

No one written off: reforming welfare to reward responsibility – NAT’s consultation response

Introduction

NAT (National AIDS Trust) is the UK’s leading independent policy and campaigning charity on HIV. NAT develops policies and campaigns to halt the spread of HIV and improve the quality of life of people affected by HIV, both in the UK and internationally.

NAT welcomes the chance to respond to the Government’s consultation on the Green Paper *No one written off: reforming welfare to reward responsibility*.

NAT commends the Government’s commitment to ensure disabled people have the additional support they need to get back into employment if they are sufficiently well to do so.

However, NAT has concerns about the new conditionality that accompanies this additional support, particularly because of the unique difficulties faced by people living with HIV. It is important to consider these difficulties within the disability framework as the Disability Discrimination Act 2005 defined people living with HIV as disabled from the point of diagnosis.

The reforms are likely to have serious consequences for people living with HIV. The DWP website notes that 1.3% of the population claim Jobseekers Allowance and 3.7% claim Incapacity Benefit. However, a study carried out of people living with HIV in London found that the rates of claiming benefit amongst people living with HIV were significantly higher.¹ This is illustrated in the table below:

Type of benefit claimed	Percentage of respondents identifying specified type of benefit as a source of income		
	White homosexual men	Black African heterosexual	
		Men	Women
Unemployment benefits/income support	23.4	24.9	29.7
Incapacity benefit/sickness benefit	25.2	8.3	9.1
Housing Benefit	22.0	23.3	29.7
Disability Living Allowance	36.3	20.7	16.3

Source: Ibrahim et al

¹ Ibrahim F., Anderson J., Bukutu C., and Elford J., (2008) ‘Social and economic hardship among people living with HIV in London’ in HIV Medicine; British HIV Association

The study also found that only 46.6% of respondents were in some kind of employment. These findings highlight the need to consider the specific needs of people living with HIV when deciding how to take this reform agenda forward.

Before responding to the relevant consultation questions, NAT feels it is important to highlight the particular barriers faced by people living with HIV in returning to employment, as well as concerns about how some of the proposed reforms may actually hinder rather than improve the situation for people living with HIV.

HIV as a fluctuating condition

It is a sign of the remarkable progress that has been made that for many people living with HIV, the virus is now a long-term condition. These advancements mean that many people can live long and full lives, working and raising families. However, HIV remains a fluctuating condition and many people will have periods of ill-health; for example when they are beginning treatment for the first time, when they are changing treatment or are experiencing treatment side effects. And of course, there are people living with HIV who do not respond well to treatment and face greater health difficulties. This means that someone may be feeling perfectly well on one day and then unable to work in a few weeks time.

It is important that the measures in this Green Paper pay due consideration to this, whether in the Work Capability Assessment (WCA) or in the way Access to Work is designed to ensure employers can support people with fluctuating conditions in the workplace. The implications of each of the proposed reforms for people with fluctuating conditions are explored in more detail under the relevant consultation questions below.

HIV as a stigmatised condition

Unfortunately HIV remains a stigmatised condition. Recent research revealed that one in three people living with HIV had experienced stigma and discrimination because of their HIV status.² Worryingly this discrimination is often at the hands of public authority staff. For example, of those that had experienced discrimination, half of this occurred in a healthcare setting.

People living with HIV also face discrimination in the workplace and NAT is often contacted by people who have been discriminated against at work, many of whom have had to leave their job.

Sadly people living with HIV often face multiple-discrimination; HIV disproportionately affects men who have sex with men and Black Africans, communities that already face discrimination. It is therefore important that all staff involved in the welfare process are aware of and sensitive to the multiple barriers people with HIV face.

² Elford J., Anderson J., Bukutu C., Ibrahim F., Discrimination experienced by people living with HIV in London, XVI International AIDS Conference, Toronto, August 2006, Abstract number TUPE0716

It is essential that all staff delivering welfare services are provided with training so that they have a basic understanding of HIV and the way the virus is transmitted so they do not unwittingly further stigmatise the condition (we were recently contacted by a member of the public living with HIV who had been ordered to leave his local Jobcentre Plus when he revealed his HIV status as he was seen to be contagious). They also need to recognise the barrier HIV-related stigma and discrimination can be to re-entering and retaining employment. People living with HIV need support to help them deal with the consequences of previous discrimination and to help them prepare for future employment.

Employers also need a better awareness of HIV so they can support staff living with HIV, prevent discrimination and act appropriately when discrimination occurs.

