be seen that Advisors had a range of 'choices' available to them and discretion in how they conduct WFIs. Claimants, however, were often nervous of attending such interviews fearing negative consequences. For those who felt that work was not realistic with their health condition, *Pathways* had few positive effects. However, for those who wish to return to work, *Pathways* could provide relevant support.

The second part of the chapter presented the data collected alongside comparison with the literature. It can be shown that whilst Advisors had many options open to them within *Pathways to Work*, they were under pressure to meet targets, which they did not feel were always in the claimant's best interest. The claimants who chose to participate in some voluntary return to work activity described their experiences, which were mostly positive. For the two unengaged claimants who did so, their experiences were not positive. Furthermore, Mark's decision to return to work was not facilitated by *Pathways* at all, although within Government statistics, he would show up as a success.

The next chapter will move on to look at a voluntary work focused activity, the Condition Management Programme (CMP), in which all 10 engaged claimants and one unengaged claimant, Jo, participated in. Jo's experiences, however, will not be presented within the chapter and can be seen in the prologue to the thesis.

Chapter 6: The Condition Management Programme

6.1 Introduction

The final empirical chapter provides an overview of the Condition Management Programme in its entirety, comprising a review of the available literature and a section containing research data and a discussion of the results' relationship to the literature. The first section will take the reader through the small amount of previous research carried out on the Condition Management Programme (CMP). The literature will be divided into how CMPs are designed by managers and clinical teams within a 'Memorandum of Understanding', and how CMPs are negotiated with the Department for Work and Pensions (DWP). Key areas of programme design will be discussed including: which staff to employ; which interventions to offer; and the location in which to deliver such interventions. The review will then describe the process of attending the CMP, including the initial assessment, why some claimants who attend assessments are rejected by the CMP and length of participation. Literature relating to engagement and outcomes will then be outlined, showing that some participants engage because they do not know that CMP is voluntary, but that for those who are not convinced of the value of CMP attendance, a more gentle approach by Advisors could also result in participation. Positive outcomes of CMP will be described in terms of returns to work (where there is controversy), reduced anxiety and depression, and soft indicators. No negative effects of participating in CMP were described in the literature, although it will be seen that for some participants in the research, CMP could have negative consequences. It will be concluded that CMPs represent a diverse range of programmes, rather than a national scheme. Furthermore, clinicians identified that wide discretion, which was viewed positively in one piece of research (Lindsay and Dutton, 2010), does have a positive effect for some participants, although this does not always translate into a return to work.

The remaining section of the chapter will present the results of the research project as a chronological account of attending CMP, contrasting engaged participants' views with those of staff and case files. Where possible such views will also be compared to the literature. The results will be divided in to:

- The participants' decisions to take part in CMP
- Views of initial assessment
- Why some claimants are identified as not suitable after assessment
- What happens during subsequent interventions
- Positive outcomes
- CMP issues, as identified by staff and participants

The chapter ends with some concluding comments, regarding the benefits of attending CMP.

6.2 The Literature

6.2.1 Programme Design

Pathways to Work (DWP, 2002) suggested that the NHS and healthcare professionals, using the best clinical practice, should play a role in ensuring people with disabilities are enabled to work, as a gap in provision was identified for 'rehabilitation' services for those with 'less serious conditions' (p29). It was stated that such a programme would enable participants to:

- Understand their condition and its impacts on activities
- Increase their confidence

- 'return to some form of employment or training and as normal a life as possible' (p.30)

At this time, CMP was a joint initiative between the Department for Work and Pensions (DWP) and the Department of Health (DoH), delivered on the ground by Jobcentre Plus, functioning as the gateway, and the National Health Service, which provided bespoke interventions. The NHS were required to deliver interventions based on a broad 'Memorandum of Understanding' with the DWP. The constraining factors within the Memorandum were: each CMP must focus on the major causes of claiming Incapacity Benefits, defined as mental health, cardio-respiratory and musculo-skeletal; the programme must not provide 'treatment'; interventions should be innovative; data should be submitted to JCP monthly (Ford and Plowright, 2008:19).

As a consequence of such limited guidance and the need for innovation, there was significant variation in the seven pilots developed.[34] This can be seen in terms of the use of privatisation: whilst the NHS in Scotland and Wales were providing all parts of CMP, the CMPs in England contracted out part of their provision to the private sector, with NHS staff adopting the role of case manager[35]. CMP staff from the pilot areas identified some difficulties with this model: it was not possible to ensure a consistent standard; it was sometimes challenging to 'track' clients' progress; the quality of some venues used for interventions was below the expected standard (Barnes and Hudson, 2006).

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[34] For a comprehensive description of the differences between the pilots in terms of organisational structure, main types of provision, staffing and client characteristics see Barnes and Hudson (2006:18-22).

[35] For details of the different ways in which the CMP pilots used private provision see Pittam et al. (2010:6). In addition, details of how Lancashire CMP contracted out part of their provision, including the 'Help for Health' course, can be seen in Ford (2008:5).

Another area open to interpretation by individual CMPs lay in the choice of clinicians. As such, a range of different clinical staff were used within CMP in varying numbers, although Ford and Plowright (2008) report that approximately half of clinical staff involved in the seven pilots were occupational therapists with approximately one fifth physiotherapists and a further fifth nurses. In addition, smaller numbers of untrained 'technicians' were utilised. Within such a collection of clinical staff, Pittam et al. (2010) found that an ethos most similar to that adopted within occupational therapy was utilised, requiring other clinical staff to change their previous professional ethos.

Differences can be seen between CMPs in terms of the interventions offered (Lindsay and Dutton, 2010; Warrener et al., 2009; Ford and Plowright, 2008). However, Ford and Plowright (2008) identified four core components that could be seen to varying degrees at different points in a participant's engagement within the seven pilot programmes. These were: activity and lifestyle; symptom management; coping; and work. Whilst one of the stated aims of CMP (DWP, 2002) was to move participants closer to work, it is odd that some programmes did not directly focus on work at all (Ford and Plowright, 2008; Warrener et al., 2009). In addition, the way in which similar interventions were carried out could vary, for example the use of work booklets, CDs and diaries to manage stress and anxiety (Warrener et al., 2009). However, the necessity for CMP to be non-treatment based resulted in some clinicians not utilising clinical skills that they believed could have supported a client. This was seen as frustrating (Pittam et al., 2010).

The location in which CMP interventions took place also varied. Whilst Jobcentre Plus offices were used in some areas, Barnes and Hudson (2006) found that some people were reluctant to attend interventions in these locations. As such, staff had to be innovative in finding locations, with church halls, leisure centres, pubs and occasional home visits being utilised (Barnes and Hudson, 2006). Research by Warrener et al. (2009) found, however, that for some clients, the idea of being seen in public during an

intervention was off-putting. Consequently, it was necessary to see the provision of a location suitable for the client as crucial to securing their engagement.

The level of interaction CMP staff had with Jobcentre Plus Personal Advisors also varied by area. An increase in communication was identified as a positive factor in ensuring that referral rates were kept high (Lindsay and Dutton, 2010), although difficulties occurred as a result of different work practices and cultures (Pittam et al., 2010). For example, both Lindsay and Dutton (2010) and Pittam et al. (2010) identified a tension between IBPAs' need to meet targets relating to CMP referrals and clients feeling pushed into attending CMP.

By 2008, a full national roll out had occurred. However, whilst the pilots were all based upon a partnership involving the NHS, it was made clear in the Green Paper 'A New Deal for Welfare' (DWP,2006) that the expansion of the CMP would be based upon partnership with the private sector with payment based upon meeting targets. A full discussion of this policy change will be included within the Conclusion.

6.2.2 Attending CMP: the process and engagement

The Process

Clients are referred to CMP by Jobcentre Plus Personal Advisors during compulsory Work Focused Interviews. Research by Warrener et al., (2009) found that it was usual for claimants to have been introduced to the concept of CMP by their IBPA, with only one out of 30 interviewees proactively asking to be referred to CMP. In addition, the research found that some of the participants in CMP would have preferred to have had more information on CMP before agreeing to participate.

Following referral, claimants 'generally' had an individual assessment with a clinician (Warrener et al., 2009:21). Within such assessments, Pittam et al. (2010) found that long and short term goals would be agreed and a decision would be made about which core components of CMP the claimant would attend. In contrast, other research suggests that following an assessment, a decision would be made regarding the suitability of CMP for the claimant. In one of the pilot areas, 28% of referrals were not offered a place on the programme (Ford, 2008:5), although other research by the same author suggests that the proportion varied by CMP (Ford and Plowright, 2008).

Factors involved in the decision to not offer a claimant a place on CMP included: the need for longer term support than CMP could provide (Lindsay and Dutton, 2010); undergoing treatment from mainstream NHS services (Barnes and Hudson, 2006); addiction to alcohol or drugs (Ford and Plowright, 2008; Barnes and Hudson, 2006). Conflicting findings exist in relation to claimants' readiness for work, based upon their condition or motivation. Barnes and Hudson's (2006) study found that if a claimant wanted to attend, even if they were a long way from being ready for work, they would be offered a place on CMP. However, Ford and Plowright (2008:59) found that 'lack of motivation to return to work' was a barrier to the successful completion of CMP, and as such, claimants would not be offered a place on CMP.

Having searched academic databases and the DWP Research Report website,, no research reports could be found that detail what occurs during CMP interventions, with qualitative accounts from clients or staff, although core components were identified earlier. Interviews with clinical staff conducted by Lindsay and Dutton (2010:255) found that staff were 'pleasantly surprised' at the amount of autonomy they had within their roles in terms of being able to plan and deliver interventions to clients and in terms of organising their workload. In addition, staff felt little pressure to move clients back into work, which was viewed very positively. Similar

amounts of autonomy were identified by managers relating to how the programme's budget was spent and which staff to recruit.

The length of CMP participation can vary considerably. Whilst interventions are supposed to last no longer than 13 weeks, Ford and Plowright (2008:58) found that a range from 4-32 weeks existed, with a mean duration of 16 weeks, although almost one half were completed within 13 weeks. In the cases where interventions lasted the longest, poor case management and the use of private providers were found to be a contributory factor. Research with participants found that almost a year after participating, respondents believed that they had attended an average of 6-12 sessions (Warrener et al., 2009). For some interviewees, this was seen as adequate, although for others, feelings of abandonment existed at the end of the programme, as they were not automatically referred back to their IBPA and, in the main, had not voluntarily contacted their IBPAs.

Who are CMP Clients?

CMP clients were found by Ford (2008:5) to have a mean age of 41 with roughly equal numbers of men and women. Analysis of clinical notes found that over half of attendees had a primary mental health condition, with 35% having a musculo-skeletal condition and 10% cardio-respiratory (Ford, 2008:5). Additionally, Barnes and Hudson's (2006:33) interviews with CMP staff found that mental health conditions were also prevalent as secondary conditions and that mental health issues were 'widespread' in all of the pilot areas. As a general finding, CMP staff were shocked by the complicated and difficult circumstances that participants lived with.

Why do clients agree to attend CMP?

During Work Focused Interviews when the question of attending CMP was raised, claimants who later participated in CMP fell into two groups: those who chose to attend immediately and those who preferred to have some time to consider attending or not (Warrener et al., 2009). For some interviewees, the lack of pressure put on them by Advisors to attend, such as allowing claimants time between interviews to decide, was instrumental in their decision to participate. This was of particular relevance, as some interviewees had low expectations of what CMP may be able to do, and so attended because they felt they had 'nothing to lose' (p17). Others chose to attend because they thought it was important to show their IBPA that they were prepared to do something. However, within Warrener et al.'s (2009) group of 30 interviewees, one attended because they believed it was a session in which they had to justify why they were not working in order to continue claiming benefits. This is concerning, although Warrener et al., (2009) did find 'good' awareness overall that CMP was voluntary (p15). Alternative research found that 'many' customers attended CMP without a clear idea of what CMP was; accordingly, CMP staff did not start out with the assumption that clients knew that CMP was voluntary, with some CMP staff having concerns about clients being 'pushed into' attending (Barnes and Hudson, 2006:34).

Having agreed to attend CMP with their IBPA was not a clear indication that claimants would go on to engage with CMP. For example, Ford and Plowright (2008:58) found that of those referred, only 44% participated.[36] Claimants reported the following reasons for not attending CMP sessions: feeling too unwell; deciding CMP was not appropriate for them; returning to work; no longer claiming IB; difficulties with travelling to CMP (Warrener et al., 2009). On the other hand, CMP staff felt that some claimants were 'not

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[36] It is possible, however, that approximately 28% of non-participation is as a result of CMP not being a suitable service for claimants (Ford, 2008).

ready' to change, and as such, were not engaging with CMP (Lindsay and Dutton, 2010:258). Furthermore, poor attendance was not uncommon, even with those who were engaged with the programme. This was described by staff as being related to a wide range of external factors such as caring roles, family problems and poverty (Lindsay and Dutton, 2010). As a result of poor attendance rates, some practitioners reported that they contacted participants routinely by telephone to remind them of their appointments (Barnes and Hudson, 2006).

In addition to poor attendance in CMP sessions, dropping out of the programme was common. Whilst Ford and Plowright (2009:58) found that only 44% of claimants referred participated in CMP, only 29% went on to complete the programme. The main reason identified for dropping out of CMP by Warrener et al., (2009) and Ford and Plowright (2008) was the unsuitability of the programme. On the other hand, Ford (2008) found that poor health was the most common factor, accounting for over one third of drop outs. It was also clear that external factors contribute to failure to complete CMP (Warrener et al., 2009; Ford and Plowright, 2009; Ford, 2008), showing the complexity of IB claimants' lives. Other factors that were relevant were the location of the CMP interventions (Warrener et al., 2009); ongoing NHS diagnosis and treatment (Ford, 2008); return to work (Ford, 2008; Ford and Plowright, 2008).

As was shown at the beginning of the section, claimants often did not have a good idea of what participation in CMP would entail. As such, some claimants expected 'treatment' such as hands on physiotherapy, and were then disappointed when this did not materialise (Barnes and Hudson, 2006:35). This can be used in part to explain why some claimants chose not to participate in CMP as a result of its unsuitability.

Additionally, whilst CMP staff saw their association with the NHS as bringing credibility to CMP as an agency separate to Jobcentre Plus and the welfare to work agenda (Lindsay and Dutton, 2010; Pittam et al., 2010), some

clients did not know that CMP staff were part of the NHS. Despite this staff were generally viewed positively, as being easy to understand, having good listening skills and being non-judgemental. Furthermore, those who did acknowledge the independence of CMP from the Jobcentre saw this as positive (Warrener at al., 2009). In summary, based on the literature, I believe that if claimants were provided with more accessible information, to explain what CMP was about, as well as what it is not, expectations of the programme may have been managed better. This may have resulted in increased engagement.

6.2.2 CMP Outcomes

When evaluating the outcomes of CMP for clients, it is important to consider the original intention behind the programme. CMP was intended to support participants to return to work or training, in addition to learning to understand their condition and increasing their personal confidence. Consequently, this section will give priority to research that describes return to work activity, the most easily measured criterion. This is not to say that the improvements in confidence are not having a very real and positive outcome for participants, but that this aim is harder to evaluate, and likely to have been of less importance to the DWP who wished to reduce the numbers of IB claimants by one hundred thousand per annum for a decade (DWP, 2006).

Return to work

Based upon data from one pilot NHS CMP, Ford (2008:8) found that 25% of CMP attendees had found work by the end of CMP. This was seen as successful, although the NAO (2010) questions the validity of the participants used to represent all new IB claimants. Additionally, it is not possible to know how many of those who gained employment would have been successful without the support of *Pathways*. Further research by the

same author using the CMP2 form[37], which was viewed as 'an indication of work readiness', as opposed to a validated measure (p.41), found that at the end of CMP, 20 per cent of completers considered themselves to be 'work ready'. In addition, two-thirds of the group considered themselves to be either 'work ready', 'moving towards work' or 'in work', leaving one-third of completers of CMP outside of these categories (Ford and Plowright, 2008:67). However, although 'moving towards work' could be used to indicate a positive change, the claimant could still be a considerable distance from the labour market. In addition to this, considering oneself 'work ready', is far from a successful, sustained return to work. The disadvantages faced by people with health conditions in the labour market have been well documented (Bricout and Bentley, 2000; Berthoud, 2003, 2006; Schur, 2003; Barnes and Mercer, 2005; Jones (forthcoming)) and many of these are likely to be evident, post completion of CMP.

In addition to concerns about the validity of the constructs utilised to show the return to work or training aimed for by the DWP, the authors question the validity of the 5 point scale used in the questions on the CMP2 form. It was thought that it was possible that in some instances scores were rated back to front (p.41). I would further question the validity of using a form that is designed to provide information from an IB claimant to their Jobcentre Plus Personal Advisor as a measure of improvement in work readiness. As the previous chapter showed, there was considerable fear surrounding losing benefits. Consequently, these results should not be treated as an accurate representation of the reality that CMP participants are experiencing, but rather what they wish to communicate to their Personal Advisor.

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[37] The CMP2 form is a standardised outcome form designed by Jobcentre Plus that all people leaving CMP should complete. Within my research, I found different approaches to completing the form eg: having a clinician write what the participant said (this was also identified by Ford and Plowright, 2008), having the participant complete the form in front of the clinician or having the form posted to the participant, which can result in missing data. A copy of the form can be seen in appendix 16.

Whilst the numbers returning to work are questionable, Warrener et al.'s (2009) interviews with CMP participants found that those who were able to return to work after CMP were already closer to the labour market prior to their interaction with CMP. Furthermore, for the substantial group who have not moved towards work, two reasons account for this lack of progress: the participant's health condition and the lack of work focus within CMP (Warrener et al., 2009). Further research published by the National Audit Office (2010) found that the choices menu, including CMP, had no impact upon leaving IB. The research will be discussed in more detail in the conclusion.

Reduced anxiety and depression

Whilst there was little reliable information to show a link between CMP participation and returning to work, the two pieces of research by Fiona Ford (2008) and Ford and Plowright (2008) performed detailed analysis of Hospital Anxiety and Depression Scale (HADS)[38] data collected by the pilot CMPs during the initial assessment and at the end of the programme. Four of the seven pilot programmes had already been collecting the data, leading to its adoption in the research (Ford and Plowright, 2008). The data is limited, however, in only showing outcomes for those who completed the programme. Furthermore, it is not possible to say that the programme resulted in the outcomes.

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[38] The Hospital Anxiety and Depression Scale (HADS) was developed in 1983 and has been used since as a self-screening tool for anxiety and depression throughout the NHS. Participants complete 14 questions and should do so quickly, using their initial response to a question. The maximum score, showing the highest anxiety or depression, is 21. Anxiety and depression are measured separately using seven questions for each area. (an example of the form can be seen in appendix 14)

However, HADS scores dropped significantly for those completing the programme. Relating to anxiety, a drop of 2.6 or 2.8 out of 21 (Ford, 2008; Ford and Plowright, 2008) was found. Decreases in depression based on the HADS were more pronounced, with a drop of 3.2 or 3.1 out of 21 (Ford, 2008; Ford and Plowright, 2008). Furthermore, the mean depression score for participants who completed CMP was below the diagnosis for clinical depression (8) at 6.9 and 7.1 respectively. Overall, for the 78% of CMP participants who had a depression score of over 8 at the beginning of the programme, 30% had recovered (ie: had a score of under 8) and 44% had improved but were still classed as clinically depressed (Ford, 2008:11). These results were found to be statistically significant. Such results were supported anecdotally during interviews with CMP staff (Lindsay and Dutton, 2010), showing that completing an NHS CMP may be linked to reducing anxiety and depression.

'soft' indicators

Other findings on the impact of CMP have focused upon 'soft' indicators such as increased confidence. Research with CMP participants found they believed that completing CMP had increased their confidence and self-esteem and had produced an increase in activity (Warrener et al., 2009). Increased confidence and an increase in activity were also found in Ford and Plowright's (2008) analysis of CMP2 forms. In addition, two of the original aims of CMP had been actualised as participants reported being able to understand their condition better and had developed techniques to be able to manage their symptoms. Additionally, some participants were still using these techniques 9-12 months after the completion of CMP (Warrener et al., 2009). The positive reports from participants were also echoed during interviews with staff who reported similar findings, although concern was expressed that CMP was unable to help some of the most difficult to help IB claimants (Lindsay and Dutton, 2010). Furthermore, in addition to benefits described for clients, Pittam et al. (2010) and Ford and Plowright (2008) found that CMP staff felt that CMP provided GPs with an

alternative to prescribing or referring to mainstream NHS services and influenced how Primary Care Trusts treated long-term conditions.

