Pathways to Work: Reforming Benefits and Support to Get Britain Working

Mental Health Champion for Northern Ireland

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The Mental Health Champion for Northern Ireland welcomes the opportunity to respond to this consultation. I would endorse the goal of reforming the welfare system to better support those who need it, increasing the opportunities for work and enhancing social mobility. I cannot however support the chosen method of cutting support payments to those already deemed in need of assistance, and I am opposed to the raising the severity threshold to reduce and prevent access. My main recommendation is that the DWP do not proceed with the proposals which will have a particularly serious impact on people with a mental illness, they will cause distress and further suffering and will result in increased costs to the economy. The impact will affect the poorest areas of Northern Ireland more than any of the other UK regions and will create additional pressure for our health and mental health services, as well as in the justice system. The mitigation measures proposed are wholly inadequate and rely on a robust system of alternative support which simply does not yet exist. The concessions announced on the 27th June will create a two-tier system and a myriad of unintended negative consequences. It is essential that adequate welfare protections are in place for people who are unable to work due to mental illness. The severity threshold and criteria should not be changed and should be the same rate for both current and future claimants.

It is regrettable and frustrating that the consultation is limited to the consideration of mitigation measures proposed to address the expected negative impact on some of our society's most vulnerable and their dependents, rather than the cuts themselves. The outlined changes, which are not open for consultation, propose fiscal gains and economic growth at the expense of reducing the already sparce and depleted safety net available to persons living with long term illness and disability. Welfare reform should be implemented in a trauma-informed manner, ensuring that the most vulnerable are protected from destitution; and it should commence with the development and expansion of tailored support packages across employment, communities, education and health.

The devolved nations also require appropriate time to plan and implement changes in line with the specific needs of their population, rather than have it rushed through with the proposed deadline. The proposed mitigation measures as presented do not adequately address or acknowledge the disparate positions each region holds when faced with the largest cuts to disability payments since 2010. The document reflects the starting position of England and Wales. Scotland is in a fortunate position of having a bespoke Adult Disability Payment scheme, which should afford the region greater flexibility in how it responds to the cuts this consultation foreshadows. Northern Ireland is not so fortunate, and in addition, the evidence demonstrates that NI will experience the most devastating impacts.

Currently NI has the highest uptake of Personal Independence Payments awards out of any UK region, at 11.3% of the population. PIP was introduced in NI in 2016 as a non-means-tested and tax-free contribution towards the extra costs associated with living with a disability. The application and assessment process, whilst stressful and contrary to a strengths-based and recovery orientated approach to mental ill-health, has protected against potential fraudulent claims, which are estimated to be less than 1%. The cuts this green paper outlines are designed to increase the severity threshold for receipt of financial assistance and decrease the fiscal burden on the UK government. Those with disabilities and conditions which cause mobility or daily functioning difficulties repeatedly but intermittently, are most at risk of losing financial support if they do not score above 4 on the daily living element. The impact of the cuts is further pronounced for those who stand to lose the daily living element of PIP and who will subsequently lose the health element of Universal Credit (LCWRA) as they will utilise the same assessment. As Mental Health Champion, I am particularly worried about the impact the new assessment criteria will have for people with mental illness, with psychiatric disorders being the leading disability conditions reported by PIP claimants (45%) in NI. This increased prevalence is unsurprising when considering the context of mental health in NI.

The evidence shows how the impact of the conflict continues to be felt; in the 2023 NI Life and Times study 29.9% reported that the conflict impacted their mental health. Similarly, 30% reported a traumatic conflict–specific event in the 2024 study of trauma and childhood adversities, and almost half the population had witnessed conflict related violence (47.5%). Over twenty years ago a World Mental Health Survey Initiative study found that the rate of Post Traumatic Stress Disorder in NI at 5.1%, was the highest of all the participating countries. Our history of violence accounted for the excess, with rates higher in the 39% of the population who had a conflict related traumatic event. Sadly, a recent study found that the situation now is actually worse, with 6.1% of the population reporting PTSD or complex PTSD. Now 17.6% report having four or more Adverse Childhood Experiences (ACEs), compared with 7.2% in 2005. ACEs carry an elevated risk of almost every negative, physical and mental health condition, and are associated with much poorer outcomes in education and employment. The Global Burden of Disease (GBD) study highlighted the differences between the UK Regions in relation to disability caused by mental illness. It shows that mental illness is a leading cause of disability in NI, with increased years lived with disability attributed to both depressive and anxiety disorders in NI compared with the other UK Regions. It shows that people in NI are developing mental ill-health at younger ages than their counterparts in the other UK Regions, specifically in relation to anxiety disorders[1].