Finally, concerns about stigma and discrimination mean that it is important that people's confidentiality is taken seriously by staff and agencies providing benefit related services. No member of staff should disclose someone's HIV status to another member of staff without the permission of the HIV positive person.

Anxiety and mental health issues

A recent UK study of HIV patients at four clinics in London and one in Brighton found that 31% reported having had suicidal thoughts over the previous week. The research found that since 1990, 271 or nearly 2% of the approximately 14,000 HIV positive people who have died in the UK, have taken their own lives.³ These findings build on a 2002 study conducted by the International Association of Physicians in AIDS Care. This found that 84% of doctors said their HIV-positive patients 'frequently or very frequently' suffered from depression.⁴ This may be linked to the issues of stigma and discrimination highlighted above.

Living well with HIV is closely connected to treatment adherence. If HIV treatment is to be effective, treatment adherence is vitally important. Adherence means ensuring that the patient takes their dose of HIV medication exactly as prescribed (at the right time, the right number of times a day). The level of adherence required for effective HIV therapy is high; levels below 95% are consistently associated with faster disease progression. Research has shown that stress and anxiety negatively impact on people's ability to adhere to HIV treatment regimes. A recent study found that those who had experienced periods of stress were three times more likely to have periods of non adherence.⁵

It is therefore vital that the benefits system does not add to the anxiety and stress of people living with HIV. It is of note that there is already widespread dissatisfaction with current welfare benefits administration. Failings identified by people living with HIV include lengthy delays and administrative mistakes; the insensitivity and bureaucracy of

3 <http://www.aidsmap.com/en/news/9833D300-43E8-45D0-942F-19FF1A985BFD.asp>

4 <http://www.aidsmap.com/en/news/47C679DE-A275-48FD-B525-3B24C3A0B8B0.asp>

5 Jane Leserman, Gail Ironson, Conall O'Cleirigh, Joanne M. Fordiani, Elizabeth Balbin. AIDS Patient Care and STDs. May 1, 2008, 22(5): 403-411. doi:10.1089/apc.2007.0175. (<http://www.liebertonline.com/doi/abs/10.1089/apc.2007.0175>)

the system; and refusal, withdrawal or depletion of specific benefits, particularly DLA. If the Green Papers reforms are to be successful, the administration of the benefits system must be improved. Disabled people must feel confident that they will receive correct advice from DWP staff, that decisions on benefit claims are correct and fair and timely, and that benefits will not be withdrawn or reduced without good reason. These improvements should help to minimise the stress and anxiety people experience when going through the benefits process.

NAT was particularly concerned by the reports from people living with HIV about how the recent DLA 'special rules' review was carried out. For example, the review was conducted in such a way that local HIV organisations were not given sufficient warning to set up arrangements to assist people going through the review with support, such as advice about how to get back into work. A more gradual approach would have allowed this to happen. NAT seeks reassurance that any future reforms will be carried out in a more thought-out way, giving people time to adjust to changes and ensuring that any stress and anxiety is kept to a minimum.

An ageing population

It is something to celebrate that people living with HIV are living longer and healthier lives. Some people originally diagnosed when there was no effective treatment are now marking twenty five years or more living with HIV. Statistics from the HPA note that 1 in 13 people accessing treatment are over 55.⁶ Though of course some people living with HIV contract the virus in later middle age, many of that age group have been living with the virus for years. During this time they may have had periods of very poor health and many may not have been employed since diagnosis. Findings for a London study found that of those diagnosed ten or more years ago (before HIV treatment was available) only a third were in employment.⁷ This group may have become disconnected from the workplace and lack the skills, and perhaps more importantly, the confidence to return to work. For those that wish to, providing the skills and support to help them return to work is a welcome development. However, for many this may be a challenge too far. NAT feels it is more appropriate to focus on supporting the newly diagnosed who have recently been in the employment market (and may still be employed) than on adopting measures such as reducing benefits, for those that struggle with returning to the workplace after a long period of unemployment.

Poverty

Research has shown that one in three people living with HIV has experienced poverty.⁸ This was further confirmed by findings from the London study that found that 40% of

6 Health Protection Agency (2007) Testing Times, www.hpa.org.uk/infections/topics_az/hiv_sti/publications/AnnualReport/2007/HIVSTIs_AR2007.pdf.