6.2.3 Conclusion

The literature review found that, in general, there is a shortage of evidence relating to CMP, particularly in peer reviewed publications. However, it can be seen that claimants agreed to participate in CMP for a variety of reasons, this should be further studied. Furthermore, participants engaged at a variety of levels and dropping out of the programme was common. However, for those who engaged and completed CMP, positive outcomes could be seen in relation to decreasing anxiety and depression and increasing confidence. At the time of research, it appeared that participation in CMP was linked with one in four completers returning to work, or 60 per cent of completers at least moving towards work, depending upon the research consulted.

Significant gaps were evident in terms of descriptions of what occurs during CMP interventions. In addition, whilst it is briefly acknowledged that staff felt that they had discretion, this has not been further explored. Furthermore, very little evidence exists in relation to privately run CMPs, which are likely to be different to NHS run CMPs as a result of their differing funding arrangements.

6.3 Results: A chronological tale

In this section, data from the original research will be presented by following the *Pathways* of the 10 engaged CMP participants[39]. The journey begins

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[39] The case of Jo, the one unengaged claimant who had attended CMP was described separately in the prologue.

with the claimant's decision to attend CMP, following a compulsory Work Focused Interview with Jobcentre Plus; attending an initial assessment; subsequent interventions; and outcomes. In addition to this narrative, a detailed exploration of staff perceptions of *Pathways to Work* generally and the CMP will be undertaken. Furthermore, staff and participants' views of each other will be discussed. At the end of the chapter, conclusions will be drawn, attempting, where possible, to identify general trends.

6.3.1 Decision to participate

During interviews, it became clear that the majority of IB claimants (both engaged and unengaged) did not know about CMP unless their JC Advisor mentioned it to them, showing that most claimants rely upon their contact with JC+ in order to gather information about support available to them. This supports Warrener et al.'s (2009) findings. Three clients discussed their decision to participate and described how they did so because of anxiety and/or depression. For example Paul stated that when he attended a WFI: '(I was) really down and depressed and I wasn't feeling good at all, just pumping myself with tablets because I was in a lot of pain, so I didn't go there with my cheerful, bubbly self as normal.' His Advisor suggested CMP to Paul but he 'wasn't keen right at the beginning.' However, his Advisor suggested that he could just go along once and leave if it didn't help, so Paul decided to take part.

On the other hand, one unengaged client participated in CMP for a very different reason. Jo's experiences of feeling pressured by her JC+ Advisor into participating in CMP will be discussed later in the chapter as part of her overall negative experience of CMP. It should be noted that two CMP staff stated that some people attending the initial assessment did not seem to be aware that it was voluntary. This was attributed to Jobcentre Plus Advisors having targets to reach. Accordingly, it was seen as important to emphasise

the voluntary nature of the programme in order to allow claimants to make an informed choice.

6.3.2 Initial Assessment

Whilst the clinical staff distinguished the Initial assessment from subsequent interventions, most clients did not see it as distinct from their general CMP experience. Prior to the assessment, all of the practitioners stated they would attempt to telephone the claimant. The clinical lead from CMP 2 described a typical phone call:

> So what we'll do before the IA (Initial Assessment), we try to phone people the day before so I'll say 'Hi it's (Christian name). I'm the one doing the assessment tomorrow, just wanted to make sure you're happy and that you're coming.' And some people will say then 'Oh no, I can't come, sorry' even though they haven't phoned you and that in itself can be a bit annoying. But it cuts (the fail to attend rate) down a bit.

These first conversations were seen as crucial in beginning the process of building up rapport (Nurse, CMP 2). However, even if contact had been established, sometimes claimants failed to attend their appointment, which would result in attempts to telephone the claimant, or to discharge them if contact could not be made.

The initial assessment was usually a one-to-one session, lasting an hour in a private office in the JC. During this time, claimants were asked an extremely wide range of questions, regarding health and lifestyle factors, as prescribed by a standardised assessment form (see appendices 12 and 13) that each CMP had developed themselves. Whilst CMP 1's form was three pages long, usually accompanied by additional notes, CMP 2's form was 10 pages long and usually stood alone. At the end of the CMP assessment, work history and future goals were questioned. Both forms end with the

clinician's recommendations regarding the claimant's suitability for the programme and any initial thoughts on which areas of CMP might be most suitable for them. This is in contrast to Pittam et al.'s (2010) findings that Initial Assessment would be about identifying goals and deciding which parts of CMP a claimant would be referred. Several staff members described how the assessment could be an emotional experience for participants, as it was sometimes the first time they had been given the opportunity to be able to talk about their health conditions and how they felt about them.

Suitable for CMP?

There was considerable discussion within interviews about how it would be decided if a claimant would be seen as suitable to continue participating in CMP after their initial assessment. All staff were clear that this was a team decision, to allow objectivity and prevent responsibility falling on one clinician. Claimants were assessed on the suitability of CMP for their condition: if the claimant's condition was outside of the expertise of CMP they would be rejected. This included alcohol or drug dependency (as found by Barnes and Hudson, 2006 and Ford and Plowright, 2008), serious mental health conditions, and chronic fatigue. In these instances, it was common to 'signpost' a claimant to more appropriate services.

Likewise, the perceived benefits to the claimant from participating in CMP were considered. It was seen that if claimants were still in the 'sick role', ie; undergoing treatment by mainstream NHS services (as found by Barnes and Hudson, 2006), in need of engaging with a medical model of treatment, or hoping that CMP could 'fix' their condition, they would not be ready to engage with the service. The concept of it not being 'the right time' to engage was discussed by several interviewees and was related to factors external to the claimant's health condition, such as having difficulties in their family or being pregnant.

Finally, if claimants were already participating in a similar service, such as pain management, CMP would not offer them a place. This can be seen as a reference to the Memorandum of Understanding on which CMP was built; CMP should not duplicate existing provision. Whilst the literature review found that the issue of being motivated to return to work could influence the decision of whether to accept a claimant (Ford and Plowright, 2008), there was little discussion of this. The manager of CMP 1 did state that being a work-focused programme may make it less suitable for some potential participants. However, the clinical lead of that CMP stated:

> We do have a lot of people who are near the retirement age and you know that they're not going to go back to work, but that doesn't dictate a difference in the provision that we'll provide them with because at the end of the we're looking at their quality of life, whether they're going to go back to work today, tomorrow or never.

Other staff also thought that there was a 'right to the treatment' if claimants wanted to participate (Physiotherapist, CMP 1), retaining the professional ethos of mainstream NHS services. This was despite the fact that within the CMP there was no 'right' to participate, and the service was explicitly not providing 'treatment'. Consequently, it is possible that people who are not likely to participate in work in the immediate future are seen by CMP under the guise of supporting them on the journey to becoming work ready, as supported by Barnes and Hudson's (2006) research.

6.3.3 Subsequent interventions

Staff Views

The literature showed a broad outline of what CMP offered, but did not offer detailed accounts of the CMP process. Consequently, as part of this research, interviewees were asked about their experience of interventions in considerable detail. Participants identified key interventions, with

descriptions of what these entailed. These are contrasted with CMP clinicians' descriptions of CMP, from both interviews and their writing within case files, an individualised approach to each of the core elements identified occurred. In addition, claimants could be involved in several interventions at once, which was not reported during interviews with claimants. Consequently, it can be seen that clinicians rely upon their training, experience and the rest of the multi-disciplinary team (MDT) to identify the most suitable way to work with each individual participant within the framework of core interventions. In addition to describing interventions in more detail, the case files also showed interventions that claimants did not identify at interview. This suggests that interviewees discussed the points that were most memorable to them, which may not have been those noted most in their files[40].

CMP staff identified that they had considerable flexibility in how they worked with claimants (Lindsay and Dutton, 2010), although they did not attribute this to a lack of official guidance. Explanations tended to focus on autonomous working practices, once the initial team decision had been made on whether to accept a claimant, and a plan of action had been devised. Staff tended to see themselves as professionals who were capable of determining if a deviation from the original plan should be made, for example, if an intervention was not working, or a claimant's circumstances had changed. Such changes were not identified specifically within the literature.

Staff identified a group of generic interventions. These included anxiety management, relaxation, pain management, hands-off physiotherapy and prescribed exercise. These modules contained elements of confidence building, increasing activity, introducing helpful coping mechanisms, and could include a work focus, if it was relevant to the participant. If the two programmes were to be compared to Ford and Plowright's (2008)

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[40] An example of a set of clinical notes can be seen in Appendix 10.

226

categorisation of CMPs, it can be seen that the key focus of core modules was 'symptom management', although 'coping' and 'lifestyle management' were an integral part of 'symptom management' modules.

All CMP participants could be considered for any group, if it was thought to be of benefit to them. For example, the relaxation class was designed with the idea of supporting people with anxiety and depression, but it was subsequently found to be 'useful for somebody who has pain or fatigue. It's also useful for somebody who has a cardiac problem...' (OT 2, CMP 1). Furthermore, whilst the physiotherapists were initially recruited to support people with musculo-skeletal conditions, they also became the gateway to the prescribed exercise schemes operated by both Local Health Boards and so supported a more diverse group of claimants.

Within the core modules identified above, an individualised, client-centred approach was adopted. For instance, the OT technician from CMP 1 described several ways he might go about 'confidence building' by finding 'something that the client would consider doing...'. As such, a flexible approach was adopted including:

- Supporting the person to get out of the house more
- 'Graded exposure', where situations are normalised over time
- Supporting the person to find educational opportunities or voluntary work

On the other hand, the nurse from CMP2 outlined the provision of 'anxiety management. The nurse would initially deal with a smaller issue. It was seen that many of the CMPs anxious participants have trouble sleeping. The approach adopted involved normalising that difficulty ('everybody at some point in their lives will have trouble with sleep...') and would then take steps to look at 'sleep hygiene', which is creating a space where the body is ready to sleep. Some issues the nurse identified as common barriers to sleep were too much caffeine, not de-stimulating the brain before bed and

worrying. In order to address the factor considered to be the most difficult, and worrying, the nurse would suggest that participants need to 'find other places to do your worrying...(and) only (worrying) in 20 minute slots'. Having enabled a participant to sleep better within the first few sessions, the nurse felt that they began to believe that they could achieve bigger goals with CMP support. At this point, the nurse would move on to tackle bigger issues, such as why the participant 'can't get to Tesco...'. This is where the nurse would introduce the concept of graded exposure.

The individualised approach, wherever possible, offers claimants the choice to be seen one-to-one or in a group. However, the clinical lead of CMP 1 stated that participating in a group was beneficial 'for reasons like social inclusion', they would try to encourage the client to have a 'mixed package', with initial one-to-one work followed by group participation. Another way in which the CMP made interventions accessible, was through different ways of disseminating information. The clinical lead and the nurse from CMP 2 described how information was made accessible to the participant's level of understanding, which could be affected by their level of depression and/or their literacy. This range of materials was also identified by Warrener et al. (2009).

Thus, it can be seen that both within and between CMPs, clinicians adopted different approaches as a result of their particular expertise. The key concept identified by all staff, however, was to ensure the most appropriate intervention for each individual participant. All staff, including managers, were uncompromising in this attitude. Which is a much softer approach than the rhetoric contained within policy statements.

Participants' views

The way in which interventions were described by claimants was very different to staff descriptions. In general, they did not appear to know that their plan was tailored specifically to them. For example, Catherine believed

228

that she had 'the anxiety management course.' On the other hand, claimants could identify the names of most of the core modules they had attended, showing a good recollection of the multi-faceted programme.

The intervention most discussed by five of the interviewees was 'relaxation'. However, this may have been because three of the five (Emma, Chris and Sarah) had been given a CD to take away with them and were finding using it at home to be beneficial to them. For these three claimants, the CD was the most noted part of the intervention. Catherine recalled learning breathing techniques in a one-to-one session with an Occupational Therapist. Like the claimants who were benefiting from their 'relaxation' CDs outside of the sessions, Catherine had been able to put her breathing exercises to use outside her CMP sessions.

Three of the interviewees described their experience of seeing a CMP physiotherapist, with Paul giving the most detail. After four sessions seeing an OT, Paul began to see a physiotherapist alongside his other sessions. The physiotherapist noticed that Paul did not stand up straight. Furthermore, due to the problem with his left leg, he stated, 'I won't walk upstairs properly'. In addition, the physiotherapist 'looked at' Paul's legs and gave him exercises to do to help him to 'straighten up'. Paul reported that the physiotherapist has stressed to Paul that 'if I don't do the exercise he told me to do...a month later, or a year or two down the road, I'm going to give myself permanent problems.' Joanne also reported similar advice about using equipment in the gym that was causing further damage to her joints. This proactive approach is beyond the scope of CMP's remit and its evaluation, although it is attempting to address conditions that could be further incapacitating in the future. This was also discussed by CMP practitioners during interviews. Such proactive, health promotion advice could apply to people with arthritis who were taught to protect their joints, the benefits of which would not be seen until many years later (CMP 1, OT 1). Benefits could also be extended to entire families, with healthier

approaches to diet and exercise passed on to children and other relatives (CMP 1, Clinical Lead).

The third most common intervention discussed during interviews with claimants was 'pain management', described by Sarah (one-to-one) and Joanne (group). Both interviewees noted how the course encouraged them to 'stay positive' (Sarah). In addition, Joanne thought "halleluiah', somebody believes me that I've got this problem with my pain...' and found that the course enabled her to meet other people in a similar situation and to normalise her pain.

Two interviewees described in detail their experience of anxiety management sessions. For Jacob, the one-to-one sessions attempted not only to teach him how best to deal with the onset of anxiety, but also to uncover the cause of his anxiety. Within the sessions, Jacob's practitioner had '(gone) through how anxiety and panic attacks affect you...The symptoms of panic attacks and anxiety and your thoughts and things and trying to alter the way you are thinking and things like that.' Jacob was the only interviewee to describe being given work to take away with him. He received a work book to complete at home, an approach he liked. In addition to this, Jacob's practitioner referred him to the CMP's physiotherapist in order to be able to participate in the prescribed exercise scheme. Jacob viewed this very positively, particularly in relation to mainstream NHS mental health services.

This shows that although the CMP participants described their interventions in terms such as 'anxiety management', what was covered in individual sessions varied greatly, depending on the client's condition, as identified by staff. Other interventions that were described in less detail included being taught to pace (Emma and Rebecca); referral to an exercise scheme (Jacob and Joanne); adding structure to one's day and graded exposure (Catherine) and challenging negative thinking (Paul). These interventions also appeared to be individually tailored.

Thus it can be seen that although generic interventions were named by participants, there were differences in how that core intervention was delivered to each person. By addressing their individual circumstances, each participant benefited from CMP as much as possible. These bespoke interventions were seen by clinicians as the key part of CMP's success. Furthermore, practitioners identified themselves as highly trained clinicians, and as such, CMP was seen as a service that non-qualified staff could not be expected to provide well or safely without considerable supervision by a trained medical professional.

Work Focus within CMP interventions

Whilst the staff and participants' views showed evidence of CMP attempting to increase understanding of their conditions and increase their confidence, it can be seen that most participants did not return to work or training. Two participants did return to work or training; Rachel, who volunteered to take part in *Pathways*, took up a full time college course, and Jacob, who had an unsuccessful return to work whilst attending CMP.

It can be seen that none of the participants identified a work focus within their interventions, although both Jacob and Rachel desired to return to work. They viewed their work with CMP as being about managing their anxiety. Among CMP staff, focusing CMP on work was not discussed at length, but two opposing views were evident. Whilst the OT from CMP2 stated 'I think it's very important' not to have a strong work focus within CMP unless it was appropriate to that participant, the nurse from the same CMP felt differently. The nurse stated that: 'I can go on about sleep and anxiety all day, but ultimately for me it's about them having a fulfilling day...that's keeping the work focus...' The strongest proponent of work was the OT technician from CMP 1 who had, along with other technicians, set up a work

231

focused group about identifying suitable occupations, completing CVs and interview preparation.

The decision to introduce a work-focused group was in response to a gap identified by the CMP, where participants left CMP feeling ready to look for work, but as they were not offered immediate support by Jobcentre Plus, they did not take the steps whilst their confidence was still high. Consequently it was seen as important to provide something to 'strike while the iron's hot', in order to keep up positive momentum (OT technician, CMP 1). In addition to this, which could conceivably be identified as part of the CMP's remit, although it is also provided by the 'job brokers', the OT technician would also support people to search for specific vacancies. The technician did not identify this as crossing boundaries into the role of Jobcentre Plus Advisors, although several other CMP staff, including both managers, maintained that the CMP had to be careful not to 'tread on toes' (Manager, CMP 1).

Occasionally, CMP staff identified those whose work goals were not realistic because of either their health condition or other barriers to work, such as their qualifications. This was not found within the literature. In such instances, staff viewed it as an important part of their role to enable participants to identify more suitable goals that took account of their circumstances. For example, a lady who had not worked for 20 years and had literacy difficulties decided that she wanted to become a traffic warden after participating in CMP. Her clinician described the journey:

> ...20 years of not working and she wanted to be a traffic warden. Major, major anxiety and her goal was to be a traffic warden...But it was about adjusting those goals...So it was about saying "why a traffic warden?" She wanted to feel in control and have power, and be important, and have a uniform. Once she could see that, she understood that she didn't have to be a traffic warden...strange ambition, but when you looked at it from a different angle, it made perfect sense (CMP 2, nurse).

The clinician went on to explain how the participant is now working for a hotel as a chambermaid, and is very happy with the situation, as her anxiety has reduced and her sense of achievement is high. It is likely that if the lady with no qualifications, poor literacy skills and an employment gap of twenty years had applied for a job as a traffic warden, she would not have succeeded. As such, supporting the participant to consider a more realistic goal enabled her to successfully return to work and increase her confidence.

6.3.4 Positive Outcomes

Introduction

This section will be organised around the improvements reported by CMP participants, with opinions of CMP staff and data from case files used to contrast the opinions in order to maximise validity. The vast majority of comments about CMP from the 10 engaged claimants were positive. These included benefits such as being able to manage their condition better, understanding their condition better, improved confidence, getting more out of life, challenging their negative thoughts and enjoying the attention of a medical professional. Likewise, CMP staff very much focused on positive outcomes of attending CMP, these included: return to work; being able to spend lots of time with a clinician, resulting in increased understanding of conditions and better management of them; increased confidence; health promotion to participants and their families. Overall, however, there was an acknowledgement that it was difficult to measure such outcomes and that return to work was what was expected of the programme.

Better Condition Management

Although supporting claimants to manage their conditions was not a stated aim of the programme (DWP, 2002), it can be assumed that the 'Condition

Management Programme' would have increased participants' ability to manage their conditions. It is not surprising that it was the most common benefit reported by engaged participants, with six out of the 11 claimants stating that after CMP intervention, they felt better able to manage their condition.

The way in which better condition management had occurred was different in each case. Both Emma and Chris felt better able to manage their pain. Emma described how, although she continues to suffer with pain, she can manage the symptoms much more effectively using relaxation strategies. Likewise, Chris has been able to reduce his reliance upon strong painkillers:

> Well, when you're in pain, instead of panicking and reaching for a tablet, or whatever it is, concentrate on your breathing. I say management, but when you say pain management, it's hard to describe because it doesn't manage it, and it's not just putting up with it, it's making it last longer then, go longer. That's what I find now.

Alternatively, both Paul and Rebecca, who were used to having very active lives before they became incapacitated, were better able to manage their symptoms by pacing themselves. Rebecca stated during her interview that she has learned to reduce her standards in terms of the housework that she was able to complete, whilst allowing herself energy to play with her children: 'I'm looking at the floor here now, while we're speaking, and it could do with a hoover. But I'm resisting. Or I won't be able to do anything later when the kids come home from school...'.

What is clear from these cases is that not only is there evidence that the interviewees believe their condition had improved, but that their confidence and ability to increase their daily activity was also increased. This positive outcome was also reported widely by CMP clinicians and managers, although most staff felt that the value of these positive outcomes was not acknowledged by the DWP.

Increased Confidence

Associated with improved management of their conditions, increases in functionality and confidence were described by both staff and participants:

> ...their mood will have lifted, this is what the outcome measures are telling us, and people are telling us. They feel less anxious and they are more able to manage... If they are experiencing anxiety, so if they have a panic attack in Tescos, they know what to do to manage it, so they feel more confident (to engage in activity) as a result... (CMP 2, clinical lead).