The root cause of mental illness is multifaceted, but research consistently shows that social and health inequalities, including experiencing poverty place people at increased risk across their lifespan. The APPG on Poverty and Inequality Report The Disproportionate Impact found that the green paper “will only make life more precarious for disabled people, potentially pushing hundreds of thousands of people further into poverty and will only further entrench existing inequalities”. It highlights that people living with disabilities are more likely to experience poverty, that poverty is cyclical and the structural barriers to employment that prevent breaking that cycle are more acute for disabled people. The Government’s own

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[1] Mental-Health-Overview-Stats.pdf

impact analysis shows that cuts to sickness and disability benefits will potentially push 250,000 people into poverty and hardship, including at least 50,000 children. However, Joseph Roundtree Foundation (JRF) analysis shows that the full impact could be closer to 400,000 more people in poverty. JRF case studies show that a single person losing both PIP and LCWRA will be £795 each month, while an in-work family losing the same benefits could lose £957 per month, which equates to 29% of their after-housing costs income each month.

Disproportionate Regional Impact

The negative impact of that financial loss will not be equally distributed across the UK and will be most concentrated in the areas of highest deprivation. The Nuffield Foundation found that Northern Ireland has a much higher proportional share of the most deprived areas in the UK than Scotland, Wales, or any of the nine regions of England, at 25%. When results are summarized at local authority level, Derry and Strabane and Belfast (both within Northern Ireland) have larger proportions of their areas within the most deprived 10%, across the UK than any of the other 374 UK local authorities. Across both education and health domains, Northern Ireland has the largest proportion of zones in the most deprived 10% at, respectively, 27% and 28%. These areas endure increased health burdens, reduced social mobility and increased likelihood of developing chronic conditions, and mental illness at a younger age. It is unsurprising that the areas identified by the Nuffield Foundation, are the same areas with increased prevalence of PIP and other disability benefit claims, as identified in Dr Russell and James Bamford report. They found a wide variation in PIP awards across the constituencies, from a low of 8.5% of persons aged 16+ in Belfast South and Mid Down, to a peak of 25.6% in Belfast West. The constituencies of Foyle (22.5%) and Belfast North (20.1%) also have a high proportion of PIP recipients. The disparity becomes more evident when comparing super data zones, the proportion of PIP claimants aged 16+ ranges from a low of 1.6% in Botanic_Q (Belfast South and Mid Down) to a peak of 40.9% in Ballyarnett_B (Foyle).

The need for reform to be accompanied by appropriate mental health services

It is important that our employment systems are equipped to support people who experience mental illness. However, we also need to recognise that people with a mental illness require treatments and services so that they are well enough to gain employment or undertake their other roles. It is therefore imperative that our health service is equipped to support those experiencing mental illness, so that they can lead fulfilling lives, including contributing to the workforce. The green paper outlines the investments the UK government have toward health and employment resources in recent years, but these developments are not reflected in NI. NI has a long history of fragile and volatile government (Heenan & Birrell, 2018). Since its inception, the NI Executive has endured six periods of suspension which has hindered the implementation of recommendations from multiple independent reviews across sectors. Not least of these is the impact endured within the Health Sector, inclusive of both physical and mental health services. In 2016, Professor Bengoa produced a report that outlined the urgent need for reform within health services here. The NI Executive has been operational for only a third of the nine years following the publication of the Bengoa report. In the intervening times, Direct Rule was not restored, the Secretary of State did not enact additional powers over transferred matters to authorize restricting and reforming actions deemed urgently necessary within Health in 2016. Professor Bengoa's report predicted that without change the budgetary requirement would double to £9bn by 2026/27 and we are currently well on the way to realizing that prediction – with the estimated cost of delivering services in 2024/25 at over £8bn.