7 Ibrahim F., Anderson J., Bukutu C., and Elford J., (2008) 'Social and economic hardship among people living with HIV in London' in HIV Medicine; British HIV Association

8 Crusaid and NAT, Poverty and HIV: Findings from the Crusaid Hardship Fund 2006, December 2006

Black African heterosexual women and 39% of Black African heterosexual men did not have enough money to cover their basic needs.⁹

NAT therefore echoes Disability Alliance's concern about the Green Paper's statement that incapacity benefit claimants on higher rates of benefit will have their benefit rate gradually brought into line with the rate they are entitled to under ESA. This appears to propose a freeze on benefit up-rating for many incapacity benefit claimants at a time when the level of relative poverty for disabled working age adults is increasing.¹⁰ NAT is surprised that these proposals, which could affect the incomes of potentially millions of disabled people, are not even subject to a specific question within the Green Paper. The Government should reconsider this approach, particularly in the current economic climate when many disabled people are facing rises in the cost of living.

We would also echo the Disability Alliance's concern about the move to up-rate incapacity benefits by the Rossi index rather than the RPI index in future, particularly the claim that this will result in increases in benefit payments overall. For example, in the 2007 benefits up-rating¹¹, the use of the RPI meant a 3.6% increase for non-income related benefits against a lower 3.0% increase for income related benefits under the Rossi index. Further, as the Rossi index is essentially the Retail Price Index less the element representing housing costs, we would like to see made public the basis under which this represents increases in benefit payments.

Training for staff within the benefits system

NAT was concerned to learn that advisers themselves recognise that they are provided with insufficient training, particularly in relation to 'more challenging' health conditions and information about other benefits.¹² On top of this we were surprised to learn that the current medical assessments for Incapacity Benefit are not necessarily carried out by doctors nor are they conducted by specialists. Atos Healthcare describe their assessors as being 'trained to undertake the medical assessments appropriate to the specific benefit being claimed.'¹³

Evidence from Citizens Advice indicates that the conduct of some medical assessors is poor, with many Citizens Advice clients reporting rude or insensitive treatment. In particular, assessors frequently appear not to give sufficient consideration to mental health problems.¹⁴ Two thirds of benefit appeal cases are either incapacity benefit or

9 Ibrahim F., Anderson J., Bukutu C., and Elford J., (2008) 'Social and economic hardship among people living with HIV in London' in HIV Medicine; British HIV Association

10 Disabled adults are twice as likely to live in low-income households as non-disabled adults, and the gap is bigger than a decade ago - Monitoring poverty and social exclusion 2007, Guy Palmer, Tom MacInnes and Peter Kenway New Policy Institute, Joseph Rowntree Foundation December 2007

11 Explanatory memorandum to the Social Security Benefits Up-Rating Order 2007, No. 688

12 Knight T et al (2005) Incapacity Benefit Reforms – the personal adviser role and practices: stage two DWP

13 www.atoshealthcare.com accessed 1 October 2008

14 Barton A (2006) 'What the Doctor Ordered: CAB evidence on medical assessments for incapacity and disability benefits' Citizens Advice; London

DLA related. Over a third of these cases are overturned. Since 2001, the following key themes are repeatedly identified as causes of concern:

- ⌘ Some medical reports underestimate the severity of disability. In the most recent examination of overturned cases, Atos Healthcare had provided medical reports in 91 per cent of cases which were overturned.
- ⌘ Both medical assessors and decision-makers have difficulty assessing the relationship between mental health issues and care needs.
- ⌘ Often DWP simply does not seek sufficient information from claimants necessary to make a fully-informed assessment of their claim for benefits.
- ⌘ DWP decision-makers, the people charged with determining benefit entitlement on the basis of medical assessments, are not clear about the appropriate evidential weight to be given to medical reports.¹⁵

These issues are of particular concern to people living with HIV which is a complex, fluctuating condition and therefore more likely to be subject to medical assessment errors.

It is vital that in advance of any changes to the current systems, long standing problems with the assessment process, such as the lack of training for advisors, are resolved. Under the new system advisors will have great discretion as to what form a given claimant's back-to-work programme will look like. Whilst such flexibility may seem attractive, it can only be viewed as a positive if there are guarantees around the quality of the advisers and their training.

Current Government proposals offer no such guarantee. Currently one of the Pathways to Work contractors, Reed in Partnership, is recruiting back-to-work-advisers. The person specification requires candidates to have experience of working in a customer facing environment and working in a target driven environment and a minimum of 5 GCSE's.¹⁶

Employers' responsibilities

Finally, before moving on to the specific consultation questions, NAT would like to highlight the lack of emphasis in the Green Paper on employers' responsibilities. The onus in the reforms is on the disabled and unemployed taking steps to find work or improve their chances of finding work. There is very little mention on the need for employers to take steps to enable disabled people to join their workforce.