This growth in confidence was described by five of the interviewees. For Dai, his CMP sessions with an OT had supported him to become more assertive: 'She's got me going to ask people things, because sometimes I just don't bother asking for things, people tell me that you should ask for this and you should ask for that, but sometimes I just don't bother.' Alternatively, for Chris, Paul and Catherine, taking small steps towards their main goal enabled them to see that they could achieve more than they previously thought possible. However, whilst this increased confidence was positive for four of the interviewees, for Rebecca a failed attempt at voluntary work resulted in a relapse of her back condition ('so, I only did a couple of days there, it was a couple of hours actually'). Whilst Rebecca expressed a desire to return to the role, she thought that her health condition would make this unlikely.

Increases in confidence were widely reported by CMP clinicians, some of whom saw it as the underpinning concept of everything CMP delivered: 'it's about confidence building, and one strong element of everything we do is about building confidence' (CMP 1, OT technician). Increased confidence was focused around changing perceptions about what participants could achieve, including relating this to work for people who had previously been told by doctors that a return to work would not be possible, very much

235

following the empowerment discourses running through many New Labour policy documents (eg: DWP, 2002; PMSU, 2005):

> ...it's quite enlightening for people, it frees people up to think...In a lot of cases, for the first time in their lives, you've said to these people "you've got a future", when they are sitting in a place where they think they've got no future... (CMP 2, nurse).

Thus, it can be seen that both staff and participants of CMP believed that claimants who engaged with the CMP experienced increased confidence. This was one of the aims of CMP as stated by the DWP (2002).

Increased Understanding of Conditions

The third most common benefit discussed by engaged participants (4/11) was an increased understanding of their condition and an ability to identify which activities were still possible. This was the first stated aim of the CMP (DWP, 2002).

An example of increased understanding can be seen throughout Chris's narrative. Following a recent meeting with his doctor, Chris had been advised that his condition was inoperable:

> So what happens then, it's that you've got that in your head, and I'm not saying that you get depressed but you do think, well, this is the end, what do I do from here? Of course, then you go on this course and it gives you different ways to look at it.

Furthermore, Joanne and Rachel described how their conditions had been normalised:

> ... I thought I was going around the bloody twist. But to have somebody sit down and explain the process of grief to you, and it was not only the loss of your partner, your husband, it's also the loss of your job...it was nice to think... what I'm feeling is I'm normal. (Joanne).

236

These positive outcomes from CMP should be viewed in the context of what was described as inadequate support from GPs and the NHS by three claimants. As such, Jacob and Joanne argued that this support should be available as part of mainstream services. The difference in provision was also noted by many clinicians. This included the use of the bio-psycho-social model, as opposed to a medical model dominated by prescribing medicines (CMP 1, clinical lead) and the 'luxury' of small case loads allowing plenty of time for each claimant (CMP1, OT2; CMP 2, clinical lead; CMP2, nurse; CMP 2, physiotherapist; CMP 2, manager). This dedicated time was seen as especially important by the clinical lead of CMP 2:

> A lot of our customers report that they feel that it's the first time that somebody has really listened to them, and that validates them and how they're feeling and that can be really, really helpful for them.

Other benefits described included increased structure to the day (Chris, Rachel and Catherine); having 'something to get up for in the morning' (Chris); being encouraged to 'get out of the rut' of inactivity (Rachel); and support to establish a more regular bed time routine (Catherine). In addition, Paul and Sarah found that CMP supported them to challenge their negative thoughts; Paul was able to be easier on himself when he could not achieve things that he wanted to and Sarah was enabled to act like her pain-free-self again:

> re-enforcing everything that, I normally, without pain, that I would normally be like anyway... but, yes, absolutely it's putting everything on the table and sort of um... and just reminding you that there is life out there, just keep positive and you know keep doing it and you'll be alright, absolutely yeah.

Increases in functionality as a result of understanding their condition, as shown above by Rachel and Chris, were also described by the CMP staff. Such increases varied from visiting their GP less (CMP1, OT 2), keeping fitter (CMP 1, OT 2) to 'quality of life' issues (CMP 1, clinical lead) such as

socialisaing (CMP 1, physiotherapist); engaging with their community; engaging in roles they had previously lost, such as being a mum or partner (CMP2, clinical lead); in some cases, 'doing things that they haven't done for many months or even years' as a result of their health condition (CMP 1, physiotherapist). This was seen as helping participants to find 'their zest for life' (CMP 2, clinical lead) which was seen as a step on the way to adopting a 'productive' role, such as work, training or education. Whilst these increases may not seem dramatic, and do not meet the aims of the CMP (DWP, 2002), the staff described cases of how these benefits affected participants in practice, often facilitating growth in their independence.

Work

A wide range of benefits can be seen from participation in CMP among the engaged group. However, the only interviewee to relate these specifically to returning to work was Paul. He suggested that CMP 'has definitely, it's got to help me get back to work because, I'm finding myself fitter all the time...'. It is not possible to compare Paul's thoughts here to his progress as identified by CMP outcome measures, as he did not complete the forms. However, clinical notes written by Paul's OT, after 12 weeks of anxiety and pain management, state that Paul was 'low (of mood) today', having done too much over the previous weekend when family visited. As a consequence, prior to discharge, the OT attempted to link Paul in with the District Nurse for 'Chronic Disease Management, but they are unable to offer a service because of their case load...'. Although Paul spoke very powerfully about his desire to get back to work in order to regain his sense of identity as a 'man', it seems likely from the OT's attempts to find Paul long term support that she thought he would be unable to return to work for some time.

This lack of work focus during interviews with claimants was very different to the interviews with CMP clinicians, each of whom discussed the return to work at some length (although they were specifically asked about return to

work). A return to paid employment was viewed as the 'top end of benefits' (CMP 2, manager) as far as Jobcentre Plus was concerned. In addition, when asked about how policy designers see soft outcomes when deciding whether to continue funding the initiative, the manager of CMP 1 stated pragmatically 'we are focused on work, we are a return to work service, not a feel good service.' However, the manager was able to show '36% work positive' in an in-house survey of CMP completers, which related to participating in paid work (full or part time), voluntary work or education. With the exception of those participating in voluntary work, those included within the 36% would be achieving the DWP's (2002) aim of returning IB claimants to work or education, although it would be necessary to investigate if such participants would have returned to work or education without the support of CMP. However, on the face of it, the statistic is much more positive than the NAO (2010) survey that found no additional employment impact from CMP participation and seems to be in line with Ford's (2008) finding that one quarter of participants returned to work.

Anecdotal accounts from research interviews also suggested work positive outcomes. The clinical lead of CMP1 stated that one clinician had 'discharged seven people last week and everyone of them were engaged in either voluntary work or employment, and that's just from leaving the programme.' This seems more likely to be the exception rather than the rule. In CMP 2, the OT technician noted that 'there have been a few (claimants) who have returned to paid work, and some who have returned to do voluntary work...'. Furthermore, one of her clients had not worked for twenty years, and following the programme had felt able to return to work. Another extraordinary case was described by the manager of the programme who stated that one lady 'who had a very bad back' and had been told that she would never work again, had secured a job prior to leaving the CMP as a result of the specialist physiotherapy the programme had been able to offer her.

Measuring progress towards work

What is clear from the way the clinicians discussed returning to work was that it was not seen as an achievable target within the confines of a very short term intervention for many participants. This was described by the clinical lead of CMP 2:

> They may not be returning to work when they finish with us, it's more about the journey, but they may be further along that journey of engaging in some kind of productive role, whether that's voluntary work, going to college, part time permitted work...we have to recognise that for some of our clients, they haven't worked for a long time and getting them back to work is a process and we, the CMP, may be a small part of that journey and hopefully their journey will continue after they have left us...

CMP is currently evaluated by Jobcentre Plus in terms of 'bums on seats' (Clinical Lead, CMP 2), or returning to full time work. This was not seen as the most appropriate measure, as CMP completers often took small steps taken on the journey to work, rather than returning to work directly. This was particularly likely for those who were further from the labour market when they began CMP. Furthermore, an outcome-based evaluation focused upon work was seen as neglecting other positive outcomes that might mark part of a journey of returning to work (Nurse, CMP 2).

Thus, it was seen as important to perform follow up research on participants some time after completing CMP, to see if they were more likely to have moved into employment then[41] (CMP 1, OT 1). Furthermore, some staff recognised the difficulty of measuring improvements in confidence and activity levels (CMP 1, OT 2) and the difficulty in getting these improvements to be taken seriously by those designing policies:

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[41] To some extent, this did occur with the Warrener et al. (2009) research that asked 30 completers about their experiences of CMP 9-12 months after participation.

I suppose it's very hard to measure, the value of giving somebody four months of a service that, 'yes it means that I can go and do my shopping now.' Well, if you are funding things, how valuable is that? Does that mean that that person who is now able to go and do their shopping is going to in a year's time be able to work? (CMP2, OT)

Official Outcome measures

The CMP2 form and the Hospital Anxiety and Depression Scale (HADS), as used by Ford (2008) and Ford and Plowritght's (2008) evaluation, were used by both CMPs. Staff from both CMPs were concerned that some of the benefits described above, such as increased activity and confidence, were not measured well by the official outcome measures. However, whilst the CMP2 form was seen as 'not really the best way to measure...information' (OT technician, CMP1), the HADS was seen as the most 'robust' of the tools available (OT1, CMP1), and was universally respected by the clinicians.

Regardless of the appropriateness of the evaluation forms, missing, or incorrectly entered, data was a problem. Some CMP staff reported claimants refusing to complete the forms, believing that it would have a negative effect on their eligibility to claim benefits in the future. This is despite the evaluation forms stating that this is not the case and CMP staff 'reinforcing' this (Physiotherapist, CMP 1).

Whilst there is very little data available, only 8 sets without missing data, it is possible to state, based upon HADS scores and self reports during CMP2 forms, that most engaged participants experienced decreased anxiety and depression by the end of their participation in CMP. Whilst Ford and Plowright (2008) found the mean drop in anxiety based on HADS was 2.8, the eight participants who had pre and post intervention data had a mean decrease in anxiety of 4.375. The lowest decrease in anxiety was

241

experienced by Emma, who did not get on with her physiotherapist and chose to leave the programme after few interventions (pre 17, post 16, difference 1). The most significant decrease was experienced by Rachel, who can be seen as engaging highly with the programme (pre 13, post 7, difference 6). Six of the eight participants who had data available experienced a stronger decrease in anxiety compared to Ford and Plowright's sample (2008).

Higher mean improvements in depression were also seen within the eight participants with valid data. Whilst Ford and Plowright (2008) found a mean improvement of 3.1 based on the HADS, the mean improvement of 4.125 was found. However, three of the eight respondents (Emma (pre 9), Joanne (pre15) and Jacob (pre 15)) only experienced an improvement of 1 and both Rachel (pre 13, post 5) and Catherine (pre 16, post 8) experienced an improvement of 8, showing that the benefits in reduced depression were not shared equally.

6.3.5 CMP issues

It should be noted that the engaged participants gave a generally positive description of their CMP interventions, although there were some negative points described. On the other hand, Jo, the only client from the unengaged group to attend CMP was very negative about her experience[42].

Unmet expectations

The most commonly described issue was one of confusion and unmet expectations regarding physiotherapy. Joanne, Jacob and Rebecca described how the approach taken by physiotherapists differed to either

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[42] Jo's story is told in the prologue to the thesis.

their previous experiences of physiotherapy or what they imagined it would be like. Joanne described her feelings:

> I was expecting a one to one session where you would get down on the floor or on the bench or whatever and be shown a couple of gentle exercises... I can remember coming away from them and thinking "that's not what I thought it would be...this isn't the impression that I was given when I said that I would come here."

It is clear that clients were happy with the treatment they received from the physiotherapists (with the exception of one conflict between client and clinician), however it did differ from their expectations and was a disappointment. As such, Rebecca suggested that perhaps adopting the more traditional hands-on-style of physiotherapy might make people 'feel better'. The CMP's rationale for not adopting this style, which can encourage clients to be passive, is understandable within a short-term service that aims to empower participants to manage their symptoms themselves in the future. As such, it is important for claimants' expectations to be more effectively managed.

During interviews with CMP staff, the idea of unmet expectations was described in two different ways. Firstly, OT1 from CMP 1 stated that sometimes claimants came to CMP with expectations that did not match the programme. Initially this was something attributed to the Advisors in the Jobcentre Plus offices giving incorrect information, although the OT believed that as the Advisors became more used to delivering Pathways, such confusion had lessened. Consequently, the OT felt that 'some people just don't listen full stop' to what they are told and hear what they want to hear. This was a view other clinicians subscribed to.

The second way in which unmet expectations could occur revolved around the distinction between treatment and management. Whilst CMP is explicitly not designed to provide treatment, some participants hoped or expected that CMP would 'fix them'. In such an instance, it was seen as important to support that person to accept responsibility for their own

243

progress. This was not always a successful strategy, with some participants self-discharging as a result.

Group Sessions

A second issue identified by participants, discussed by both Rachel and Chris, was the CMP's inability to run group sessions due to lack of numbers. Rachel, who was extremely shy and anxious in social situations, felt that she would have benefited from being seen as part of a group as it would have forced her to interact with others in a safe environment. On the other hand, Chris's primary concern was financial: 'I'm only thinking of it now as a cost effective way... I'm thinking now, I suppose of the tax payers (laughs)... because we could be three or four of us with the same problems having that session breathing and relaxing and talking through your different problems.' In addition to being more economical, Chris thought that he would have liked to have heard about other people's experiences to make the sessions 'not so formal'. Having discussed this with his Advisor, Chris was told that the reason for the lack of group sessions is because they can't get enough people to participate in CMP. Similarly, Rachel believed that because she lived in a more rural area, it was difficult to run group sessions.

During interviews with CMP staff, both explanations were given. In Rachel's area (CMP 2) most clinicians stated that it was not always possible to run groups due to the geographic spread of participants. The inability to run groups could inhibit the use of innovative ideas. For example, the physiotherapist suggested that they would offer a core stability group, that would primarily benefit people with musculo-skeletal conditions but would be available more widely 'but...I don't think I've got the numbers I need to run groups...'.

Personal Conflict

An issue that caused Emma to withdraw from CMP was a conflict with her clinician. Emma felt uncomfortable around her clinician and that the clinician was insensitive and unprofessional in their manner. She stated 'I didn't like (clinician's) approach...I just felt so uneasy.' Emma was unsure of what to do, so decided to speak to me before doing anything. When I offered to support her to make the CMP aware of the situation, she did not want to make a complaint (official or otherwise). This shows the relative powerlessness of the 'customer' in this sense. Had Emma felt confident enough to ask for a different clinician, she may have gained more from the service. Whilst there was no overt conflict in Joanne's case, she felt that as the majority of the clinicians were younger, their ability to empathise with her situation was compromised: 'because when you're in your twenties everything is lovely and ... then you find that life isn't like that. An older person doing it would have been better perhaps for the older people that they had there.'

Both issues were picked up on during interviews with CMP staff. The clinical lead of CMP 2 remarked that as CMP was dependent upon building a therapeutic relationship, that they might not be the best clinician to work with a particular client. This was identified as an issue to be aware of by the Clinical Lead of CMP2. Joanne's concern about age was also discussed by the OT technician from CMP 1 who felt like the life experiences they had had, as both an older person and someone who had worked in a variety of jobs including factory work, meant that older people and those from non-professional backgrounds were more able to relate to them. Had Joanne spent time with the OT technician, it is possible that she would have valued the advice given more than from somebody she thought did not understand her position.

The 14 week time limit – clinical discretion v dependency

Both Jacob and Joanne expressed a desire for their time with CMP to last longer, both during their interview and on their CMP2 evaluation form. However this may have been more to do with a lack of confidence in their coping abilities, rather than a more concrete need, as CMP staff tended to refer clients who were seen as needing longer-term services to mainstream NHS departments. In addition, during interviews with staff, two issues around extra time were identified: those needing the time and those who were likely to become dependent upon CMP.

Several of the clinical staff of CMP 2 discussed their feelings about keeping participants beyond the 13 week time period. Interestingly, the staff talked about the time period allowed as ranging from 12-16 weeks, showing a lack of concrete knowledge of the details of the Memorandum of Understanding. The clinical lead, who would influence team policy heavily, remarked that 'ethically you can't always discharge some people after 14 weeks, so we do have some people who are breach(ing the policy) technically...'. This view was shared by the nurse from CMP 2, who had, in some instances, worked with a participant for a year, but only for 16 sessions within that time. Such extensions were allowed by the clinical lead and manager of the programme, 'if it's a clinical decision'. However, the nurse also mentioned 'we get told off if we have them on for longer than 16 weeks...'. Such a view was echoed by the OT tech from CMP 2, who sometimes felt that participants could benefit from an increased duration in interventions. This was viewed as frustrating:

> I've been in the NHS for so long and I've never had to reach targets like that
> before. And I find that quite difficult, I would prefer to work with people until they
> are ready to be discharged, rather than getting to 16 weeks and thinking: "Oh God!
> I'd better go and see my manger not to make sure it's OK to see them for another
> three sessions!" I mean, Christ! I'm a highly qualified, very experienced, trained
> clinician. I should be able to make those decisions regarding whether somebody
> should be discharged rather than the Government (nurse, CMP2).

On the other hand, discouraging dependency was seen as being of crucial importance in enabling participants to progress beyond their time attending CMP. Participants were identified who returned to CMP during 'every crisis in (their) life' (CMP1, Clinical lead). Consequently, both teams worked hard to ensure possible issues around dependency were identified early on and not encouraged. An example quoted was that during the feed back session to the team after an initial assessment a clinician might answer the question 'how many sessions do you think they should have?' with 'Only four. And we need to keep this really tight, because this could run on and on...' (CMP 2, Clinical Lead). In such cases, clinicians would be supported by their clinical lead to ensure professional boundaries remained in place.

This issue can be seen in Joanne's case. Whilst Joanne provided practical and emotional support to many friends, she did not feel that they support her in the same way. Joanne mentioned many times during her interview (and twice on her CMP 2 outcome form) that she thought she should have been seen for longer. However, within her case file, a different story can be seen. Joanne's initial action plan mentions only 'CBT x 6'. Unlike all other clients, who were only discussed once at the team meeting, Joanne's case was discussed after two weeks, five weeks, 14 weeks and 19 weeks where the note stated: 'reviewed in clinical team meeting. Concerns raised regarding possible dependence on service. Client also awaiting pain management Group' (although Joanne had already attended Pain Management at this time, so it is possible the OT was referring to the anxiety management group). Joanne's case was also discussed separately with the clinical lead at five weeks. Although it was not noted within her clinical notes (with the exception of week 19), it is likely that it was issues of dependence that were discussed within the team meeting, as referrals to other services did not occur after the meetings, nor was her action plan amended.

As a consequence of Joanne's desire to use CMP to the full, she undertook almost all of the interventions the CMP had to offer. Firstly, she completed the CBT that was originally planned. In addition, Joanne experienced hands-off physiotherapy, prescribed exercise, pain management (group) and mood management (group). Towards the end of her interventions, Joanne did not attend several appointments and was not contactable by telephone by the CMP for almost two months. This may have been a way for her to attempt to control being discharged. Eventually, the CMP sent her the outcome measure forms and a letter of discharge. At this point, Joanne telephoned the CMP. As such, Joanne was officially on the books of the CMP for exactly 11 months, considerably beyond the 14 week limit imposed by the Memorandum of Understanding.

Alternatively, some clinicians and both managers identified a need within participants for 'aftercare', either at a set point in time, 'just to check in', or if participants returned to work and felt the need for such support. Providing such support was seen as sensible, to enable the benefits of CMP to be continued. Consequently, the manager of CMP 1 had introduced the facility for staff to give follow up advice by telephone if it was requested. Likewise, in CMP 2, the OT stated that one female participant who had felt that she would struggle when she re-entered work, was given in-work support in the form of regular telephone calls than enabled the participant to effectively negotiate accommodations to lower the effects of her health condition. However, the clinician stated that this was 'not part of our role at the moment.'

Two participants, Sarah and Rachel thought that it would have been better for them if they had received support from CMP earlier. Early intervention was not something discussed directly by clinical staff, but the difficulty of supporting those who had been away from the labour market for some time was widely acknowledged. Furthermore, some clinicians described how they had been shocked at how long some people had been economically inactive as they had assumed that, as *Pathways* was only mandatory for

248

new IB claimants, most participants would have only recently left the labour market.

Other Issues

Joanne also described how the enthusiastic nature of her clinician combined with her depression overwhelmed her. During one of her sessions, Joanne expressed an interest in 'doing something', and as such was referred to an OT technician to 'discuss volunteering' (OT technician referral form), but instead ended up withdrawing from CMP:

> I felt a bit I can't say pressurised because that is the wrong thing, but it is like, they were like vultures. I said, I said to them one day, 'I would like to do something' ...the next thing I knew they were like vultures around me. They said, right you want to do voluntary work and I said 'hang on a minute!