The Mental Health Strategy

In response to increased awareness of the extent of poor mental health in NI, and commitments to improve services in the New Decade New Approach and the Stormont House Agreements, Minister Swann launched The Mental Health Strategy in June 2021. The Strategy comprises 35 actions to transform mental health services and create a Regional Structure to deliver care. To date the Strategy has resulted in several reviews and a series of more detailed plans. It included a Workforce Review for the Statutory sector, which indicated the need for a 45% uplift in staff, and plans for a joined–up Regional Crisis Intervention Service including responsive interventions via the Community and Voluntary Sector. Important and necessary as these developments are, progress falls short of what stakeholders might have expected, given that we are more than a third of the way through the Strategy's implementation period. There now needs to be a dramatic uplift in investment to translate into meaningful change that can be felt by the general population. The funding deficit is stark, the Funding Plan stated that in 2023–2024 we needed over £40 million for implementation, the Department of Health allocated around £5.1 million in this year. In 2025–2026 we need over £60 million, and it looks likely that the money available may remain similar to what was invested last year. The NI health service is experiencing increased budgetary restrictions. This is impacting all areas of care and waiting lists for diagnosis and treatment. Between December 2012 and September 2023, the number of pathways (per 100 population) where a patient was waiting for a first outpatient appointment has increased from 3.9 to 9.8 in Scotland, and from 5.9 to 22.3 in NI.

This disparate system has increased demand for private health care across the UK. People who are languishing on waiting lists for diagnosis and treatment, which can often take years are incurring the extra financial burden of paying for health services to avoid the deterioration of their health, or to access the support services which they are excluded from without a diagnosis. The changes this green paper outlines to UC and PIP are included within the Universal Credit and Personal Independence Payment Bill, and while they are not open for consultation it includes a change in wording which may restrict access to these benefits for persons who have been driven to use private health care for diagnosis and treatment of mental ill-health. Article 41(A) outlines specific provision for NI wherein capacity assessments for claimant with a severe condition has been diagnosed by an appropriately qualified health care professional in the course of the provision of health and social care services. Health and social care within the meaning of the Health and Social Care (Reform) Act (Northern Ireland) 2009 which includes provision for private health partnership but only when carrying out duties under statutory supervision.

Current legislation Personal Independence Payment Regulations (NI) 2016 (No.217) includes provision of medical evidence in support of incapacity from registered health professionals as outlined in The Social Security (Medical Evidence) and Statutory Sick Pay (Medical Evidence) (Amendment) (No. 2) Regulations 2022 wherein a "health care professional" means—(a) a registered medical practitioner; (b) a registered nurse; or (c) an occupational therapist or physiotherapist registered with a regulatory body established by an Order in Council under section 60 of the Health Act 1999 M20. It does not have the same requirement of the provision of care or diagnosis from within the health care system which the current Bill includes. While the hope is that it is an unintentional oversight, I'd urge that a change in wording be addressed before royal assent. Those who have been able to access private health care to address their health needs, which the current health and care system have not been able to address within expected timelines, should not be restricted from accessing benefits they would otherwise be entitled to.

JRF and Ulster University hosted a seminar event in April 2025 wherein 40 local stakeholders including those with disabilities and long-term health conditions, academics, DPOs, voluntary and community organisations, unions, civil servants and political party representatives discussed the implication of this green paper for the people of NI. The Office of the Mental Health Champion was in attendance and was immensely grateful for the insights it afforded. These insights are discussed in more detail under each consultation question. It was stark to hear the closing remarks from Department of Communities who while advocating for the great work being done in employment support programmes, was clear that funding has been cut year on year, reducing those services. The level of support available in England and Wales is not enough, but it is more than what people in NI can access. Again, the green paper does not reflect this disparity.

I firmly oppose these cuts on account of the negative impact it will have, which by the Government's own admission will plunge people further into poverty, in turn impacting their mental health further. It is unconscionable that the proposed timeline to gain royal assent by late Autumn, limits how devolved regions can respond on behalf of their population.

The impact of these cuts will be felt more acutely in Northern Ireland, with regard to the percentage of the population it directly impacts and due to the availability in alternative supports within the health and employment sectors. As with mental health, the reasons why the situation in NI is more complex and disparities more pronounced include the transgenerational impact of the conflict. Nevertheless, the reality is that the NI population has not yet recovered, our systems and structures have not yet recovered. Acknowledging that this is a legacy the current Westminster Government has inherited, in no way lessens the responsibility it holds towards the people of Northern Ireland to take due consideration of this context. We therefore advocate for a Region-specific approach to these measures and provide the following comments on the specific questions relating to the current consultation.