The Government needs to take greater steps to ensure employers are more aware of the benefits of employing disabled people, including people living with HIV. The need for this is illustrated by the Chartered Institute of Personnel and Development (CIPD) findings from 2003 that discovered that more than 60 per cent of employers said they

¹⁵ 'President's Report: report by the President of Appeals Tribunals on the standards of decision-making by the Secretary of State 2007 – 2008' (2008) The Tribunal Service; London

¹⁶ <http://www.reedinpartnershipjobs.co.uk> accessed on 1 October 2008

disregarded applications from people with drug or alcohol problems, a criminal record, a history of mental health problems or incapacity. More than half of respondents said nothing would persuade them to recruit from these 'core jobless' groups.¹⁷

Further research reveals that one in ten employers has withdrawn a job offer because the applicant had lied or misrepresented their health situation on the health-screening questionnaire. Seven per cent of employers have dismissed an employee while in employment for the same reason. Withdrawn job offers or dismissal on these grounds is twice as common in large organisations.¹⁸ This is particularly relevant to people living with HIV as people's experience of stigma and discrimination mean that some are unwilling to disclose their status on health-screen questionnaires.

Given this evidence, it is clear the Government need to take further steps to educate employers about their responsibilities under the DDA 2005. Employers need to be informed about conditions such as HIV, both in terms of what they need to do to be a supportive employer and also the understanding that just because someone has HIV does not mean they cannot bring a great deal to the workforce.

The proposed introduction of mandatory measures seem to assume that it is the disabled or unemployed person that does not want to return to the workforce and fails to acknowledge that often someone does want to return to work but it is the lack of suitable employment / employers that causes the problem. This will be particularly important given the current economic situation. Unemployment statistics released on 12 October 2008 revealed that unemployment has risen to over 1.7 million and many forecast that this could reach 2 million by the end of 2008. In this environment it is even more important that the Government take steps to ensure employers recognise the value of disabled staff and provide additional incentives to encourage employers to take steps to increase the number of disabled people on their staff.

We agree with the Government's position that in general, when someone is well enough, being in work can improve their health and well-being. However, sadly for many people living with HIV, it is the lack of employer understanding and flexibility that means working is difficult or impossible. The focus of the Government's green paper as it stands does not sufficiently address these issues.

17 CIPD (October 2005) Labour Market Outlook: Survey Report Summer/Autumn 2005

18 Labour Market Outlook: quarterly survey report – Autumn 2007' (2007) Chartered Institute of Personnel and Development

Before responding to the specific consultation questions NAT would like to make the following recommendations:

Recommendation: When taking forward the proposed welfare reforms, the Government should consider the consequences for people living with HIV, bearing in mind the fact that:

- ⌘ 1 in 3 people living with HIV has experienced poverty
- ⌘ A recent London study found that less than 50% of people living with HIV were in employment
- ⌘ Significant numbers of people living with HIV are dependent on more than one type of benefit
- ⌘ Stress and anxiety have an impact on treatment adherence which can then have subsequent health consequences for people living with HIV
- ⌘ HIV is defined as a disability from the point of diagnosis in the DDA 2005 so when thinking about reforms for disabled people the needs of people living with HIV should be considered.

Recommendation: The reform of the welfare system provides an opportunity to rectify identified administration problems within the current system and ensure that these are not brought forward into the new system.

Recommendation: Government should ensure that all staff within the benefits system have adequate training, particularly around complex, stigmatised conditions such as HIV. This is particularly important when considering training for medical assessors.

Recommendation: The onus in the proposed reforms is on disabled people and the unemployed taking steps to enable them to enter employment. The Government should take further steps to ensure employers are willing and able to employ disabled people, particularly those with stigmatised conditions such as HIV.

NAT welcomes the chance to respond to the questions in the green paper on the proposed welfare reforms. Please note that we will only be responding to those areas which we feel will have specific implications for people living with HIV. We have used the questions to structure our response; in some instances our comments extend beyond the questions to comment more generally on a particular area of reform.

Question 1: How long should ‘work for your benefit’ last at different stages in the claim?

Question 2: How could capacity and capability to provide full-time work experience in the community sector be provided and incentivised to produce the best employment outcomes for participants?