Subsequently, Joanne decided that the time was not right for her to start volunteering.

An issue raised by Rebecca shows a confused system for claiming expenses. Rebecca thought it was positive that she was able to claim back a mileage allowance for travelling to CMP sessions: 'I got the petrol money back which wasn't a lot really but you know it doesn't cost anything then does it, to do this thing.' However, she then, hesitantly, went on to describe a confused system:

> They only gave me like 30 pence a mile or something they worked it out...Which I don't know whether, (CMP practitioner), love her, didn't really know how much... She had a word with the people in the office and they worked out something between them. But I've heard of people getting more than 30 pence a mile.

The issue identified by staff was broader than just determining a mileage rate; staff, particularly in CMP 2, which is more rural, were concerned that some participants could not afford to pay for the bus fare to travel to CMP.

As a consequence, some practitioners were performing interventions in venues such as pubs and cafes as they were within walking distance of the participant's home. This was not seen as a good alternative, as the venue should be seen as 'psychologically safe' (CMP 2, nurse). For this reason, some clients were identified as being less willing to meet in the Jobcentre (CMP1, OT 2).

An issue identified by two CMP staff was that by being part of CMP, which is a non-prescribing, non-treatment service, they were losing their skills. This could potentially make them less employable in the future (CMP 2, nurse; CMP 2, physiotherapist). Finally, one member of staff spoke at some length about how it could be very different supporting professional people. For those people, anxiety and/or depression were felt to be the main issues, but as motivation was normally high, it was a 'different type of problem' to solve to enable their return to work (CMP2, nurse).

6.3.6 Discretion and self-identity of CMP staff

Concepts of occupational self-identity can be seen as closely linked to levels of discretion and clinical judgement allowed by job roles. It is of considerable relevance that all clinicians had primarily worked within mainstream NHS services in their previous roles, and comparisons were made between the two roles. Accordingly opportunities for discretion will be considered in some detail alongside CMP clinical staff members' reported identity within the constraints of working for the DWP.

The previous chapter showed that Jobcentre Plus Advisors were subject to a wide range of constraints on their discretion, such as the need to meet targets. However, within Pathways to Work guidance, the only constraints upon the discretion of CMPs was that it was to be a short-term service that did not replicate existing services and did not provide treatment.

It can be seen that the clinical staff found all three constraining factors to be frustrating at times. The need to stay within rigidly pre-determined time frames was seen as inappropriate by most clinical staff, including the clinical leads, and was seen as a serious breach to the professional discretion of the nurse from CMP 2 who felt that without a high level of professional training, these decisions should not be made. As such, whilst the principle of providing a short term service was definitely the intention when selecting which claimants to recruit, if claimants then needed 'a little bit of extra time' (Senior practitioner, CMP 2), they were given it in both area 1 and 2. These rules were breached significantly in some cases, for example one man who was seen for almost one year in CMP 2, although he only attended 16 interventions. Such autonomy was allowed, as long as there was a solid clinical rationale for it. However, careful monitoring occurred when claimants were 'in breach' of the time regulations.

Whilst clinical staff were happy to refer claimants to existing services rather than replicating them, there were cases when they felt uneasy doing so. This was the case with claimants who were most anxious or depressed where a rapport had already been established (OT 2, CMP 1, clinical lead CMP 2). On the other hand, the need to not provide treatment was incredibly frustrating for some clinicians. In particular, both physiotherapists fully subscribed to the aim of 'hands off' physiotherapy, where claimants were empowered to learn how to improve their symptoms without the presence of a physiotherapist, providing a longer term effect in the relief of pain. However, in some cases, they felt that performing manipulation on claimants would have been beneficial in addition to the exercises that claimants were undertaking at home. Although this was a tension highlighted, physiotherapists did not state that they performed treatment.

In not providing treatment, clinical staff could lose valuable skills, and this was something that the clinical leads of both services identified as an issue in the continuing professional development of their clinicians. In addition, the physiotherapist from CMP 2 was the manager of a more junior

colleague. In order to ensure the junior physiotherapist remained employable at the end of their contract with the CMP, the senior physiotherapist sent the junior to mainstream physiotherapy teams when workloads were light, and thereby ensured the junior colleague attended training commensurate with their level of experience.

In addition to the external requirements imposed upon the CMP, both CMPs had decided that, although a lone clinician would assess each claimant, the decision of whether CMP was the most appropriate service for that claimant was to be a team decision. In practice, the decision was made by a multi-disciplinary team at a weekly team meeting, which was attended by all staff in CMP 2, and by at least one representative of each discipline in CMP 1. This was a practice that the majority of clinicians were familiar with, with the exception of the physiotherapist from CMP 1. Accordingly, this was seen as a way of ensuring best practice through the use of multi-disciplinary working and of sharing the responsibility and accountability for accepting a claimant onto the service. For example, the nurse from CMP 2 had occasionally noted that claimants were taking inappropriate combinations of medication. By meeting as a team with a nurse (CMP 2) and a GP (CMP 1), the service felt that it was covering itself against any legal issues that may arise in the light of such issues.

Whilst individual staff sometimes disagreed with the majority view, all were clear that ultimately this was about sharing responsibility, rather than doubting or challenging professional competence. As such, in CMP 2 the clinical lead noted that it was important for all staff who felt that they wanted to contribute something to the debate to be allowed to, and discussions of whether to accept a claimant could take up to half an hour per claimant.

A second requirement was that clinicians should not have 'too many' claimants active on their caseload at any one time. Whilst there was not a hard and fast rule, in CMP 2, if a clinician had accumulated more than 20 claimants, they would be told to reduce their numbers. This was seen, in

part, as a way to ensure a high quality service, but was also seen as essential to the well being of clinicians so they did not experience 'burn out' (Manager, CMP 2). In comparison to caseloads in mainstream services, CMP staff felt that these were 'luxurious', allowing them additional time to work with claimants (Nurse, CMP 2). However, this was also seen as a waste of resources by some clinicians who felt that they were able to support more claimants, and saw this as undermining their own autonomy (Nurse, CMP 2, OT 1, CMP 1).

Whilst the social workers in Broadhurst et al.'s (2010a) research were subject to ICT processes that automatically flagged up a case that had missed a deadline, there was no such monitoring for CMP participants who had been a participant for longer than the twelve week deadline. This is despite the official guidance that CMPs were subjected to by the DWP. It may be as a result of the differing aims of the programmes: Broadhust et al.'s social workers were part of a child protection team; the need for speedy assessment was to manage risk. On the other hand, the CMP practitioners in this case considered that discharging a participant too early could have a negative effect on them, and as such breaking this particular rule, imposed by an agency that staff believed to have little knowledge of health, was seen as in the claimants' best interests (Blazeley et al., 2006).

Likewise, it appeared that CMP staff were largely free of control imposed by ICT, unlike Jobcentre Plus Advisors. In part, this was essential in the context of delivering interventions within the community; whilst computers were available within the programmes' office space, clinical staff spent the majority of their time outside of the office (see Pithouse et al., 2009). Accordingly, case notes were always hand written.

6.3.7 Staff views of participants

Throughout the interviews, most of the CMP staff described their clients in terms of their demographics and or/their health conditions rather than making moral judgements. The manager of CMP 1 described the demographic of the programme's clients:

> I would say that by and large the majority of the people we tend to see are in the post-forty age group and I think that's largely to be expected (pause). In terms of their length of time on IB, at the outset we were expecting new and repeat claims, and we thought, perhaps naively, that we would be getting people who had fallen out of work recently. In our experience that is not the case. A lot of cases, even if they are a new claim, tend to be a repeat claim, so the majority of people that we see tend to have been on benefits for a number of years, you know ten years, eight years. It's quite rare that we see somebody who has actually.,.. is new to the benefit system. In terms of skills we do experience high levels of users who do have a basic skills deficit. And that is an issue that we experience quite a lot. To that end we supported one of our team members to undertake a basic literacy course, so they are able to guide people... we don't do assessments as such but we do have the skills to support people to take the next steps.

The manager of CMP 2 described his client group as more mixed in terms of age, with approximately 40% below 25 years and 40% over 50 years, which he attributed to JC+ targets to return certain groups to employment. Furthermore, the manager stated: 'I wouldn't like to say that there is a standard skill or education level, there doesn't seem to be any consistency about the level of person that we have...'. Finally, there seemed to be some differences in the employment histories of claimants:

> It's certainly not the case that there are people who haven't worked for 20 years, certainly not the case, a lot of people have very recent employment records, certainly more so than the people who haven't worked for 10 years, you know, but that's primarily because the people that we're dealing with are either new or repeat claims for IB, so it follows that they would have recently been in employment.

254

In terms of both areas, the manager's opinions were not contradicted by their staff, showing that the challenges in each CMP were very different.

Some of the clinical staff discussed the type of client that they received in terms of their diagnosis, for example OT2, CMP 1 described how they have less cardio-respiratory clients compared to mental health and musculo-skeletal. This was attributed to the quality of mainstream NHS services in the area. Within area 2, the OT technician stated that 'if I'm right, mental health tends to be the top, that's what we see most of, that's what most people will be seen for.'

6.3.8 Participants' views of Staff

Whilst interviewees discussed their view of Jobcentre staff at some length, they said far less about their CMP *staff* as opposed to their *interventions*. This may be as a result of the different relationship between the claimant and the advisor and the client and the clinician. With the exception of Emma, who described a difficulty with one of her clinician's styles of working, all of the interviewees were positive about the CMP staff. Furthermore, whilst Emma had a difficult relationship with one clinician, she had a positive relationship with some of the other staff:

> I like (Occupational Therapist) and there was another gentleman there and they were lovely; really, really lovely, I couldn't fault them. You know, they were all bringing in biscuits for the tea break and because I'm diabetic she was brining in fruit for me, that she was buying from Asda, and she didn't have to do that, did she?

Other positive comments about staff involved a feeling of confidence in the capabilities of the staff 'the physiotherapist was a lovely girl and she really knew her job...' (Joanne) and their ability to inspire positive change in interviewees:

And, the one that is helping me at the moment (CMP OT), all I can do is sing their praise, they have helped me to see things differently which I'm pleased about. I do think differently now. And exercise wise, the physio has been brilliant as well, so that's been very good. (Paul).

6.4 Conclusion

This chapter began by outlining the available literature on the CMP. The empirical section of the chapter moved on to provide a chronological account of attending the CMP. It was shown that voluntary participation was beneficial to the 10 claimants, and was perceived as positive by CMP staff. Major benefits identified were: being better able to manage their condition; increased confidence; better understanding of their condition. However, the benefits of CMP did not necessarily extend to a return to work, and steps towards a 'productive' role may not have been sustainable. Despite this, improvements in claimants 'zest for life' were seen by clinicians as a step on the, sometimes long, journey to work from IB.

The next chapter will return to the key themes identified in chapter 2, discussing discretion and morality throughout *Pathways to Work*.

Chapter 7: Morality, Discretion and *Pathways to Work*

7.1 Introduction

This chapter will begin by reminding the reader of the policy intention which has been at the heart of this exploration, as expressed by the primary Green Paper (DWP, 2002). It will then move on to explore notions of 'scroungermania' (Moore, 1981) through an examination of views of benefit claimants. It will be shown that whilst the claimants in the research spoke critically and at length about their peers, Advisors and clinicians said much less about claimants and in general avoided negative remarks. The third section of the chapter will examine the way in which *Pathways to Work* was experienced on the ground, contrasting this with the official policy documents and guidance produced by the CPAG (2009). The final part of the chapter will consider whether *Pathways to Work* was successful in meeting its aims?

7.2 The Policy Intention

The main thrust of the policy intention can be found within the Green Paper, '*Pathways to Work*' which has been referred to throughout the thesis (DWP, 2002). To recap, *Pathways to Work* was supposed to facilitate IB claimants in labour market (re)entry. By supporting IB claimants to return to work, it was suggested that claimants would be empowered and would exit social exclusion. Furthermore, the well publicised aim of facilitating the return to work of 1 million IB claimants was aimed to strengthen the economy by increasing the available work force and reducing the numbers of economically inactive people.

In order to bring about such a change, new IB claimants were required to take part in Work Focused Interviews with a Jobcentre Plus Advisor. During such interviews, Advisors could refer claimants to a variety of initiatives on a 'menu of choices'. One of these initiatives was the Condition Management Programme, funded by the DWP, but provided by the NHS. The stated aims of the CMP were to support claimants to:

- Understand their condition and its impacts on activities
- Increase their confidence
- 'return to some form of employment or training and as normal a life as possible' (DWP, 2002: 30).

7.3 'Morals': the views from within *Pathways to Work*

7.3.1 Introduction

Within this section, it is important to note that whilst claimants discussed their opinions at length, the staff members of Jobcentre Plus and the Condition Management Programme were much more formal in their responses. During interviews, I did not feel as though this was because they were trying to mislead me, or to evade questions, but perhaps because they tried hard to act professionally, and that expressing strong views of claimants, either positive or negative, was not seen as desirable.

7.3.2 Claimants' views of 'IB claimants'

This section will examine the thoughts of the engaged and unengaged IB claimants on the phenomenon of benefit 'scroungers'; that is those who claim benefits when they could be working. During the interviews, claimants were not asked about other benefit claimants or scrounging more generally,

although it was mentioned in the majority of interviews. Whilst some reference was made by a handful of claimants to being made to feel like a scrounger by other people, in the main, the claimants discussed their thoughts on 'other' claimants.

7.3.3 'Other' benefit claimants: views of unengaged IB claimants

Of the 11 interviewees, only four did not discuss their views of other benefit claimants. The most common view expressed by three of the interviewees was that 'youngsters' and 'kids leaving school' are the problem today; they are 'lazy' and 'don't want to work'. This view was often coupled with the notion that young people who are unemployed are undeserving of benefits whilst they, the long term sick who have paid National Insurance contributions, are deserving of government support:

> And then you get people leaving school who don't want to do a stitch in their life and they are getting paid all the benefits under the sun and I can't claim nothing and I've been working all my life to pay for them. (Ben)

The explicit suggestion by two of the respondents who held these views was that young unemployed people should be a 'target' for government intervention to force them into employment. It was stated by IB claimant 1, area 1 that 'If people really want to (get a job), they can do it. If they have got the initiative to do it.' The respondents did not see the similarity between the situation that they were in and the suggestions that they were making for young unemployed people. Likewise, labour market factors were not taken into account during these discussions. As such, it can be seen that the claimants were attempting to distance themselves from 'other' IB claimants (Becker, 1963), in order to justify their status as 'deserving' of Government support. The undesirable 'other' group of claimants are those who are breaking society's moral code: not working when they are not able bodied.

259

Thinking more specifically about those claiming IB, only three short references were made by two separate interviewees. Firstly, Michelle stated 'I do think people go for a run and then they say that they can't walk...'. This suggestion fits well with Stone's (1985) concept that deception has always been considered alongside claims of disability. Despite the strong views held by Michelle, she did not suggest reasons why people might choose to behave in this way when she was prompted. Furthermore, the same interviewee discussed the case of a man with learning disabilities known to her family who claims IB. During a conversation with her sister, it was stated that as he goes to the gym daily, he could go to work. Reflecting upon this conversation, the interviewee states 'He could go and do some shelf stacking for two hours a day which was true ... so, I think there are people who could (return to work).' Michelle's concept of the type of work that might be open to the claimant with learning disabilities is probably accurate of the type of work he might be expected to gain. Whilst for Michelle, the concept of him being able to go to work was about fulfilling his duty, this is very different to the arguments around social exclusion and fulfilling lives held within the policy documents (see for example PMSU, 2005, which argues very strongly for fulfilling employment, not any employment).

Secondly, Ben's mother stated:

> You know there are people out of work that we know, that live around by us, I mean have got drink problems, and are claiming all sorts of benefit because of that and living quite highly in pubs...

Within this quotation, it is possible to see two major parts. Firstly, for Ben's mother, being an alcoholic is not an acceptable reason to be considered sick. Discourses regarding the use of alcohol, to some extent, and drugs, to a larger extent, were present in several other interviews, including those with Jobcentre Plus staff. Secondly, Ben's mother can be seen as self-

identifying as part of the respectable poor (Murray, 1990), living on a low income with high moral values. Consequently, to see those who are claiming benefits appearing to have a higher standard of living seemed unfair to her. This issue was not raised by any other claimant.

In addition to these views, one interviewee who has claimed IB for more than 20 years answers the question 'can you tell me how you first ended up claiming IB?'

> I was twenty one. I was coming up to the end of having unemployment benefit. I had one week's worth of unemployment benefit left, found out I was pregnant and just signed on the sick, like everybody did at that time.' (Ann)

The assumption in this comment that it was acceptable to 'everybody' to use sickness related benefits as a safety net when unemployment benefits were inadequate in times of recession is well documented (Waddell and Aylward, 2002). Later in the interview, the interviewee suggested that this view is less acceptable today, even by people who would be eligible to claim the benefit, there is a presumption in favour of work.

However, another interviewee from the same area who attended the Condition Management Programme (Jo) suggested that among the eight or so participants in her CMP group sessions, only one man seemed to be keen to leave IB and return to work. The two primary reasons for this were the seriousness of claimants' health conditions and a general sense of hopelessness at being able to find 'good' work, which would not aggravate their health conditions. In this instance, the 'other' IB claimant was not the morally undeserving claimant, but the claimant who appeared to the interviewee to be overly optimistic about his chances in the labour market.

7.3.4 'Other' Benefit claimants: views of engaged IB claimants.

Within this group, five of the ten interviewees did not mention scrounging and one other claimant (Sarah) stated "(as) for people who are not working, I've got a personal view on that, there you go. I don't think I'll put that on tape.' The remaining four interviewees covered a range of topics. Three of the interviewees had relatively homogeneous views, suggesting that claimants were to blame; however, one interviewee placed the blame with the government.

Of the three interviewees who suggested that some benefit claimants are scroungers, Joanne discussed the issue the most, although her interview was longest. She stated that 'some of them are lazy buggers'. In a similar light, Emma told the story of a man who was in her CMP group session who refused to go on a course because he would have had to have taken two buses and was concerned 'that he'd lose his rent'. These were not viewed as legitimate concerns about how the man would cope financially if he lost his right to Housing Benefit, but as an excuse not to go on the course. She continues 'And they're being helped but if there's no money involved, they don't want to know, do they?' Emma also fails to note that the man in question was, by participating in CMP, already taking part in some voluntary work-focused activity.

This idea of unmotivated claimants is taken further by two of the interviewees who suggest that some claimants believe it is their right to claim IB. Paul described an incident in the waiting room of his local GP practice where he was talking to a man he did not know who was also claiming IB 'and the one bloke says to me, you pay for it all your life, (and I'm) thinking no, no, that ain't the right attitude. (When I said this) He looked at me like I was stupid.' Likewise, Joanne suggested that 'then there's the fact of they don't want to come off benefit... you've got a quarter of people

then who've been in the system for so long that they think it's their god forsaken right.' Whilst Joanne does not think that she will ever work again, and intends to stay on IB until she retires, she did not see herself in this same category; as she had worked for 28 years, Joanne felt 'entitled' to claim IB. This process of 'othering' can be seen as attempting to legitimate Joanne's own claim for IB.

It was suggested more strongly by Emma and Jacob that some IB claimants were not ill enough to be on the benefit. Both interviewees initially used their own conditions as an example and suggest what should be done to scrounging claimants:

> But I think a lot of people with say depression, I (don't) use that term lightly, because I wouldn't want somebody to have the depression that I have...or people that have never worked and suffer with so called "depression", but I do think a bloody good day's work would pull them out of their depression. It should be, 'well you've never worked so on so and so date you will work, this is where you will go to earn your money. And if you don't turn up you won't get your money. Simple as, you know? I think we need to adopt that, I just, I really go off on it, I've worked all of my life since the day I left school. (Emma)

Emma's support for workfare approaches as a way to 'pull' claimants out of their depression shows an adoption of some of the policy discourses about work being good for health (DWP, 2006). However, I believe that Emma would have not coped well were this approach to have been used on her; her depression was severe and she was unable to cope with everyday events, let alone compulsory participation in work. Likewise, Emma did not know when she would be able to return to work. Again, this approach could be seen as a way to legitimate her claim for benefits against those illegitimate claimants.

Jacob was less harsh than Emma when describing people with panic attacks 'pulling a flanker', but he questioned the incapacity of drug addicts:

Like um... some people are on Incapacity Benefit...and you (can) see there is nothing wrong with them like, they are on the sick and there is nothing wrong with them....you find some people then who like, you know they like, use drugs and things like that and they are just on the sick for nothing really...when they tell you things like that when you go to a medical, "oh you are fit for work" and then you get a junkie then or a druggie or whatever you want to call them, I call them junkies, they walk in there and they get a medical and you know, happy days, they say their heads have gone and that's it, they are still on the sick.'

Jacob's concern about the visibility of some claimants' symptoms appeared to contradict his own circumstanaces: Jacob's own reporting at interview and his CMP file reported only mental health issues and described Jacob as being fit and well. However, his frustration at drug addicts 'passing' a medical board, when he failed his, showed how he was unable to see the incapacity of a drug addict as worthy of state support. Throughout his interview, Jacob demonised drug addicts, as taking the scare resources of his local community mental health team, resulting in him having to 'reach rock bottom', before he was given any support.

Tangled in among these viewpoints, as with the unengaged claimants were comparisons to the interviewees being deserving, good claimants and others being bad claimants. The views of the unengaged claimants tended to focus more on younger people; another category of people whom the government would like to return to work. However, the engaged group moved firmly away from this and only discussed the more general terms of 'benefit claimants' or those 'on the sick'. By dividing IB claimants into a deserving and undeserving group, the claimants' views mirror the new Employment and Support Allowance, which defines two groups of 'sick' claimants: one deserving of unconditional support and the other only deserving of support if they engage in work-focused activity. What is clear throughout is that all claimants considered themselves to be genuine but believed the populist discourses that there was a group of scroungers. Whilst the unengaged claimants distanced themselves from this group by ignoring the notion that some IB claimants were scroungers, the engaged group appeared more confident of their deserving status, and thus identified

scroungers within the population of IB claimants. In addition, the engaged benefit claimants moved on from just describing the problem, to suggesting solutions.

7.3.5 Jobcentre Plus Advisors' views of Benefit Claimants

Whilst Kingfisher's (1998) research in the USA found that those who were administering welfare could view claimants as lazy or dishonest, the Advisors in this research made very few moral judgements of claimants. The most critical stance taken about claimants was by Advisor 1, area 2 who also performed Disability Employment Interviews with Jobseekers Allowance claimants. The Advisor suggested that the JSA claimants 'have more quite severe health conditions compared to' the IB claimants, and that 'the more severe somebody's health condition is, the more motivated they are to find a job.' Later in the interview, the Advisor suggests that this is related to claimants' perceptions of their job readiness; for those who have severe disabilities, the Advisor argued, coping becomes a way of life. Despite seeing JSA claimants as more incapacitated that IB claimants, however, the Advisor thought that most IB claimants would like to return to work. The view that the majority of IB claimants would work if suitable employment could be found was shared by all Advisors.

The only other Advisor to make a direct statement about the legitimacy of some IB claimants within their interview was Advisor 2 from Area 2. In this instance, the Advisor categorised IB claimants into two groups:

> the more disabled people (who) are the ones that want to get out and do something, that have got serious barriers to work but they want to go and do something... (and) the people that really can't be bothered are the ones that have got a bit of man flu or something, you know the equivalent, do you know what I mean? They are not really disabled as such, you know, they have got health conditions maybe but some of them are more than capable of working but they don't want to...

265

It is interesting to see that genuine claimants are seen as those who are not only the most disabled, but are the ones who are most motivated to return to work. From the interview data and evidence from previous research presented in Chapter 4, it is clear that many of the IB claimants have very severe health conditions, and may desire to return to work, but the severity of their condition makes that impossible without a very accommodating employer. . Finally, at the end of the interview with Advisor 2 from area 1, the Advisor suggested that he 'knew' some of the claimants were fraudulent, citing an example of people 'coming in to sign on in the works' van, covered in paint...and you just think "can't you at least try to hide it?"'

Whilst explicitly moral statements were rare, Advisors were comfortable identifying groups that they 'found hard to help', which typically included those with drug and alcohol addiction. In this instance, however, instead of condemning claimants who have an addiction as several of the claimants did, Advisors would attempt to support them. For example, Advisor 2 from Area 1 described how she was able to refer claimants to a local support group. On the other hand, Advisor 5 from Area 1 felt extremely frustrated that she was not able to make similar referrals because of a lack of local provision. Through discussion with CMP staff, she knew that claimants who were struggling with addiction were often viewed as not suitable for a short-term service. The Advisor described how she had had to work very hard to find work preparation placements for claimants with addiction, but how finding a good quality placement could result in a positive outcome for participants.

The relative lack of disclosure of moral judgement by the Advisors can be seen as a weakness of the research design. The Advisors did not know me, and consequently, a stronger ethnographic approach may have elicited further insights as Advisors became more comfortable with my presence. Within the period of observation, Lydia, the Advisor I shadowed, did make some moral judgements about claimants, although these were rare. Firstly,

she described, through a positive example of a claimant, how there was a culture of benefit dependency. One young woman, who I did not observe, was keen to return to training. However, Lydia suggested that as she was married to a man from a family where 'for generations and generations, they've all claimed benefits', she was discouraged from interacting with the Jobcentre Plus Advisors. Lydia was pleased that the young woman had decided to participate in the course anyway, but saw the family as a barrier.

I was also able to identify, through Lydia's use of the Advisor Discretion Fund, where up to £300 can be awarded to a claimant, those who she thought of as more deserving. For example, one claimant was offered money that she had not requested because 'she hasn't had anything from us yet, and you'll see her, she never asks for anything, she's a lovely kid.' On the other hand, a man who had previously been seen by another Advisor claimed that he had been offered some money to pay for a licence in order to drive a taxi. The man appeared drunk, and was unkempt in appearance. He claimed that he needed more than twice the amount of money that the licence cost, and afterwards Lydia confided that she might not have given the money to him if another Advisor had not 'promised' it to the claimant. Whilst the first claimant had the additional funds paid straight into her bank account, the Advisor arranged with the Council to pay for the second man's licence directly. In a discussion about this afterwards, Lydia described how many claimants attempted to abuse the system and how some Advisors in her office did not ever use it for that reason. This discretionary treatment has also been identified within the USA (Kingfisher, 1998), showing that the evidence uncovered here is unlikely to be an isolated example.

Finally, through the example of one older female claimant, Lydia's frustration with some IB claimants was possible to see. The claimant had claimed a wide variety of benefits for many years and had just 'failed' her medical to continue claiming IB. Lydia stated:

I'm being good to her; when she fails her appeal, and if she's put on the form what she said to me here, they'll just dismiss it, and she'(ll be) on JSA, they won't offer her a nice course (like I have), they'll say "You've worked as a cleaner before, we've got plenty of jobs for cleaners here!" And that'll be it...She just can't see it...There are 19 years until she retires; it's a long time to stay on benefits, we need to get something sorted for her... I do try to be sympathetic but I've been seeing her for years and years and I just think 'Oh (name), please just do something, anything!'.

7.3.6 CMP staff views of Benefit Claimants

Whilst the Advisors rarely described claimants in moralistic ways, the clinicians did even less so. The Senior Practitioner from CMP 2 did argue that the team at CMP 2 expected the service to be busier when it was first established, and that they believed their low numbers were because some people were content to remain on IB (this is in contrast to the official evaluation which showed that Advisors were not confident in referring people initially, Corden et al., 2005). On the other hand, the nurse from CMP 2 described her surprise at the 'resilience' of some of the claimants she had encountered who had been 'surviving' on an incredibly low income, sometimes for a period of many years. However, these were the only explicitly moral comment made 'on the record'. Several 'off the record comments' would have been interesting to include, and it is noteworthy that clinicians felt able to express what they felt were controversial opinions in front of me or to me, but did not desire their inclusion within the thesis.

In comparison to the Advisors who rationalised why some claimants were frightened to attend Work Focused Interviews, clinicians were able to use their expertise to extend this explanation, by describing how some claimants have got into a 'safe routine' (OT technician, CMP 1). Furthermore, like the Advisors described above, the severity of a claimant's health condition was not seen as linked to the extent to which they engaged with CMP or the level of benefit from the service (Clinical Lead, CMP 2).

268

The main way in which the CMP staff made judgements about claimants with whom they came into contact was regarding the claimant's engagement with their services. Those who 'failed to attend' interventions were a source of frustration to all clinicians. This was different to the resigned acceptance displayed by Advisors. In part this can be explained as an issue of time; whilst Advisors are stationed at their desk and can carry out other work if a claimant does not attend, Advisors meet claimants in their communities. Both Areas had a relatively wide geographical spread of claimants, and as such, a 'failure to attend' could result in a time-intensive wasted journey. Another possible explanation for this trend is that most CMP clinicians were used to working within mainstream NHS services where rates of attendance were described as higher. By contrast, all of the Advisors had worked in similar roles for around a decade and may have been more used to lower levels of engagement. However, unlike the Advisors, the clinicians were much more likely to see a lack of engagement as related to a claimant's condition, and treat them accordingly, for example offering them an alternative meeting venue if the Jobcentre Plus office was seen as a barrier to their engagement (Physiotherapist, CMP 2; OT 2, CMP1), or different interventions (Clinical Lead, CMP 2, Physiotherapist, CMP 1, OT1, CMP 1).

Later on in the CMP process, when a claimant had been attending for some time, several clinicians expressed feelings of frustration when claimants did not regularly attend, as it was seen as preventing progress. Another area in which claimant engagement was registered was in terms of doing 'homework', such as completing paper-based tasks, like work books or pain diaries, or carrying out physiotherapy. When this was discussed, clinicians were positive about claimants who generally admitted if they had been unable to complete the work: 'They're generally very honest; most of them are very honest' (Physiotherapist, CMP 1). Furthermore, some claimants were identified as very engaged, and carried out more work than they had been asked to do. This was remarked upon very positively, and was

identified as a sign of someone who really wanted to improve their condition (Nurse, CMP 2, Physiotherapist, CMP 1). As such, it can be seen that clinicians identified claimants who were 'a joy to work with' (Nurse, CMP 2), as opposed to those who 'waste my time' (Senior Practitioner, CMP 2). Despite the contrasting discourses, all claimants agreed that it needed to be 'the right time' for a claimant to engage. As such, if a claimant was not able to engage, a discussion would follow where they were asked if they wanted to be discharged and re-referred by their Advisor when they felt more ready. This was seen as sensible clinical practice that would not dishearten claimants by expecting too much of them nor waste clinician time.

Whilst these are not the 'scrounger' type discourses identified in Chapter 2, the ease of working with a claimant was a factor in clinician perceptions. Returning to the case of Joanne, described in chapter 6, it is clear that her CMP clinician was finding her difficult to work with. Joanne, it was suggested in her file, was in danger of becoming dependent on the CMP. Despite the staff concerns, discussed within several team meetings, Joanne was accepted on to all of the interventions she desired, despite overrunning the 16 week time period in which CMP are supposed to discharge claimants. In exercising professional judgement in this way, it is fair to argue that the CMP staff identified strongly as NHS clinicians, as opposed to bureaucratic instruments of the Department of Work and Pensions. For this reason, and because of their more autonomous position, for example, not having any targets to meet as individuals, I believe that CMP staff were able to distance themselves from more negative discourses.

7.4 How was *Pathways to Work* Implemented?

7.4.1 Introduction

Within this section, it will be recalled that both Advisors and CMP clinical staff can be seen as Street Level Bureaucrats (SLBs), following Lipsky's (1980) definition. However, as described in Chapter 2, the scope within their respective roles for discretion is very different. Firstly, a focus upon Advisors' discretion within compulsory Work Focused Interviews will be considered in light of the primary policy document (DWP, 2002) and the guidance produced by the Child Poverty Action Group (2009). Secondly, the use of discretion, or clinical autonomy as it is more commonly referred to within the literature, will be discussed in relation to CMP interventions.

7.4.2 Discretion within Work Focused Interviews

Chapter 5 showed a diverse range of approaches to conducting Work Focused Interviews. Advisors spoke of the importance of attempting to address claimants' fears and to build up a rapport. This approach did not appear to be noticed by many of the claimants, particularly the unengaged claimants, who remained concerned about their interaction with Jobcentre Plus and the possibility of losing their benefits.

Within interviews, Advisors had targets to meet in terms of 'being productive', although they could do this through referral to any of the 'menu of choices'. Despite this, Advisors had clear ideas about which were the 'best' interventions. Where 'choices' were outsourced to private companies, Advisors worried about the quality of interventions offered and this could result in them acting in three ways: having to take on a strong 'case manager' role; ensuring provision was of an acceptable standard; or not using 'choices' that were of an unacceptably low standard.

Beyond these concerns, Advisors tended to think of the most suitable 'choice' for a claimant's circumstance and offer them that one. Whilst this practice might be criticised for disempowering claimants, from my period of observation, I found that when claimants were offered a choice between several programmes, they often asked the Advisor about which one they thought was most suitable. Thus if claimants were given a choice between 'Work Preparation', 'Work Trials' and 'Permitted Work', the distinction between the schemes would often be unclear to claimants who were rarely experts in this area.

Whilst Advisors were able to exercise their discretion by recommending specific 'choices' to claimants, they could feel severely constrained by the need to meet targets, as measured by the 'Advisor tool' computer system (Bain and Taylor, 2000). However, there appeared to be less emphasis on office specific guidance than was found in the 1990s, although managers' attitudes to failing to meet targets were still important to Advisors (Foster and Hoggett, 1999). However, whilst Wright's (2003) research into the implementation of Jobseekers' Allowance (JSA) found that Advisors concentrated their efforts almost exclusively on areas where their performance was measured, the Advisors within the research often made considerable effort that was not able to be measured by the 'Advisor Tool'. Furthermore, some Advisors actively refused to conduct interviews with targets in mind, as to them it did not represent acting in the claimants' best interests (Lipsky, 1980). This may be as a result of the different levels of expertise, with *Pathways* Advisors typically having considerable experience of working in this area, or differing pressures within the two work roles. At the time of the research, Advisors had between five and ten minutes, depending on the office, in which to 'sign on' a JSA claimant. Incapacity Benefit interviews, on the other hand varied between 40 minutes and an hour for the initial interview and 20 minutes to half an hour for subsequent interventions. As such, the reduced time pressures may make it easier for Advisors to go beyond the scope of their targets.

The main way in which engagement can be monitored through the Work Focused Interview portion of *Pathways to Work* is through claimants' attendance. All Advisors had regular 'failure to attends', generally at least one per day. Although there is no requirement for Advisors to attempt to make contact (CPAG, 2009) with claimants following a missed appointment, all Advisors used this approach. As such, they were attempting to minimise the harshness of the policy, by not imposing a benefit sanction straight away. Additionally, the use of benefit sanctions was uncommon for many Advisors, despite the regularity of 'failure to attends' and the clear guidance in this area. Whilst the CPAG (2009) guidance states that claimants can also be seen as not fulfilling the Work Focused Interview requirement unless they participate and agree to an action plan, none of the Advisors mentioned this rule, nor appeared to have made use of it through their discussion of sanctioning claimants. This can be seen as staff using their discretion to the advantage of claimants (Moore, 1981).

Within the research, interpreting guidance in an advantageous way for claimants was common. It is necessary to see this as a result of a policy that allows staff to act in this way, rather than leaving them with no option but to treat claimants harshly to manage demand (Social Fund Commissioner, 2009; Hall, 2007; Rowe, 2002). Consequently, the *Pathways to Work* policy design can be seen as affording Advisors some scope in which to treat claimants positively. The replacement benefit for IB, Employment and Support Allowance, can be said to reduce these opportunities, and this will be discussed in more detail in the next chapter.

7.4.3 Discretion within the Condition Management Programme

Among those who 'agree' to take part in CMP within their Work Focused Interview, there are a large minority, approximately one quarter, who never engage with the service. As was described in Chapter 6, CMP clinicians will

attempt to increase engagement by contacting those who have been referred prior to their Initial Assessment. This was seen as good practice and was widely adopted, although it did not appear to be contained in any official guidance within either CMP. However, guidance from the DWP was minimal and it appeared that the CMPs themselves had not produced detailed guidance. This contrasts with Foster and Hoggett's (1999) finding that decreased guidance in areas relating to social security would result in the increasing use of local guidance. Consequently it is necessary to view the CMP as something added on to social security provision, rather than as social security provision.

With the exception of 'all decisions (regarding accepting a new claimant) are team decisions' (Clinical Lead, CMP 2), there did not appear to be any hard and fast rules that were stuck to. This one rule, however, was always adhered to, minimising the room for individual discretion within the team. One clinician explained that sometimes the discussion could become heated and that it could take over half an hour to decide on one case (Nurse, CMP 2). In this way, clinician's autonomy over whether to accept a claimant and which interventions they should receive is less than Advisors' discretion. In this way, the types of discretion experienced by Advisors and clinicians can be contrasted. Whilst Advisors have little discretion regarding waiving interviews and the need to be productive within them, they have complete autonomy over how to make their interviews 'productive'. On the other hand, CMP clinicians have almost complete autonomy within the *Pathways to Work* guidance, but choose to voluntarily surrender that autonomy within their multi-disciplinary team.

In all other parts of the CMP process, clinicians have extremely wide discretion, as there is very little guidance to follow. Such freedom was viewed very positively by clinical staff, who saw it as a mark of their professionalism (Lindsay and Dutton, 2010). As such, venues were largely decided by the clinician (Barnes and Hudson, 2006) and levels of interaction with Jobcentre Plus Advisors could vary significantly, depending on if CMPs

274

utilised the interview rooms available within the Jobcentre Plus offices (Lindsay and Dutton, 2010). However, clinicians were supposed to follow two DWP set rules: they should not provide treatment, and interventions should last for a maximum of 16 weeks.

Clinical staff found it difficult to distinguish between 'management' and 'treatment'. In terms of physiotherapy, it was rare for hands-on interventions to be used, with most claimants being shown exercises to do themselves. However, when it came to claimants with anxiety and depression, it was much harder for staff to say that they were not providing 'treatment'. Many claimants 'felt better' (Joanne) having attended CMP, and as such, they could be said to have crossed the artificial distinction between management and treatment. However, for some clinicians, the distinction meant that they were unable to use some of their skills, such as acupuncture, to treat claimants. As such, they felt that this artificial distinction prevented some claimants from receiving the most appropriate interventions.

Furthermore, as was discussed in Chapter 6, clinical staff were extremely reluctant to discharge claimants who they felt would benefit from further interventions. Consequently, many claimants fell outside the 16 week time limit, although this was found in other research on the CMP (Ford and Plowright, 2008). Thus it can be seen that staff and managers of the CMP were prepared to not meet their targets in order to ensure claimants received the most appropriate treatment possible.

7.5 Did *Pathways to Work* meet its aims?

7.5.1 '1 Million IB Claimants back to work?'

As the first section of this chapter recalled, *Pathways to Work*'s primary publicised aim was to return one million IB claimants to work. Within the

sample of claimants interviewed, only one, Mark, out of twenty-one returned to work. In Mark's interview, however, he describes how he found a job and subsequently engaged with a private provider in order to claim the Return to Work Credit. Prior to this, Mark had taken part in Work Focused Interviews but been too depressed to envisage returning to work, and consequently did not participate in any of the 'menu of choices'. Whilst it may appear that the additional £40 a week the Return to Work Credit provides inspired Mark, it did not play any part in his decision making, as he was not aware of the Credit until he began work.

On the other hand, one other claimant attempted to return to work but was unable to sustain their labour market re-entry because of their health conditions. Jacob, who had worked as a self-employed plasterer prior to claiming IB had returned to work part-time for his previous 'employer'. However, the increasing severity of his anxiety and panic attacks meant that Jacob was unable to continue, despite his employer making considerable adjustments for him. Likewise, Sarah attempted to work voluntarily for a charity shop, but her back pain resulted in her being unable to complete even her first day. Both Sarah and Jacob were left demotivated after their failures.

7.5.2 Was CMP successful in meeting its aims?

Whilst the previous section showed that *Pathways to Work* had little success in returning even the most motivated of claimants to work, the aims of CMP were somewhat more realistic. Chapter 6 showed that the CMP was able to support claimants to understand their conditions better and how to be able to increase their activity within the confines of their health condition. Furthermore, claimants spoke at length of their increased confidence, which was supported by comments made in their clinical notes. However, it is important to note that these claimants were all voluntarily attending an NHS CMP. Readers should recall Jo's story, contained in the

prologue. Jo attended a private CMP because she thought it was a requirement to claim IB. Unfortunately, Jo did not experience any positive outcomes from attending the service. Therefore, the experiences of the 10 engaged claimants should not be seen as representative of all claimants attending all CMPs.