1. NAT would question the value of introducing ‘work for your benefit’ at any stage of a claim. Evidence from other jurisdictions shows that requiring people to work or under-take full time work-related activity in return for benefits does not work well for people with multiple needs. Arguably, anyone who has been continuously claiming JSA for two years has, by definition, multiple needs.¹⁹
2. By suggesting ‘work for your benefit’ should be introduced after two years, the Green Paper appears to be targeting JSA claimants who have, at least to some extent, essentially been failed by a Flexible New Deal (FND) contractor. As the Disability Alliance suggest, the proposal that someone who has not entered employment at the end of a FND programme should subsequently be made to work for their benefit seems to deny the very real possibility that the person in question could have been failed by the FND provider for reasons beyond their control.
3. As the proposals stand, there is no recognition that the reason someone has not found employment is because they face multiple barriers to entering the job market which the FND has failed to properly deal with.
4. A recent report stated that the FND approach could run the risk that those claimants furthest from the job market will be left behind under the Government’s current proposals.²⁰ Providers currently receive uniform payments for employment placements, which means that those who require more support at greater cost will “inevitably not be offered services appropriate to their needs”. Also as claimants remain with contractors for a maximum of 12 months, there is an in-built strong incentive to identify those who can be helped most quickly and to park the others.
5. It is important to recognise the different individual needs people have. Any ‘work for your benefit’ programme, if needed at all, should be tailored to the individual; there can be no one size fits all approach when dealing with the long term

19 Crisp R & Fletcher D R (2008) ‘A comparative review of workfare programmes in the Unites States, Canada and Australia’ DWP; London

20 Flexible New Deal: Making it Work, Ian Mulheirn and Verena Menne, Social Market Foundation, September 2008

- unemployed. It is particularly important that an individualized approach is developed as many people who have previously been entitled to Incapacity Benefit may now fall into this system (the Government expects 50 percent of those taking the new ESA assessment to fail).²¹ This group, which may include people living with HIV, are likely to have complex needs which need individual attention.
6. Evaluations of similar programmes have found they provide little or no direct employment assistance and can lock unemployed people into longer unemployment durations.²² It is unlikely that employers will view 'work for your benefit' programmes as truly readying people for work. One of the key attributes that employers seek in potential employees is motivation. In no way does a period of 'work for your benefit' demonstrate that an individual is self-motivated – quite the opposite.
 7. As highlighted above, people living with HIV face many barriers to returning to employment (stigma, discrimination, fluctuating health, lack of confidence, the need to refresh skills) and the Government should focus on identifying and breaking down the barriers those with complex needs have to employment, rather than adopting a compulsory 'work for your benefit' programme. Compulsory work may be very distressing for people inadequately prepared for the labour market and could in fact prove to be a backwards step.
 8. If the Government does decide to introduce 'work for your benefit' there should be no uniform period of work at different stages of the claim. The programme should be tailored to the needs of the individual, and focus on providing them with the work experience they need, rather than being used as sanction for not finding employment.

Recommendations

9. Instead of introducing 'work for your benefit' programmes, the Government should ensure back-to-work programme providers invest in schemes to address the barriers that are preventing claimants with multiple needs from moving into work. This should reduce the number of people who have not found employment at the completion of a FND programme.
10. Government should provide incentives for employers to take on those with complex needs, whilst ensuring that employers have the training and support required to understand the needs of disabled employees (for example the need for confidentiality about someone's HIV status).
11. If 'work for your benefit' is introduced, this should not be for fixed periods at different stages in the claim. Instead the programme should be flexible and the period of work should be determined by the individual's work experience needs.

²¹ <http://www.dwp.gov.uk/mediacentre/pressreleases/2007/nov/drc055-191107.asp>

²² Finn D & Simmonds D (2003) 'Intermediate Labour Markets in Britain and an International Review of Transitional Employment Programmes' DWP; London

Question 4: What penalties do you think would be most effective to deter more people from committing benefit fraud?

Question 5: Do you think it would be appropriate to reduce or withdraw entitlement to benefit after a first offence? How long should the sanction period be?

12. NAT believes that as well as considering the issue of fraud, DWP should consider the waste of resources which occurs due to poor decision making. The administration and decision-making with relation to the Personal Capability Assessment and its replacement, the Work Capability Assessment, causes serious concerns, as does decision-making and assessment for Disability Living Allowance. These are between them responsible for more than 60% of all social security appeals lodged, with success rates running at more than 50%.²³ The high level of appeals is not only a waste of public resources but also a cause of stress and anxiety to disabled people because of poor decision making.

Recommendation

13. As well as addressing benefit fraud, the Government should improve its benefit administration and decision-making process to reduce the amount of resources wasted through people unnecessarily going through the appeals process.

Question 6: Do you agree with the proposed approach for identifying problem drug use? How should it be implemented? Do you think that everyone claiming a working-age benefit should be required to make a declaration of whether or not they use certain specified drugs?