The aim that CMP struggles to meet is the requirement to facilitate claimants to: 'return to some form of employment or training and as normal a life as possible' (DWP, 2002: 30). Of the ten engaged claimants, only one, Rachel, met this requirement. It should be recalled that Rachel attended Jobcentre Plus Work Focused Interviews on a voluntary basis, unlike any of the other claimants, and as such should be seen as more motivated to move towards work. However, despite Rachel being enrolled on a full-time course in administration, she was still unsure if she would be able to secure employment after her course as she considered herself to be slower than the other course participants, who were mainly aged 16-18.

Whilst the CMP participants did not, in the main, return to a productive role, the increases in confidence and better understanding of their health conditions were seen by clinicians as the 'start (of) a journey' (Clinical Lead, CMP 2), where employment is the end destination, but it could be some time away. Consequently, longitudinal research with participants could show that some of these extended trajectories, which were not visible within the current research, could end in work or other productive roles.

7.5.3 Why Didn't Pathways to Work achieve its aims?

I believe that the principal aim of Pathways to Work, to return 1 million, or one third of all, IB claimants to work, was optimistic from the outset. This view was adopted by Fothergill and Wilson (2007), and many disability rights groups were critical of Pathways in their responses to the Green Paper (see for example: Leonard Cheshire Disability, 2002). Whilst it might

be suggested that the economic downturn was in some way responsible for the failure, Timmins and Barker (2009) argue that the national roll out of *Pathways*, primarily undertaken by the private sector, was set to fail to meet its targets regardless of the recession. Consequently, I believe that the New Labour Government chose the wrong target. Within many of their policy documents, discourses surrounding the empowerment of disabled people were to the fore (see for example PMSU, 2005), although this presumably was not able to be formed into a politically attractive target.

Whilst *Pathways* can be seen as having adopted a somewhat heavy-handed approach, for example with publicity focused around finding 'benefit thieves' and using sanctions to force compliance, the policy did have a positive effect for some of those who chose to participate. The next chapter will show how the private sector had considerable success with 'voluntary' claimants (that is, those who had no requirement to attend, but chose to do so) but were less successful with mandatory *Pathways to Work* customers. This story of success for voluntary claimants can be seen strongly within Rachel's case. Having self-referred to Jobcentre Plus, Rachel wanted 'to try anything' to get better, attended the CMP and began a full time college course. All of the clinicians interviewed suggested that claimants 'need to be ready to change' (OT 1, CMP 1), consequently, a more positive publicity campaign, allaying the fears of claimants that their benefits will be removed, may have attracted more voluntary claimants to Jobcentre Plus and gone further towards achieving Labour's ambitious target.

7.6 Conclusion

This chapter has returned to the literature found in Chapter 2 in order to examine the moral order involved in *Pathways to Work*. It was shown that claimants were the most judgemental group regarding scrounging activity among benefit claimants. This judgement can be theorised through

Becker's (1963) concept of 'outsiders', where claimants attempt to display their separateness from deviant outsiders by attributing negative characteristics, which they do not engage in, to benefit scrounging. The chapter also showed that CMP staff had considerable discretion when compared to Jobcentre Plus Advisors, which was viewed by CMP staff as an essential part of their job role, and linked to their self-reported expert status as NHS clinicians. Finally, it was argued that *Pathways to Work* failed to meet its primary aim of returning one third of IB claimants to work because the aim was unrealistic. However, this is not to suggest that *Pathways* was without value, particularly for those who chose to engage with CMP, where positive change was encountered in a number of ways, which may at some point in the future translate into a productive role. The next chapter will conclude the thesis. It will outline the policy change since the beginning of the research project, before making policy recommendations and suggesting areas for future research.

Chapter 8: Conclusion

8.1 Introduction

This final chapter begins with an explicit statement of the claims to be made from the research reported. It will then examine the policy context after the fieldwork period. The replacement of IB with Employment and Support Allowance, introducing a two-tiered system, will be described. Alongside this change, the end of *Pathways to Work*, including the Condition Management Programme will be discussed. Furthermore, the chapter will speculate upon changes that are likely in the current Conservative/Liberal Coalition Government. The chapter also describes areas in which policy could, and perhaps should, be changed as a result of the research. Finally, avenues for future research are explored.

8.2 The Contribution of the research

Firstly, the research has focused upon policy change from the point of view of all of those involved (within NHS run CMP areas), using multiple sources of data to gain a detailed understanding of how the policy change was experienced on the ground. Furthermore, by recruiting IB claimants from outside the *Pathways to Work* context, as well as within it, it has shown differences between these groups that the DWP official evaluation has been unable to identify. The research also highlights the importance of a worker's labour market security when they become sick, or pregnant. The latter point was largely neglected within the literature.

The research also built upon the discretion literature from the 1980s finding that Jobcentre Plus Advisors use their discretion in many ways, but must work within significant constraints. On the other hand, the CMP clinical

staff, whilst paid by the DWP, were still able to maintain much of their usual clinical autonomy.

8.3 Discretion, Policy and front-line service workers

The previous two chapters have shown that Lipsky's theory of Street Level Bureaucracy continued to have relevance for those administering IB, and also for those who were attempting to facilitate improved condition management. There were, however, some major differences between the two occupational groups.

Jobcentre Plus Advisors were subject to a large amount of official guidance which, on the face of it, reduced their opportunities for discretion. However, within the guidance, I believe that Advisors were treated as semi-professionals. For example, the guidance could have set out a prescriptive way in which the menu of choices were delivered to claimants, such as a 'better off calculation' (see section 5.3.4) always having to occur in the first interview. By making Pathways to Work a service tailored to the circumstances of each individual claimant, Advisors' expertise was recognised. This forced Advisors to act with discretion in interviews, although it was reported that some Advisors would have preferred increased guidance, for example, in relation to the Advisor Discretion Fund. Furthermore, managerial support enabled official guidance to be bypassed, despite breaching office targets, if Advisors could provide a reasonable explanation for such a breach. This can be understood to indicate a good working relationship, but may also be an acknowledgement that Advisors are a valuable commodity: all Advisors had worked in similar roles for at least nine years, and thus they held a large amount of knowledge, both relating to official guidance, and also to local programmes. Advisors who participated in interviews described how new Advisors had little training in comparison. Whilst some Advisors appeared to recognise their relatively strong position, others did not and worried about failing to meet targets.

Whilst Advisors were primarily constrained by DWP guidance, CMP clinicians had many fewer DWP-inflicted constraints. However, the service managers and clinical leads introduced other guidelines within which clinicians were supposed to work. As these were not official guidelines, with targets to meet, and clinicians saw themselves as being the best judge of how to treat claimants and manage their workloads, opportunities for discretion were considerable within the CMP service. If, however, a 'difficult' claimant, such as one who might become reliant upon the service, was identified, clinical staff worked together in order to find the best solution for the claimant. Accordingly, the research found that clinicians sometimes resented the DWP official guidance, whilst working within it the vast majority of the time. It was argued that such guidelines did not always work in the claimants' best interests and also deskilled staff and failed to acknowledge their clinical expertise. Contrariwise, clinical staff did not always agree with the team decision when cases were discussed at the (multi-disciplinary) team meeting, but they respected the decision of other health professionals, and valued the safeguard that team-decision making gave them (Blazeley et al., 2006).

Therefore, it can be stated that both groups of workers were able to exercise discretion *because* of their expertise, as perceived by managers, for the Jobcentre Plus Advisors, and by the DWP's official guidance, for CMP clinical staff. These differences appeared to be as a result of how the DWP perceived the different groups when the Pathways to Work Green Paper was written in 2002. At this time, a tough stance was declared upon those who could be working, and accordingly Advisors were seen as needing to perform a policing function, such as by sanctioning non-attendance at interviews. On the other hand, as the idea of a DWP funded DoH delivered back to work service was entirely new, and was hoping to be innovative in order to result in the most efficient practice, hence relatively low levels of guidance were deemed to be appropriate. Furthermore, once the 2007 Welfare Reform Act was put into place, the majority of CMP

282

services were to be provided by private companies with payment on results. As such, by allowing these companies (which declared themselves to be experts in this area) to have a high level of freedom, it was supposed that best practice would be found, increasing job entries. Unfortunately, this very clearly did not occur, with Pathways to Work found to have no impact upon job entry among IB claimants (NAO, 2010). As such, if the DWP are to re-introduce a health-based back to work programme in the future, it is possible that discretion may be more narrowly cast.

8.4 The evolving policy context

8.4.1 The Introduction of ESA

Whilst the thesis so far has focused upon the changes introduced by *Pathways to Work*, significant policy change regarding benefits for the long term sick and disabled occurred during the data collection period. Incapacity Benefit was replaced by Employment and Support Allowance (ESA) in 2007. The very name conveys a different policy objective; the previous income maintenance policy was a 'benefit'; to which the individual had a right to claim on the basis of contributions paid or as recognition that the recipient had in some other way earned the state's support. The reason that such support was seen as desirable was because of 'incapacity'; put simply the claimant was seen as incapable of work to a significant extent. ESA, on the other hand, conveys nothing of the sort. The 'Benefit' is replaced by an 'Allowance' which can be defined as:

> An amount of something, especially money, given out at regular intervals or for a specific purpose... (Encarta Concise Dictionary, student edition).

As such, the 'specific purpose' behind the Allowance is to promote work. The very first statement contained in the Jobcentre Plus leaflet about ESA states 'Employment and Support Allowance helps people with an illness or

disability to move into work' (JCP, 2010: 6). Thus, the entire rationale behind the primary benefit for those who are excluded from the labour market as a result of their health condition is to 'support' them to re-enter work.

A further way in which ESA changes the policy for the long-term workless sick and disabled comes through dividing them into two categories. Thus whilst IB could be criticised for drawing a harsh distinction between those who 'passed' and 'failed' the medical test, ESA further divides those who 'pass' the test into those who are seen as being 'severely' affected by their health condition and those who are seen as less ill (CAB, 2010). For those who are 'less ill', the full level of ESA will not be paid unless they participate in work focused activity. This requirement is similar to the conditionality attached to claiming Job Seekers Allowance, which changes the benefit from a safety net to a trampoline (Bambra and Smith, 2010). A third group who entirely 'fail' the medical assessment will be ineligible for ESA.

Whilst commentators and historians focusing upon the Poor Laws showed the distinction between 'vagrants' – the undeserving - and those who were defined as sick in some way, and seen as deserving (Stone, 1981; Marshall, 1985), the line of demarcation is now much less clear. Although the notion of widespread fraud was rejected by the New Labour Government, the arguments of Beatty and Fothergill (1996) that Incapacity Benefit covers up hidden unemployment have been adopted: the 'support only' group claiming ESA are now treated as an extension of the unemployed. It may well be that this group is largely composed of those who Beatty and Fothergill (1996) would define as being able to work in conditions of full employment, but it is clear that full employment is far from realistic at the moment. The concept of being ready for some work, but being unable to access suitable employment was a common tale from the fieldwork.

In addition to rising unemployment since 2008, employment conditions in the UK have become increasingly insecure over the past two decades,

particularly for those with limited skills and qualifications (Rodgers, 1989). Within my research, the concept of precarious employment that offered little to claimants aside from the financial gain, was common. As such, the aim behind the policy can be seen as social control. By keeping ESA claimants 'work ready', even if jobs do not exist, they are prepared to take up employment when required, even if it may not be what can be thought of as good quality employment. Furthermore, by engaging with work-focused activity, claimants are less likely to be socially excluded and the work ethic can be passed on to their families.

In order to claim ESA, conditions in addition to personal eligibility characteristics must be fulfilled. These include:

- 'fully' taking part in a medical assessment (JCP, 2010:9)
- Taking part in an interview considering work prospects for 'most' claimants (JCP, 2010: 11)

Claimants of ESA will have to undergo the new 'Work Capability Assessment' which involves completing a questionnaire and attending a medical assessment where a health care professional 'will assess how well you can do things like walk, sit and stand up, use your hands, see and hear' (JCP, 2010: 12). This new test is stricter than the previous test.

The rationale for a two-tiered system continues to focus upon reducing poverty: the leaflet also points out that 'Research shows that people are better off in work' (JCP, 2010:12). This, however, is a contested concept (Child Poverty Action Group, 2008) that may well not match with the lived experiences of those who are claiming ESA. Furthermore, when the costs associated with work are taken into account, such as travel and childcare, some people claiming ESA may be financially better off claiming benefits.

8.4.2 The end of the Condition Management Programme

In 2007, following the award of almost all of the new *Pathways* contracts to private companies, as advocated by the Freud Report (2007), an independent enquiry found that some locally based third sector groups, who would have been likely to deliver *Pathways to Work* well, chose not to submit bids (Barker and Timmins, 2007). It was concluded that this may have resulted in diminishing knowledge of local areas within contracts and a dilution of innovation, as national companies succeeded (McDonald et al., 2007). More recently, this concern has also been aired in a specifically Welsh context by the Welsh Council for Voluntary Action (Jarrold, 2010).

Within the newer private CMPs, 70% of payment was related to targets (Lindsay and Dutton, 2010). This approach to policy delivery is politically popular in the wake of the Freud report as a way to facilitate innovation, and was used for the New Deal for Disabled People with some success (Freud, 2007). Criticism by academics focused upon the potential for private companies to focus upon job-ready claimants rather than addressing the significant barriers to work faced by many IB claimants because of their performance related targets (Grover, 2009). Likewise, it was suggested that there was no evidence that the private sector was better able to implement Labour's welfare-reform agenda, particularly in the light of the model used during the pilot stage (Davies, 2008, Lindsay and Dutton, 2010).

Evidence uncovered by journalists based upon Freedom of Information requests found that the private companies implementing *Pathways to Work* were failing to meet their targets by a staggering 73% (Timmins and Barker, 2009:1). However, the private companies were consuming almost 100% of their expected expenditure. As a result of contracts that paid based upon results, it is reported that *Pathways to Work* providers were losing money (Timmins and Barker, 2009). In areas with private providers, where almost three quarters of payment related to job entry targets, it seems likely that IB

claimants would experience a different service from a private CMP to an NHS CMP that was not based on targets.

There was very little review of the provider-led CMP. Early findings presented by Davidson and Weston (2010) on how private companies were implementing *Pathways to Work* found that clients did not always feel that services were tailored to their needs, staff workloads were prohibitively high and staff turnover was also high. In addition to this, referrals to the CMP were low, which was attributed to private Advisors being less aware about the Choices package than their Jobcentre Plus peers. Furthermore, levels of service could be low as providers could sub-contract out any part of their provision without allowing the DWP any right to monitor the service. In addition, as suspected by Davies (2008), Advisors used a strategy of 'creaming' those closest to the labour market and 'parking' those who were harder to help (Davidson and Weston, 2010:9), thereby failing to meet the overarching aims of *Pathways*.

Such difficulties were also found by a National Audit Office Report in May 2010. The report found that *Pathways* had cost £538 million between 2002 and March 2009, (p.6), however the savings predicted in removing one third of claimants from IB were not apparent. It was found that the choices package in the original *Pathways* pilots appeared to perform well, but were based upon flawed research, which involved people who enquired about claiming IB but did not necessarily go on to claim IB. Consequently, the main way in which the Labour Government's approach to welfare reform for IB claimants was reducing the claimant count (accounting for 80% of the reduction in length of claim) was through medical assessments being carried out more quickly (p.8). Furthermore, for those who did move into work, a cycle of insecure employment and returns to IB can be seen, as found in Chapter 4, and were not prevented by *Pathways*, showing that the scheme failed to address labour market disadvantage. For each of these precarious labour market entries, the NAO found that each entry cost almost £3,000 (p.8), and that those exiting IB were just as likely to do so without the

support of *Pathways*. Therefore, it was concluded that the voluntary aspects of *Pathways*, including the CMP 'have no additional employment impact' beyond the earlier medical testing (p.9).

Regarding the private contracts awarded to many companies, the NAO also found many negative issues. Whilst the article by Timmins and Barker (2009) found that targets were being missed, the NAO (2010:9) report found that 40% of the job entries reported by private companies were through the voluntary participation of IB claimants who had not yet been subject to compulsory elements of *Pathways*. This was more than four times the job entries reported in the Jobcentre Plus/NHS areas, and thus it can be seen that private companies focused upon quick wins at the expense of harder to help claimants. Furthermore, despite 'creaming', the NAO found that, even accounting for the effects of the recession, the private companies would have underperformed, and, as such, been paid less than they initially expected.

Prior to the publication of the NAO report, however, the New Labour Government announced its intention to reshape *Pathways to Work* in the Command Paper *Building Bridges to Work* (DWP, 2010b: 1.9). The Government reiterated its desire to create opportunities, such as the New Deal, but stated:

> ...we need to go further. Radical reform of welfare and employment support is even more important as we come out of recession to prevent the long term scarring that we saw in previous decades. (DWP:2010b:1.4)

This radical reform includes compulsory work for those claiming Job Seeker's Allowance, or workfare as it is known elsewhere. Likewise, those who are sick will not be consigned to a life of claiming benefits after the recession. The Command Paper continues in much the same way as Labour's earlier documents outlining support and increasing conditionality. One of these conditions is additional medical assessments, with the expectation that most claimants will leave the benefit within two years.

8.4.3 Increased Conditionality: the Coalition Government 2010 and beyond

The Coalition Government elected in 2010 has announced its intention to increase conditionality attached to IB and ESA claimants. Iain Duncan Smith, Secretary of State for Work and Pensions, has stated that all IB claimants will be subject to another medical test between October 2010 and March 2014, using the more strict criteria of the Work Capability Assessment. Those who are seen as well enough to work following the test will be moved in to the ESA 'work related activity' group, with benefits paid at a lower rate to the 'support' group, for those who are judged to be most ill (see Table 8.1, below). Consequently, it can be argued that ESA is a much less attractive benefit to the Pre-*Pathways* IB. Whilst previously, benefits were automatically paid at a higher level than unemployment benefits, those who are placed in the 'support' group who do not engage in work-focused activity will only receive the lower level of benefits. Furthermore, whilst IB, before *Pathways*, had the practical advantage of not having to engage with Jobcentre Plus, unlike the regular 'signings' for Job Seekers Allowance, ESA removes some of these practical advantages. From a labour market perspective, the identified increases in conditionality could reduce the numbers claiming ESA as it becomes less attractive. On the other hand, increased conditionality was viewed negatively by the Social Inclusion and Social Mobility task group of the Marmot Review (Piachaud et al., 2009).

Table 8.1 Rates of Benefits payable April 2010-April 2011

Benefit	Age (if applicable)	Amount (weekly)
JSA	16-24	£51.85
JSA	25+	£65.45
ESA 'work focused activity group' but not engaging with work focused activity		£65.45
ESA 'work focused activity group' and engaging with work focused activity		£91.40
ESA - support group		£96.85

Source: Warwickshire Welfare Rights Advice Service (2010)

I believe that the fundamental shift brought about by the introduction of ESA, which is being extended by the Conservative Government to all previous IB claimants, has focused upon the concept of the claimant who is pretending to be incapacitated. Whilst this thinking has been present before in policy (Stone, 1985), it has never been so thoroughly tested within the UK. In creating this two-tiered system, those who are seen as most ill become the new deserving group. For incapacitated workers who do not make it in to this group, they are treated as part of Beatty and Fothergill's (1996) 'hidden unemployed' group. To clarify, the Government acknowledges the health problems of this group, offering them additional support, and additional financial compensation if this work-focused activity is taken up. However, the security blanket that was IB has been removed.

8.5 Policy Recommendations

8.5.1 'Active Patient' techniques

The CMP very strongly focused upon empowering claimants. It aimed to provide claimants with the tools that they needed to manage their condition in the future. There is some evidence from the interviews with CMP participants and the existing research evidence that this worked. As such, the treatment model embodied within the CMP can be said to be improving the independence of claimants, one of the New Labour Government's aims (PMSU, 2005).

The Clinical Leads of both CMPs were passionate about this approach, and many of the clinicians wanted to work for CMP because of this treatment model which was seen as embodying the essence of occupational therapy (Watson, 2006). However, the lower case loads that practitioners held in order to use this approach would obviously make adopting 'active patient' techniques throughout the NHS initially very costly. However, I believe that there is scope for this model to be used more widely within mainstream NHS services, particularly with people who are at risk of being off sick from work for long periods. The research reported showed that participants experienced less pain and felt more able to cope. If these benefits are sustainable overtime, the initial expense of using more costly treatments should be weighed against the longer-term benefits.

8.5.2 Should the NHS be involved in determining eligibility for social security?

One of Beveridge's (1942) plans for the welfare state was that each pillar of the state should be separate. Accordingly, collaboration between the Department for Work and Pensions and the Department of Health to create

the CMP would have been viewed critically by Beveridge. At the time of the interviews, attending CMP was voluntary, although Advisors had referral targets. Consequently, if a claimant was referred to CMP and chose not to attend, there was no possibility of a benefit sanction being imposed (although Jo's story, in the prologue, shows that claimants did not always realise this).

Within a climate of increased conditionality, the increased use of clinical staff to determine eligibility to ESA could occur. I would argue, however, that if the CMP, or a similar intervention, were to occur in the future, the clinicians should not be involved in decisions of eligibility. At present, the doctors involved in assessing ESA claims are not treating these claimants, and perform the tests for the DWP. I believe that this division in roles should be retained and clinical staff attempting to facilitate a return to work should not be asked to perform this function; their role should be restricted to attempting to support claimants to better manage their conditions. If the role were to be included within clinician's job description, clear guidance may result in compliance (Bergen, 2005). However, if clinical staff were asked to perform this function, I believe that their sense of professional autonomy would result in strong resistance to policies that may disadvantage claimants (Lipsky, 1980; Adler and Asquith, 1981). Furthermore, I believe that clinicians would retain their professional ideologies, and consequently refuse to perform work that was not seen as meeting claimants' needs (Wells, 1997).

8.5.3 Employers – the elephant in the room?

What was most noticeable about New Labour's policy approach was an absence of willingness to compel employers to employ disabled people, although it was noted that employers wanted to employ more disabled workers (DWP, 2002; PMSU, 2005). The quota system introduced by the 1944 Disabled Persons (Employment) Act and replaced by the Disability

Discrimination Act 1995, necessitated that employers with more than 20 employees ensure that three per cent of their workforce was disabled. However, despite being law for several decades, the Act was seldom enforced and Government bodies, including the NHS, were exempt (Floyd, 1991).

I believe that if the New Labour Government was truly committed to raising the employment rate of those with disabilities (as it reported - see for example PMSU, 2005; DWP, 2006), it would have introduced a system where work was a more realistic possibility for people with health problems, and so increased the accommodations possible. Furthermore, employers would need to see the benefit of employing workers with disability, perhaps through Government subsidies or some form of compulsion. Consequently, if the Coalition Government is serious about reducing labour market disadvantage in this area, it must place more emphasis on the employment of disabled people, perhaps by further strengthening the weak legislation in this area.

8.6 What next?

In light of the increasing harshness of income maintenance policies for the sick and disabled, it is crucial for research in this area to continue. Furthermore, in light of the findings presented here from a data collection period that happened at the beginning of the economic downturn, it is important to see how Advisors are carrying out their role in a climate of increased unemployment, decreased job opportunities and increased conditionality. Following Lipsky's (1980) argument, Advisors should attempt to make their job more bearable within this context, unless they are constrained by increasing guidance, consequently claimants of IB and ESA may become treated more harshly in the light of the new guidance.

Additionally, as the Conservative Government continues to place contracts for employment services in the hands of the private sector, it is essential for independent research to be focused in this area, regardless of the difficulties of access noted by myself earlier and by Davidson and Weston (2010). By necessity, a return to covert methods as advocated by researchers in other hard to access areas (see for example Hobbs et al., 2003) may be required.

A further area in which more research should be carried out is in how disabled people are treated in the workplace and more generally the quality of the working environment, in the broadest sense, into which they are placed. Within the research, evidence of significant labour market disadvantage was shown that did not form part of the thesis. For example, during the observation period, one of Lydia's claimants phoned her. Having been declared in remission from cancer, and feeling stronger than she had for some time, the claimant had found part time work in an office. However, having completed their occupational health questionnaire, the offer of a job was removed. The employer acted in an illegal way. Despite Lydia intervening to have the job offer reinstated, the claimant decided not to take the job. It is likely that cases like this are happening throughout the UK. These should be brought to the attention of the Government and the public alike to secure a positive policy change.

8.7 Conclusion

The thesis has examined a period of significant change in social security for the long-term sick and disabled. It has been shown that the Condition Management Programme could be a very positive experience for claimants who wished to engage with the service, although this was not the case for those who were less willing to attend. Introducing the ethos of privatisation to CMP led to further concerns over access to information in order to be able to research the services. Previous research, however, was able to

show that private CMPs were unable to meet their targets. Moreover, damning evidence from the National Audit Office (2010), found that *Pathways to Work* was largely unsuccessful in meeting its aims via the support found in the choices package.

Consequently, it is likely that the reforms introduced by the Coalition Government are likely to focus less upon the expensive provision of support, and more upon increasingly harsh medical testing, in order to lower the numbers claiming IB and ESA. It is important that in this evolving policy context that the lessons learned within *Pathways to Work*, and more specifically the CMP, are not lost with the introduction of the new Work Programme. Active patient techniques could improve the quality of life for many long-term sick and disabled people. Moreover, the Coalition Government must address the weak position of disabled workers within the labour market if it is truly committed to increasing the numbers of disabled people in work.

8.8 Conceptual Highlights

The thesis has combined a number of theories and applied these to data from a back to work programme for IB claimants. Some of the conceptual points made in relation to this data have wider applicability.

- The concept of evidence based theory was paid lip service by New Labour, who rolled out Pathways to Work nationally before the pilot programmes had been fully evaluated.
- IB claimants come from a wide variety of health backgrounds, and many have been ill for considerable lengths of time before leaving the labour market.

- Once a sick worker has left the labour market, it can be very difficult to return to employment unless a worker has a high level of skills and an accommodating employer can be found.

- IB claimants and some of those who are attempting to support claimants on their return to work, have adopted the notion of deserving and undeserving claimants (Stone, 1984).

- Lipsky's theory of Street Level Bureaucracy continues to have relevance in Jobcentre Plus offices in 2008-09, showing that although Pathways to Work could have resulted in a high level of benefit sanctions, this did not appear to be common within this study.

- IB claimants were able to retain a positive self-identity through identifying as sick or productive in some other way, as opposed to identifying as IB claimants.

- Despite Jobcentre Plus Advisors largely aiming to support claimants, and act within their best interests, claimants were scared by the idea of Pathways to Work, as a result of letters that were sent to them in the post and reports in the media.

- The majority of claimants who attended CMP reported a wide range of benefits from attending, and thus occupational health support can be seen as enabling IB claimants who feel ready to change to feel better.

- Some NHS clinicians found it uncomfortable working within rules set by the DWP, suggesting that clinical staff expect to be afforded more discretion than Jobcentre Plus Advisors.

- In failing to consider the contribution of employers to the employment rate of IB claimants, the thesis argues that Pathways to Work was unlikely to be successful from the outset.

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Appendices

Dear Sir/Madam,

I am carrying out a piece of research into people's experiences of the Condition Management Programme. I would really appreciate it if you could spare me some time to talk about how you have found the Condition Management Programme, even if you have only been once or twice. I have enclosed some information, but if you have any other questions, do not hesitate to contact me using the details on the next page, if you would like to speak to me by telephone, I can call you back. I will contact you if you complete the attached form.

Many thanks,

Aimee Grant.

Welfare to work policies for incapacity benefit claimants: information about research [CMP].

You are being invited to take part in a research study about your experiences of back to work programmes for people on incapacity benefits. It is important for you to understand what this will involve for you and why the research is being carried out before you decide if you would like to take part. Please read this information carefully. You can contact me if you have any questions.

What is the purpose of the study?
I am investigating changes in policies for people claiming incapacity benefit. In order to do this, I want to talk to people who have had direct experiences of such policies. This is an area that academics don't know much about.

Who is the researcher and who is funding the research?
My name is Aimee Grant. I am undertaking a PhD at Cardiff University supervised by two senior lecturers. The research is funded by the Economic and Social Research Council.

Who has reviewed the research?
The research has been reviewed by two senior researchers at Cardiff University. It was also given a favourable opinion by the NHS Research Ethics Committee.

Why have I been chosen?

I am asking people who are part of a welfare to work scheme (such as *Pathways to Work* and *Want to Work*) to participate as they will have had first hand experience of changes to the benefit.

What do I have to do?

I would like you to take part in an interview. I would like to discuss your experiences of welfare to work schemes for Incapacity Benefit claimants in Wales. The interview will be audio taped so that I have a record of what has been said. If you are part of the Condition Management Programme (CMP), I would also like to observe one or more of your CMP sessions and/or have access to your case file held by the CMP.

You can choose to do some or all of these parts of the research.

What will happen to the information I give?

The transcript of the interview and any notes that I make will be accessible only to myself and my supervisors, and will be kept securely, in strict accordance with the Data Protection Acts. An analysis of the information will form a PhD thesis and will be published in academic journals. You are welcome to see a copy of the articles prior to publication. You can also choose to receive written feedback on the research if you like. All data will be destroyed five years after the end of the project.

Will my taking part be confidential?

No one will be named or identifiable in any way in the reports of the study, and you can give as much or as little information as you wish.

What if I wish to withdraw?

Your participation is completely voluntary and you can withdraw at any point that you wish, without giving a reason and with no negative effects. Likewise if you do not wish to answer any of the questions, that is fine. If you do choose to withdraw any data that has already been collected on previous occasions will be used by the study.

Contact Information

If you would like any further information about the study, please do not hesitate to contact me:

Aimee Grant: Telephone: 07872 932837

                  Email: granta2@cardiff.ac.uk

What if I have a complaint?

If you have a concern that you are not happy talking to the researcher, Aimee Grant, about, you can contact her supervisors at Cardiff University:

Mark Drakeford -   Email: Drakeford@cf.ac.uk

Telephone: 02920 875040

Gareth Williams -   Email: WilliamsGH1@cf.ac.uk

                  Telephone: 02920 875500

Or, you can follow the NHS complaints procedure. In the first instance your complaint should be made to your Condition Management Programme, either your practitioner or the manager who may be able to resolve your concerns without making a formal complaint. If you wish to make a more formal complaint, it should be in writing, or written by the manager if the complaint is made orally. You should receive a response from a within 10 days although this deadline can be extended with your agreement. Further guidance can be found within organisational policy available on request from the Condition Management Programme.

Please contact me directly on the telephone or email address above or return the following slip to your CMP practitioner.

I, ..., would like/ would not like to participate in the above research project.

My telephone number is .... It would be best for you to call me during the day/during the evening/ at weekends/ any time.

Welfare to work policies for incapacity benefit claimants: information about research [non-CMP].

You are being invited to take part in a research study about your experiences of back to work programmes for people on incapacity benefits. It is important for you to understand what this will involve for you and why the research is being carried out before you decide if you would like to take part. Please read this information carefully. You can contact me if you have any questions.

What is the purpose of the study?
I am investigating changes in policies for people claiming incapacity benefit. In order to do this, I want to talk to people who have had direct experiences of such policies. This is an area that academics don't know much about.

Who is the researcher and who is funding the research?
My name is Aimee Grant. I am undertaking a PhD at Cardiff University supervised by two senior lecturers. The research is funded by the Economic and Social Research Council.

Who has reviewed the research?
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Why have I been chosen?
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What do I have to do?

I would like you to take part in an interview. I would like to discuss your experiences of welfare to work schemes for Incapacity Benefit claimants in Wales. The interview will be audio taped so that I have a record of what has been said. If you are part of the Condition Management Programme (CMP), I would also like to observe one or more of your CMP sessions and/or have access to your case file held by the CMP.

You can choose to do some or all of these parts of the research.

What will happen to the information I give?

The transcript of the interview and any notes that I make will be accessible only to myself and my supervisors, and will be kept securely, in strict accordance with the Data Protection Acts. An analysis of the information will form a PhD thesis and will be published in academic journals. You are welcome to see a copy of the articles prior to publication. You can also choose to receive written feedback on the research if you like. All data will be destroyed five years after the end of the project.

Will my taking part be confidential?

No one will be named or identifiable in any way in the reports of the study, and you can give as much or as little information as you wish.

What if I wish to withdraw?

Your participation is completely voluntary and you can withdraw at any point that you wish, without giving a reason and with no negative effects. Likewise if you do not wish to answer any of the questions, that is fine. If you do choose to withdraw any data that has already been collected on previous occasions will be used by the study.

Contact Information

If you would like any further information about the study, please do not hesitate to contact me:

Aimee Grant: Telephone: 07872 932837
                  Email: granta2@cardiff.ac.uk

What if I have a complaint?

If you have a concern that you are not happy talking to the researcher, Aimee Grant, about, you can contact her supervisors at Cardiff University:

Mark Drakeford -   Email: Drakeford@cf.ac.uk
Telephone: 02920 875040
Gareth Williams -   Email: WilliamsGH1@cf.ac.uk
                  Telephone: 02920 875500

Consent Form

Welfare to work schemes for incapacity benefit claimants.

	Please initial
1. I confirm that I have read and understood the information sheet [version number.............. dated ...../..../......] for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason.	
3. I agree to take part in an interview.	
4. I agree to my interview being digitally recorded.	
5. I agree to my Condition Management Programme session/s being observed.	
6. I agree to my Condition Management file being used in the research.	

_____   _____   _____

Name of participant   Date   Signature

_____   _____   _____

Name of person taking consent   Date   Signature

2 copies : 1 for participant and 1 for research file.

Appendix Five: Consent form for non-CMP client participants – interviews only [Version 3, 02.12.08]

Consent Form

Welfare to work schemes for incapacity benefit claimants. [Non-CMP]

	Please initial
1. I confirm that I have read and understood the information sheet [version number.............. dated ...../..../......] for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason.	
3. I agree to take part in an interview.	
4. I agree to my interview being digitally recorded.	

_____   _____   _____

Name of participant   Date   Signature

_____   _____   _____

Name of person taking consent   Date   Signature

2 copies : 1 for participant and 1 for research file.

Consent Form

Welfare to work schemes for incapacity benefit claimants.
[Jobcentre Plus]

	Please initial
1. I confirm that I have read and understood the information sheet [version number.............. dated ...../..../......] for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw, or ask the researcher to leave at any time, without giving a reason and that this will not affect the service I receive from Jobcentre Plus.	
3. I agree to my interview being observed.	
4. I agree to my interview being digitally recorded.	

_____   _____   _____

Name of participant   Date   Signature

_____   _____   _____

Name of person taking consent   Date   Signature

2 copies : 1 for participant and 1 for research file.

Interview schedule – Advisors

Can you tell me a bit about your professional background
How long working here
Have you always seen IB claimants

Can you imagine that I was a new client of yours, can you talk me through the process of what you would do with me.
How long would you have with each client?
How do you chose what each client should do?
Do you have any constraints/targets?
Do you think the process is simple to understand for yourself and clients?
Can any adjustments be made for people who would struggle to come to the JC+ for their interview?
How many clients would you have at any one time?
Do you have a fast turn over of clients?

What do you think is the most successful intervention in your experience?

Thinking about the Condition Management Programme, can you tell me how you would decide if somebody was suitable?
Do you have a lot of interaction with the CMP staff?
Is this more or less than you have with other groups who are part of *Pathways*?
when clients are on a service such as CMP how much information would you get about their progress.
CMP is a relatively short intervention, do you think this is suitable for your customers?
Do you think the NHS is the right partner to deliver CMP or do you think that a private company could be better?

Can you think of any ways that JC+ could implement *Pathways* better?

do you use sanctions often?

If so do you feel that they are effective?

If not, why not?

How do you measure success with IB claimants – only back to work or other measures?

Government documents suggest that nearly all disabled people want to work, do you think this is true in your experience?

Also do you think they CAN work and that work would be beneficial for them?

Can you think of any barriers to work for disabled people?

Both in general and in this particular area?

Some IB claimants fail to engage with JC+ and the support that is being provided, can you think of some reasons why that might be?

Any other thoughts?

Appendix Eight: Interview Schedule: Clinical staff and Managers – CMP

Interview Schedule: Clinicians/Managers CMP

Can you tell me a bit about your background?

what job did you do before?

Different types of conditions worked with?

How did you end working for the CMP?

How does it compare to other employment you have had?

Are you and your colleagues generally satisfied with your work?

How do clients get recruited to CMP?

GP, JC+, self-recruited.

what sort of relationship do you have with JC+ etc

Are any referrals rejected? If so, on what grounds?

What type of conditions do you mainly work with?

- respiratory, back, other joint or muscle problems, mental health, other

What type of intervention do you offer to these clients?

- is this decided by the individual practitioner or a group of practitioners?

does this vary depending on the person, for example thinking about gender, age, range of qualifications?

In your experience is any particular intervention more/less successful than others?

Do you have a set pattern and/or length of time when you see clients?

do you think 16 weeks is always long enough

do you think clients are adequately supported once they are in employment?

what level of engagement do you have from clients?

-punctual, not cancelling appointments...

Do you think that the CMP will enable clients to work either now or in the future?

- do you think specific job demands are addressed or more general coping skills?

-disappointment found in users in other studies when W2W schemes don't end in a job.

-how do you see the relationship between state of health and ability to work

-are there other 'barriers' to getting disabled people back into work? Research has found that in order to enable disabled people to work, there needs to be a match between person, occupation and environment.

Do you think that CMP offers benefits to clients aside from trying to increase their employability?

-eg; self confidence, better coping strategies with pain/stress

-are these measured in some way? [need to show positive outcomes to retain funding]

How strong are the links between the CMP and employers?
do you feel that you know what employers want in employees?

How strong are the links between the CMP and policy makers?

Can you think now about IB claimants who don't engage with JC+, and as such don't get referred to you, what factors do you think might influence their decision not to become part of Pathways to Work?

Are there any other things you want to say?

Interview Schedule: Engaged users – CMP

Can you tell me a bit about how you ended up on Incapacity Benefit?

      - have you worked before?

      -type of illness

- did you have to stop work right away? Was your employer sympathetic?

-duration of absence from work, has it all been on IB or other benefits, any time without benefits?

Have you participated in any training or other schemes to try to get you back to work? If so who referred you to it/them?

When did you first here about reforms to Incapacity Benefit?

      -what was the first thing that happened to you? Eg: WFI,

How have you found the Job Centre?

Do you have a Personal Advisor or a Disability Employment Advisor?

      - do you think that they understand your condition?

How did you end up part of the CMP?

What does your participation involve?

Do you think that this is having any positive or negative effect on you?

      -in terms of health, readiness for work

Are you participating in any other part of the 'Pathways to Work' programme?

      What are the effects of these?

      If so, how do they compare or enhance CMP?

Do you want to return to work?

Do you think that it would be realistic for you to return to work in the near future?

       If yes, what do you think has changed?

       If no, what barriers do you feel you face to your employment?

Do you currently have caring responsibilities? Who do you think could support you with these if you were to return to work?

Do you think that the introduction of *Pathways to Work*, including CMP, was a good idea?

Can you think of any ways in which CMP or *Pathways to Work* could be improved?

Some research has shown that disabled people feel that employers would rather employ a person without a disability, in your experience do you think that this is true?

if yes, do you think that *Pathways*/CMP can solve this?

Is there anything else you would like to tell me?

Interview Schedule – non CMP IB claimants

Can you tell me a bit about how you ended up on Incapacity Benefit?

     - have you worked before?

     -type of illness

- did you have to stop work right away? Was your employer sympathetic?

-duration of absence from work, has it all been on IB or other benefits, any time without benefits?

Have you participated in any training or other schemes to try to get you back to work?

-If so how did you end up on it?

     - did you find any of them helpful/ unhelpful – in what ways?

Have you heard about the reform to Incapacity Benefits that changes the name to Employment and Support Allowance?

     -If yes, can you tell me what you know about the changes?

     - If no, provide brief explanation.

Have you been contacted by the Job Centre to ask you to attend a work focused interview?

Are you participating in any other part of the 'Pathways to Work' programme? These include the New deal for Disabled People.

     Can you tell me a bit about your experiences of each of these, positive and negative?

Do you want to return to work?

Do you think that it would be realistic for you to return to work in the near future?

If yes, what do you think has changed?

If no, what BARRIERS TO WORK do you feel you face?

Do you currently have caring responsibilities? Who do you think could support you with these if you were to return to work?

Can you think of any other barriers to work that IB claimants might face in your area or more generally?

Do you think that the introduction of *Pathways to Work*, including CMP, was a good idea?

Can you think of any ways in which CMP or *Pathways to Work* could be improved?

Some research has shown that disabled people feel that employers would rather employ a person without a disability, in your experience do you think that this is true?