14. NAT is particular concerned about these proposals because of the link between injecting drug users and blood borne viruses (BBVs), including HIV. Approximately one in 75 injecting drug users is estimated to be HIV-positive.²⁴ People living with HIV have serious concerns about disclosing their status because of the stigma and discrimination issues discussed in the introduction to this response. Any sharing of data between authorities is likely to cause them concern. The measures set out in the paper seem to further stigmatise drug users, making it even more unlikely that this hard to reach group will engage with public services. This could have health implications as they are then less likely to engage with treatment programmes and support, including safer injecting programmes (thereby potentially increasing the likelihood of spreading BBVs).

15. NAT also has substantial reservations over the use of sanctions for those who fail to disclose a drug problem. Failure to disclose may not be motivated by a desire to defraud or mislead. Many individuals will be fearful of the implications

²³ Quarterly Appeal Tribunal Statistics: March 2006, DWP

²⁴ Shooting Up – Infections among injecting drug users in the United Kingdom 2006. An update: October 2007. (2007)

Health Protection Agency, London

of disclosure. For example, women with children may be afraid to disclose for fear their children will be taken into care. There is a danger that by adding sanctions vulnerable individuals may be driven away from the benefits system, leaving them and their dependants in poverty.

16. Drug testing of claimants who Jobcentre Plus suspect of drug use is morally dubious and would subject claimants to an unacceptable level of speculative invasive surveillance.
17. Jobcentre Plus staff might be uncomfortable asking all claimants about drug use. If this screening is applied on the basis of the subjective view of staff (who 'looks like a drug user'), it may fall foul of anti-discrimination legislation.

Recommendation

18. All barriers to work should be examined during work-focused interviews. This is the point at which issues around substance dependency should be raised in a sensitive manner.
19. The views of drug users on these proposals should be sought. Involvement from the beginning will help to alleviate problems of non-compliance and ensure services meet the needs of drug users.
20. Rather than focus on sanctions if individuals do not disclose, the onus should be on providing incentives to disclose. If drug users feel they will receive assistance if they disclose they are more likely to do so. For example, one option could be to remove the obligation to 'sign on' at the Job Centre Plus if an individual is undergoing treatment; they could be given the option of signing in at treatment centres instead. This would allow the individual to focus on their treatment instead of having to interrupt the process to meet with another agency.
21. Information about drug use should not be shared between agencies.
22. If proposals were implemented, where information about current use is held and shared, the claimant should be provided with a copy of that information. This should not include information about a person's HIV status or other medical conditions unless the claimant has specifically given their consent.

Question 7: What elements should an integrated system of drug treatment and employment support include? Do you agree that a rehabilitation plan would help recovering drug users to manage their condition and move towards employment?

23. Research suggests that the barriers to employment for problem drug users include: literacy and numeracy problems; lack of educational and occupational qualifications; no work experience or interrupted work histories; CV gaps; requirements to disclose health problems and criminal records; fear of relapse and the need to renegotiate benefits if things go wrong; and restrictive pharmacy dispensing of substitute drugs like methadone.

24. The main structural barriers are employer discrimination and lack of engagement between drug and employment services.²⁵
25. The proposals do not outline how employers will be encouraged to provide employment for recovering drug users. Without employer buy in it is hard to envisage how this scheme will work and drug users may lack motivation to participate.
26. Programmes must also be flexible enough to support individuals. In many cases expecting a drug user to move straight from treatment into full-time employment is unrealistic. Ensuring individuals can build up their working hours and not end up worse off than if they were on benefits is essential.

Recommendation

27. Any back-to-work support for drug users should effectively address all barriers to work and not skew focus onto drug use at the expense of other issues (for example mental health problems, HIV status etc).
28. The process also needs to address the fact that drug treatment is not a linear process. In many cases, people will not enter treatment at one end and emerge fully recovered and ready to work. The current proposals need to be adapted to reflect this.
29. Any programme designed to facilitate a move into employment by former drug users must also involve employers to ensure there are suitable employment opportunities for people to access.
30. Any programme designed to facilitate a move into employment by former drug users must tackle employer prejudice.

Question 8: When is the right time to require ESA claimants to take a skills health check?

Question 9: Should ESA customers be required to attend training in order to gain the identified skills they need to enter work?