- if yes, do you think that *Pathways*/CMP can solve this?

y   DAI   **Condition Management Programme Referral Form**   NHS

Part of the Department for Work and Pensions

To: Provider   CMP ▓▓▓▓

From: Jobcentre ▓▓▓ RECEIVED 30 JUN 2006 JOBCENTRE PLUS
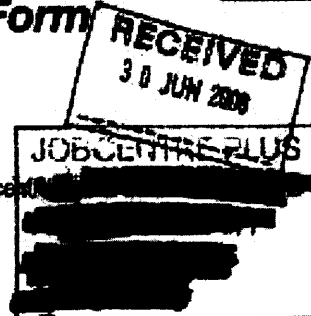
Title   Mr ✓ Mrs   Miss   Ms   Other (Please Specify)

Surname ▓▓▓▓
First name ▓▓▓▓

Address ▓▓▓▓

NI number ▓▓▓▓

Date of birth 2▓▓▓▓ —Aged 32 Telephone Number ▓▓▓▓

▓▓▓▓
▓▓▓▓
▓▓▓▓
▓▓▓▓

Brief outline of customer's current condition, length of time of incapacity and treatment to date.

▓▓▓ had an accident at work in September when he was working as a refuse collector when the lorry drove off as he was getting in the cab and he fell. He has had low back pain ever since. He has had an MRI scan which shows that his pelvis is tilted backwards and that he has 2 bulges out the base of his spine. He is having physiotherapy and takes painkillers daily.

I understand that Jobcentre Plus and the NHS programme provider may exchange information pertinent to my participation in the Condition Management Programme. I further understand that information may also be passed to my GP or treating clinician and that the outcome of my participation in the programme can be copied to my NDDP Job Broker. I am writing to be referred to the NHS Condition Management Programme.

Customer's Signature	Date	27 6 08
IB Personal Adviser's signature	Date	27 06 08
Date referral made	Date	

Assessment Date	07 07 08	
Programme Start Date	15. 07 08	
Anticipated End Date		

Details of Health Condition Management Programme	Goal setting

The Programme is not suitable for this customer

Provider's Signature	Date	

Reason not suitable

I have read this form and agree that the information is correct. I understand that Jobcentre Plus and the NHS programme provider may exchange information pertinent to my participation in the Condition Management Programme. I wish to participate in the NHS Condition Management Programme.

Customer's Signature	Date	7 7 08
Provider's Signature	Date	07 07 08

Emma - cmp 1

(b)

PATHWAYS TO WORK - CONDITION MANAGEMENT PROGRAMME
RECORD OF INITIAL REFERRAL

TITLE (Delete as appropriate)	MR	MRS	MISS	MS	Other (specify)
SURNAME		▉▉▉▉			
FIRST NAME		▉▉▉▉▉			
ADDRESS		▉▉▉▉▉▉			
What is the client's medical condition:		Low Back Pain, Low mood - Tearful			
When was the client first diagnosed with the condition?	Oct 2007				
What are the client's reported symptoms?	Low Back Pain -, Tearful.				
Is the client currently on any medication?	Yes		✓	No	
If you answered "Yes" to the above please give details if available.	Pain Killers, No Anti Depressants				

When did the client last see their GP regarding their condition?	1wk		1wk-1mth		1-3mths ✓
	3-6mths		6-12mths		over 12mths

Does the client have any additional medical problems?	Yes		✓	No	
If you answered "Yes" to the above please give details.	Slightly Depressed				
Is the client on a waiting list to see a hospital specialist/consultant	Yes		✓	No	
If you answered "Yes" to the above please give details.	Has Had MRI Scan. Waiting to discuss				
Is the client on a waiting list to receive treatment, eg, physiotherapy, counselling	Yes	✓		No	
If you answered "Yes" to the above please give details.	Physio Has Finished				
Is the patient awaiting an appointment for investigations, e.g. scans, x-rays (not routine blood tests)	Yes	✓		No	
Has the client seen any hospital specialist in the last 3 years?	Yes	✓		No	
If you answered "Yes" to the above please give details.	MRI Scan.				
Has the client undergone a personal capability assessment	Yes			No ✓	
If so, have they satisfied or not satisfied?	Satisfied			Not satisfied	
How long has the client been off work?	October 2007.				
What was the client's previous occupation?	Production operative				
Are there any times when a client would be unable to attend an appointment, e.g. other commitments?	NO				

RACHEL - CMP 2.

CONDITION MANAGEMENT PROGRAMME

Date: 21/7/8	CMP Reference number: 93291
Surname:	First name:
Date of Birth: 14/2/62	Assessing Practitioner:

☑ Understanding and Explanation of CMP
Practitioner may use the following statement: These questions are not being asked to assess your entitlement to benefit, they are to help us to get an overview of your current lifestyle and how it may affect your return to work.

☑ Complaints (CMP Manager contact via 01267 244140)

☑ Confidentiality

☐ Customer Consent x 2 Signatures obtained

1	HEALTH CONDITION AND TREATMENT
1.1	What is your main health problem at the moment?

Anxiety & Depression. Struggled c it on & off for years. Personal things, & work happened together & she then couldn't cope. Daughter had serious car accident. head injury. Mental health support worker. working in community for Gwalia. *Daughter kinda better now & happy (?). Move to Birmingham (getting on with it life). Glangwili → Bath → Bath discharged herself. Work. was struggling / under pressure. one incident child paranoid. schz. threatened to petrol bomb her house.

1.2	Is this what you claim Incapacity Benefit for? (Yes) No
	If No, what did you claim benefit for (include history and current management)

1.3	What medication are you taking on prescription?			
Drug		**Purpose**	**Frequency**	**Helpful?**
[handwritten notes, largely illegible: mentions "years", "Bispn Initially →", "not helping", "arthri— dry", "Stopped Cipralex in Jan —", "Jan 2008 — hill really", "on couldn't cope & went onto Efexor."]				

1.4	Do you take any non-prescription (over the counter) medicines/herbal treatments?

1.5	Do you have any other significant medical problems at present?
	Psoriasis since a child. used to get worse c stress

1.6	Have you had any other medical problems in the past?

1.7	Are you waiting to see a specialist or have you seen a specialist in the past 3 years?
	No

1.8	Are you currently awaiting any other investigations or treatment?

Doesn't have a good diet.

Smokes: 15-20 day - stopped smoking for 3 yrs.. went back on to it 3/24 ago. New partner smokes

Alcohol : occasionally

Sleep : Can usually get off to sleep 10.30 - 11 pm - always around 3 + 5.am She would prefer to be waking around 6.30 - 7 am When she awake she usually stays in bed - used to read a magazine if she wakes - more inclined now to just lie there. years ago did 'autogenics'.

Exercise - walks 2 dogs depending on how she feels - gets out of breath -

poor concentration.
poor memory -
can't concentrate on a good book

4	OCCUPATIONAL PERFORMANCE DIFFICULTIES: SELF CARE, PRODUCTIVITY AND LEISURE (INCLUDE ADL – PERSONAL, DOMESTIC AND COMMUNITY)

Some days will lie in bed - & may stay there for most of the day. Sometimes she doesn't get up til midday - would like to achieve more in the day

5	SOCIAL HISTORY (INCLUDE KEY RELATIONSHIPS, SUPPORT NETWORKS, DEPENDENTS AND COMMITMENTS)

▓▓▓ & her daughter, but she is hoping to go to Brim University College to study business retail

gets on well c ex husband but he is moving to Wolverhampton -

▓▓▓ finds this a problem as she has been v. dependant on him

6	LIVING SITUATION INCLUDING ACCESS, ANY AIDS/ADAPTATIONS, ERGONOMICS ISSUES
	no.
6.1	Transport/mobility issues
	Drives own car.

7	CURRENT DAILY STRUCTURE, ROUTINES AND HABITS (INCLUDING INTERESTS AND HOBBIES)
	Unstructured. Wakes around 3 + 5 am gets up around midday if she has no reason to go into town. If her friend has stayed over ▓▓▓ takes him into town at 7.45 - takes dogs with her + then gives them a walk on way home + doesn't go back to bed. Feels better on those days. Sometimes will have a sleep in afternoons TV from 6 pm - looks after daughter. Hobbies - likes art. calligraphy. Doesn't have other friends neighbour asks her in for coffee but she doesn't feel able to go due to anxiety. would like to be able to

8	OCCUPATIONAL HISTORY (INCLUDE POSITIVE WORK EXPERIENCES, REASONS FOR LEAVING PREVIOUS EMPLOYMENT & LENGTH OF TIME OFF WORK, ANY PREVIOUS SUCCESSFUL RETURNS TO WORK.
	2001 — 2004. Worked at Gowellian support worker. Did personal work & didd pre chin team before that— Home Start Volunteer Cleaned caravans Did Access course for nursing initally the Biology & to logy o level after that as she didn't want to leave children.
8.1	Have you discussed any ideas of future employment or return to work options with your Personal Advisor at the job centre? Business admin work couldn't do support work any more & doesn't want to do care work.
8.2	What would help you return to work? Hoping to do course in the autumn Business Admin

347

9	GOALS, ASPIRATIONS AND POSSIBLE BARRIERS
9.1	How would you like your life to be in 6 months time?
	Health: _Less anxious in social situations._
	Work: _still be doing admin course_
	Social: _would like to be able to go out for a meal_
9.2	Do you have any other goals not previously discussed?
	_no_
9.3	What possible barriers do you identify re returning to work? (include motivation)
9.4	What are your expectations of/what do you think the Condition Management Programme can offer you?
	To feel less anxious + better able to cope
9.5	Any issues re engaging with CMP? (group work, male/female practitioner)

Anx 13

Dep 13

10	**ASSESSMENT SUMMARY AND FORMULATION OF DIFFICULTIES, INCLUDE STRENGTHS, MALADAPTIVE BEHAVIOURS, MOTIVATION TOWARDS CHANGE AND SUITABILITY.**

Suffered from Anxiety & Depression for years,
not sure exactly what caused it, probably
fact that she was under pressure at work &
her daughter suffered a serious car accident - head injuries.
She felt she couldn't cope with it all. ~~Had one~~
~~particular ctr~~
~~was on Cipralex for~~ a ~~several~~ years (~~since~~
2004) ~~stopped taking this instead of went~~ error REL
~~into Zispin which~~ she felt didn't help → then
~~onto another drug - couldn't remember its name~~
was on Cipralex for 2 years up until
Jan 2008 & was managing reasonably well,
had occasional 'low' days however her mood
deteriorated & she was then put onto Efexor
a few weeks ago. + Diazepam which she takes
as & when she needs it to help her sleep. Was
addicted to codeine for years but she has stopped
taking that now. Takes Tylex on occasion for
headaches. Also gets migraines. Has had stomach
problems for years.
Gone back to smoking 15-20/24 - stopped for 3 yrs.
New man friend who smokes.
Occasional alcohol.
Sleep - usually gets to sleep ok - 10.30/11 - wakes
around 3-4 am. may not get up til noon if nothing
planned for the day. Has 2 dogs takes them for
a walk 2/7. If friend stays over, she gets up at
7.30 & takes him into work & then walks them
& doesn't go back to bed altho may sleep in afternoon.
Says she feels much better if she had done more in daytime.

10.1 Client is suitable for CMP Yes No

If not suitable why?

10.2 CMP plan/modules anticipated:

Any further action required?

CONTINUATION	Surname		
HISTORY SHEET	Mr/Mrs/Miss ▓▓▓▓▓▓▓▓▓		
	First Names ▓▓		Page No. 1

Date	CLINICAL NOTES (each entry must be signed)
21/7/8	Continued - IA.

Can't concentrate on reading a book - but she
says that it's been a long time since she
really had to concentrate on anything.
She has her daughter living [with] her (has 3
daughters in total) who has recovered well from
the accident although she suffers from some
impaired cognitive function. Daughter wants to go to
University in Birmingham to study business retail.
▓▓▓ hopes she will succeed, but is dubious about
whether she will manage the course. ▓▓▓ ex-husband
is supportive & they get on well - he has been living
in Aber but is due to move shortly to Wolverhampton.
▓▓▓ feels she will miss him & wondering whether
this has been instrumental in lowering her mood. ▓
▓▓▓ suffers from psoriasis & is self conscious of
her poor complexion. She won't go anywhere without
make-up. Was foundate all right if her friend is
staying over won't let him see her without make-up.
Anxiety is stopping her have any sort of a social
life. Her next door neighbour has invited her in for
a coffee, but she won't go. Would very much like

Hospital Anxiety and
Depression Scale (HADS)

nferNelson

I feel tense or "wound up"

I feel as if I am slowed down

I get a sort of frightened feeling like butterflies in the stomach

16. A set of clinical notes

JACOB.

 Local Health Board

CONTINUATION	Surname Mr./Mrs./Miss ▓▓▓▓		
HISTORY SHEET	First Names: ▓▓▓▓		Page No: ①

Date	CLINICAL NOTES (each entry must be signed)
19/02/08	▓▓ attended his 1st IBA informed of ▓▓ ▓▓ attendance Plan discussed at Clinical meeting on 01/10/08 ————————— ▓▓▓
01/10/08	Discussed at Clinical meeting. Plan Anxiety Mngt. ————— ▓▓▓
07/10/08	Telephone Call to ▓▓ to inform him that he has been offered a place on the Condition Management Programme to look at Anxiety Management Strategies ▓▓ was pleased with this. Plan Send out appointment to Start intervention. ▓▓▓
21/10/08	▓▓ Attended his appointment as planned. Discussed Plan for 6 sessions to look out Anxiety Mngt and referral to CAP. Introduced ▓▓ to 5 Areas workbook. ▓▓ informed one his coordinator died on Friday and confirmed with ▓▓ he needs to allow himself the opportunity to grieve and this may ↑ levels of anxiety in the short term. Goals set with ▓▓ ① ▓▓ to access booklet the ▓▓. Con ② ▓▓ to complete exercises in workbook

CONTINUATION HISTORY SHEET	Surname ██████ Mr/Mrs/Miss ████████		
	First Names: ████████		Page No: ②

DATE	CLINICAL NOTES (EACH ENTRY MUST BE SIGNED)
████	⑤ ███ to engage in at least █████ exercise everyday.
	Plan next appt 28/10/08 @ Embling work Llanelli 10.00 J. Adams.
28/10/08	███ attended his appointment today. He informed me he has been exercising for 20 mins+ per day and brought completed workbook 16 to the session. Discussed
	Anxiety diary which ███ will complete at the next week. Introduced ███ to workbook 1c (Panic Attacks) which ███ will complete at home. Discussed
	███ progress in managing his anxiety and explored work issues/ back to work opportunities that ██████ available. ███
	███ identified he would like to be a self employed plasterer. Plan Next Appt 04/11/08 @ Embling Work. _____ ██████ ⑥
28/10/08	██████ Anxiety group referral completed _____ ██████ ⑤
04/11/08	███ attended his appointment as planned. ███ informed me he had had a 'bad' weekend following a drinking session Friday night which resulted in him hitting the pub

Surname Mr/Mrs/Miss	███████	
First Names:	███████	Page No. ③

DATE	CLINICAL NOTES (EACH ENTRY MUST BE SIGNED)
	Landlord. Discussed impact of Adult on anxiety and long term effects. Explored Thought Feeling physical Symptoms + behavior re anxiety and discussed process ████ has made in controlling his Symptoms
	Situation At red traffic lights
	Thoughts I want to get home I am stuck here. Something awful is going to happen - heart attack physical Heart rate + Cant get breath feel Shaky Feels Sweaty body feels hot
	Behavior Fiddles with things in the car sign of green feeling Sweaty inside

356

CONTINUATION HISTORY SHEET	Surname Mr/Mrs/Miss ██████	
	First Names. ██████	Page No: ④

Date	CLINICAL NOTES (each entry must be signed)
	discussed thought stopping technique and breathing technique see goal sheet. Plan next Appt 17ᵗʰ November 10.00 Enabling work.
17/11/08	██████ attended his appointment as planned. ██████ is going to the gym most days and is reporting a significant improvement in reduced anxiety levels. Discussed Challenging negative thoughts with ██████ with example 'I am going to die' looked at evidence for and against and balanced conclusion. ██████ found this helpful and will complete the workbook with this example. Plan next Appt Enabling work 25/11/08 10.00am ——————————— (S)
25/11/08	██████ telephoned CMHT office to cancel his appointment today as he has got the Flu. Appt re-arranged for 02/12/08 at Enabling work 10.30am ————— ██████ (ST)
02/12/08 11.25	██████ attended at 10 25am today. Reviewed progress ██████ feels he is managing his anxiety much more effectively he reports still feeling anxious at times but feels

DATE	CLINICAL NOTES (EACH ENTRY MUST BE SIGNED)
██/12/08 cont'd	much more in control. ██ said he has been much more aware of -ve thoughts and being able to challenge them earlier to prevent anxiety increasing. ██ said he has not been to the gym for a couple of weeks due to flu symptoms. Discussed work as ██ is very keen to return to work and plan to arrange d/ch meeting with ██████████ ISPA in Jan. Discussed referral to DEA but ██ declined this. Discussed other services such as working links who may provide "in work" support. Plan. ① ██ to see GP to review meds and get support reducing diazepam ② ██████████ to arrange d/ch meeting with ██████████ ISPA ③ ██ to continue with the gym ④ D/ch meeting to be arranged Jan 09
4/12/08	Discussed d/ch meeting with ██████████ ISPA date set for 16/01/09 at ██████████ ✗ P Plan Discuss d/ch with CMHT Physio ██████████
9/12/08	Physio aware of proposed d/ch date cont'd

CONTINUATION

HISTORY SHEET

Surname
Mr/Mrs/Miss ▓▓

First Names: ▓▓

Page No: ⑥

Date	CLINICAL NOTES (each entry must be signed)
9/12/08	they will offer ▓▓ an appointment prior to 16/01/09 to review progress in the gym
16/01/09 10.15	▓▓ DNA his discharge meeting today. Plan Send 10 day letter —
16/01/09 10.15	Attempted T/C to ▓▓ No answer
16.01.09 10.34	T/C to ▓▓ discussed d/ch today over the phone ▓▓ reports that he is continuing to manage well and that he is going to go to the gym this week to find out about membership. Plan Send d/ch letters out in the Post for ▓▓ to complete
16.01.09 12.30 pm	Evaluation forms posted to ▓▓ with SAE for return of info —

17. CMP 2 Evaluation form

Condition Management Programme Outcome Form

NHS

jobcentreplus

Part of the Department for Work and Pensions

Part 1:

To: Jobcentre Plus Office

From: Provider

Part 2: Customer's personal details

Title   Mr ☐   Mrs ☐   Miss ☐   Ms ☐   Other (Please Specify) _____

Surname _____

First name _____

Address _____

NI number ☐ ☐ ☐ ☐ ☐ ☐ ☐

Date of birth ☐ ☐ ☐

Telephone Number _____

Part 3: General Practitioner (GP) or current treating physician's details

Part 4: Duration of Condition Management Health Programme

Modules of the programme attended _____

From ☐ ☐ ☐ ☐ ☐   To ☐ ☐ ☐ ☐ ☐

Part 5: Condition Management Programme not completed (to be completed by the customer or provider as appropriate)

Customer withdraws consent

I no longer wish to participate in the NHS Condition Management Programme

as from [| | : |]

Customer's signature [   ]   Date [| | | |]

Customer does not attend programme

The customer has not attended for [|] weeks without explanation. Participation in the programme is deemed to have been withdrawn.

Provider's signature [   ]   Date [| | | |]

Customer does not complete the programme

The customer has not fully completed the programme for the reasons given below. Of the [|] weeks in the programme the customer participated for [|] weeks.

Provider's signature [   ]   Date [| | | |]

Reasons

Please indicate how you feel on completion of the programme by scoring the following options out of 5 (choose all that apply). The scores are 1 – much less confident, 2 – less confident, 3 – no change in confidence, 4 – more confident, 5 – much more confident. Comments can be made on why you have chosen these scores in the box provided.

(score out of 5)

- I feel confident that I can work
- I feel more confident that I will be able to find work
- I feel more confident in my ability to manage my condition in a work environment
- I feel confident that, in general, working would NOT make my condition worse

Comments

Following this programme do you feel that with the right support, and in the right environment, you would be capable of working now, in the next 3 months or in the next 6 months?

What are your work-related plans following completion of the programme?

What are the most useful aspects of the programme?

Any additional comments

Part 7: Outcome Details (to be completed by the NHS Provider)

What can you add to the customers comments?

Part 8: Programme completion

Signature _____ Date [| | |]

Position Held _____

Customer's
Signature _____ Date [| | |]

COPIES REQUIRED X4   PA [ ]   PROVIDER [ ]   GP [ ]   CUSTOMER [ ]

IBRCMP2
Version 3.03