31. NAT would recommend that the Government focus on a voluntary approach to training and skill development. It is unlikely that claimants obliged, at risk of benefit loss, to attend training will be at their motivational optimum. It would be more beneficial to explore why ESA claimants not willing to engage in training do not wish to do so. Once these barriers have been identified they can then hopefully be overcome. This will be more effective than simply forcing people to attend training.
32. DWP's own research has found that personal advisers regard themselves as enablers rather than enforcers - 'they felt that allowing customers to move forwards at their own pace, and emphasising the voluntary nature of participation, were critical to gaining customer commitment and co-operation'.²⁶ The research notes that 'if further elements of compulsion are introduced, care [is] needed that

^{25[2]} www.drugscope.org.uk

²⁶ Incapacity Benefit Reforms: Personal Adviser roles and practices - qualitative research by Tim Knight, Sarah Dickens, Martin Mitchell and Kandy Woodfield for the DWP 2005

it is not detrimental to the enabler role of IBPAs'. Undermining the relationship between advisers and ESA customers by introducing a mandatory element to the programme would be a backwards step.

Recommendation

33. All barriers to work should be examined during work-focused interviews. This is the point at which issues around education and skills should be raised.
34. Claimants should be encouraged to engage in training where a need has been identified, but should not be compelled to do so. Extra benefit payments for those who do engage, as is being proposed for lone parents, should be piloted.
35. For those that do not engage in training, extra time should be spent identifying why they did not take up training opportunities, and aiming to overcome these barriers.

Question 14: Do you agree that the WCA and WFHRA should be re-focused to increase work-related support?

36. NAT welcomes the Government's commitment to provide disabled people with more support to access employment. However, there is a concern that the WCA will become simply a more stringent gateway to Incapacity Benefit / ESA which goes further than the Personal Capability Assessment, an assessment that is already acknowledged as one of the most exacting eligibility tests in the world.²⁷ Government's proposal to look again at some of the measures of impairments suggests an intention to make this test even harder. The consequence of this may be more claimants with disability/health needs who are unable to secure work claiming JSA.
37. NAT seeks reassurance that the WCA is not simply a way to move Incapacity Benefit /ESA claimants on to the JSA which may not meet their needs. NAT has concerns about this as the JSA regime offers only extremely limited health or disability-related support to claimants. If a claimant's health issue impedes their search for work, he/she may be eligible for specialist help from Jobcentre Plus. They may be referred to Disability Employment Adviser (DEA). However, there are only between 500 and 700 DEAs in the UK.²⁸ People getting JSA are not eligible for help from the New Deal for Disabled People.²⁹
38. NAT is also concerned that those carrying out the WCA and WFRHA will not have the appropriate training to understand and identify the barriers people living with HIV face when returning to employment. There are complex medical factors to consider as HIV is a fluctuating condition, as well as the psychological barriers caused by stigma and discrimination and, in some cases, the impact of being out of employment for long periods of time. NAT does not oppose a focus on work

²⁷ OECD (2003) 'Transforming Disability into Ability: policies to promote work and income security for disabled people' OECD

²⁸ NAO (2005) Gaining and Retaining a Job: the Department for Work and Pensions' Support for Disabled People

²⁹ www.direct.gov.uk/en/DisabledPeople/Employmentsupport/WorkSchemesAndProgrammes/DG_4001963

related support, but this must be combined with a clear understanding of the complexities of living with HIV and the barriers it creates in returning to work.

Recommendations

39. The WCA should not be altered to further limit access to Incapacity Benefit / ESA unless those with lower level disabilities that are moved onto JSA can access the health and disability-related support they need to find employment.
40. The Government should recruit and train additional Disability Employment Advisers in anticipation of the increased number of disabled people moving from Incapacity Benefit / ESA to JSA.
41. The WFHRA should be conducted by fully trained professionals that are qualified to properly assess health/disability-related barriers to work, including those relating to HIV. It is important that the psychological barriers, as well as physical barriers, are fully considered.

Question 15: What expectations should there be of people undertaking the personalised support we will now be offering in the Work Related Activity Group? Could this include specific job search?

42. NAT welcomes the Government's commitment to a 'universal offer of personalised support' for all incapacity benefit claimants. However we feel a blanket prescription of expectations of people taking up this support is inappropriate; what will work as an effective back-to-work strategy will be different for each claimant.
43. The Government predicts that 50 percent of those that take the WCA will fail and will move from the ESA to the JSA. This means that only claimants deemed so functionally limited that it is not reasonable to require them to work are eligible for ESA.³⁰ Given this, it seems inappropriate to include a condition to engage in specific job search in order to qualify for the full rate of benefit.

Recommendations

44. Back-to-work strategies should be designed around each claimant's particular needs.
45. People in receipt of ESA should not be expected to engage in specific job search.

Question 16: How can we make Access to Work more responsive to the needs of claimants with fluctuating conditions – including mental health conditions?

46. NAT welcomes the Government's recognition of the need to specifically consider fluctuating conditions. As well as following the recommendations set out below about Access to Work, the Government should make it easier for people to take

³⁰ Welfare Reform Act 2007

- the step of returning to work, allowing them to continue to access benefits (even at a reduced rate) for an agreed transitional period.
47. NAT has heard from people living with HIV who return to work, only to experience a change in their condition which means it is no longer possible for them to continue in employment. However, by this time they have been removed from the benefits system and have to go through the assessment process again. The Government should ensure people living with HIV and other fluctuating conditions are given simple access points to the benefits system so they are not deterred from seeking employment when their health improves.
 48. NAT endorses the Disability Alliance's recommendation to ensure greater integration between Access to Work and the WCA and the WFHRA. Ensuring that healthcare professionals and personal advisers are aware of the availability of the scheme should increase the profile of the scheme. There needs to be greater flexibility within the scheme, with the introduction of support for people with fluctuating conditions in times of poor health.
 49. We would welcome consideration of financial assistance being made available to small and medium sized employers to help support people recently diagnosed with a fluctuating condition through a period of disability leave. This leave could be statutory, subsidised by Government, and could work in the same way as maternity and paternity leave. This would enable employees and employers, to assess an individual's condition and how this affects their role, and consider how best to facilitate a return to work.

Recommendations

50. The Government should make it easier for people to return to work by allowing them to continue to access benefits (even at a reduced rate) for an agreed transitional period.
51. There should be a statutory right to Access to Work for people with support needs that can be met via the scheme.
52. People with fluctuating conditions should retain an underlying entitlement to Access to Work. This would mean that, once qualified for Access to Work, clients whose support needs reduce, such that they do not need Access to Work support for a period, can reactivate the support on request if their support needs increase at a later point.
53. Access to Work support should be available for as long as it is needed.
54. Employers (particularly small and medium) should be able to receive support from Access to Work to compensate them for when people with fluctuating conditions need periods away from work (e.g. when people living with HIV are adjusting to changes in their treatment regimes).
55. Access to Work needs to be integrated with the WCA and WFHRA.

56. There must be robust, accessible and transparent appeal and review procedures for the Access to Work scheme.

Question 17: What additional flexibilities in the system or forms of support would claimants with multiple and complex problems need to enable them to meet the new work-focused requirements proposed in this Green Paper?

57. As highlighted throughout this response, the new work-focused requirements must account for the needs of people living with fluctuating conditions such as HIV. The nature of the virus may mean that at some point people are well enough to meet the work-focused requirements, but at other times they may not.
58. For example NAT is concerned about proposals to increase the financial penalties, or sanctions, for non-compliance with regards to appointments and interviews. As the Disability Alliance note, the fact that “a significant minority” repeatedly fail to attend appointments and interviews with Jobcentre Plus advisors despite the existing threat of sanctions appears to undermine the case for greater measures of an automatic loss of benefit. Current sanctions already allow for the removal of benefit in cases of non-attendance at interviews or non-compliance with jobseeker’s directions for example, so it is difficult to understand the rationale for further sanctions. This is especially so in light of the likelihood of greater numbers of disabled people needing to claim JSA as the entitlement test for ESA becomes more rigorous. Any penalty for not attending appointments or meeting work-focused requirements must take into account the needs of people with fluctuating conditions as a change in someone’s health may impact on their ability to attend appointments.
59. The system needs to take into account the psychological impact of a person’s condition on their ability to seek work or meet the work-focused requirements in this Green Paper. For example, as set out in the introduction, someone living with HIV who was diagnosed many years ago may not have been in employment for a long time. Although, with advances in treatment their physical health may have improved, they will need additional support to build their confidence and skills so they feel able to return to work. Considering their physical health alone as a determiner of whether they are able to work does not take into account the significant psychological barriers some people living with HIV face (including issues around stigma and discrimination).

Recommendations

60. The WFHRA should be conducted by trained professionals with an adequate understanding of disability related barriers, both physical and psychological, including those relating to fluctuating and / or stigmatised conditions such as HIV.
61. Claimants with multiple and complex problems should be allocated highly trained advisers who are specialists in the claimant’s ‘main disabling condition’ and the particular issues associated with that condition e.g. stigma and discrimination.

62. The Government should ensure that people with fluctuating conditions do not face penalties for missing appointments or not meeting work-focused requirements because of changes in their health.

NAT
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