Chapter 2: Reforming the structure of the health and disability benefits system

1. What further steps could the Department for Work and Pensions take to make sure, the benefit system supports people to try work without the worry that it may affect their benefit entitlement?

In the first instance more must be done to communicate to the people applying for and in receipt of these benefits, exactly how and when their entitlement will change, what is expected of them in return and what supports they can access in the interim. The changes to the benefits system are complex and the public narrative around it is divisive. It is difficult for anyone to digest the volume of information being presented, but more so for whom these decisions directly impact and potentially threaten their ability to meet their needs and that of their families. Everyone in receipt of disability payments needs to have access to this information from the beginning, with increased efforts to ensure that individuals understand the guidance provided to them.

Chapter Two recognises that the information currently available under the previous government lacked clarity which this government will try to address by engaging with stakeholders. Whilst that effort is valuable, the guidance that is provided needs to be concise in relation to the following:

- When will a reassessment be triggered once someone utilised the right to try mechanism? Is it time based/dependent on the physicality of the position?
- Will a reassessment be triggered for each new employment, even if the type/area of work remains the same (particularly relevant for bank staff, contract work, short term contracts)?
- Can the individual trigger a reassessment when experiencing increased acuity of their symptoms, and can this process be streamlined for individuals where the cycle of acuity and recovery is consistent with their diagnosis?
- Will the reassessment decision stand should the individual maintain employment after the "right to try" period ends?

Attendees at the JRF/UU event raised the following considerations:

- Within certain support eligibility processes, people with learning disabilities and difficulties are often assessed repeatedly for permanent/unchanging conditions. JRF event attendees felt that this should be reviewed and avoided, and employment/other supports should remain consistent.
- Clear understanding and response to the fact that cuts to PIP will create new additional barriers to work for ill and disabled people in NI. New ways of providing financial support to access work should be provided.
- Participants highlighted that small businesses in NI do not have adequate resources to implement good employment support processes and often have concerns about creating unintended harm. Consideration should be given to how the department will address these resources gaps.
- Job Centres are susceptible to a lot of staff turnover which undermines any trust that might be built. There needs to be concerted effort from the Department of Communities to create the conditions where trusting-relationships can be established.
- Funding for adaptable workplaces is vital and needs to be easily accessed for businesses and employers of a range of sizes.
- Funding for training packages for employers (of different sizes and sectors) must be better identified and advertised. Some programmes are available but there is a need for a coordinated and well communicated regional approach.
- There was a sense that there had been historic underinvestment in this area for NI, and loss of external funding mechanisms like European Social Fund were a major blow. Some stakeholders also felt that certain programmes targeting these groups had poor or limited outcomes.
- They also noted that the lack of a strategic approach, and delay of either a Disability Strategy or Disability Employability Strategy, was likely to make the impact and challenges posed by the Green Paper significantly worse in NI. However, there was a strong plea against the 'politicisation of the issue'

- Queries were raised around how the Block Grant (through Barnett Consequential) will be impacted, and then the subsequent impact on Departmental budgets. Many people were concerned that the Department for Communities would not receive sufficient or any additional resources to mitigate any impact, because generally Health and Education are the departments that are prioritised. Stakeholders felt that the Department for Communities would need significant resource to respond to the potential impact of the Green Paper's proposals.

2. What support do you think we could provide for those who will lose their Personal Independence Payment entitlement as a result of a new additional requirement to score at least four points on one daily living activity?

The new PIP assessment is particularly problematic for people living with chronic illness and disability wherein the impact on daily functioning differs greatly between periods of remission, recovery, crisis and acute need. The intermittent nature of these physical restrictions will exclude many for the daily living element of PIP. It is unclear if the daily living element can be reassessed in a timely manner to coincide with this intermittency. The conditionally of the LCWRA being based on the same assessment further compounds the perception of a hierarchy of illness and reduces the accessibility of support should someone find themselves unable to gain or maintain employment. Likewise Universal Credit is an out of work benefit and the health element (LCWRA) accommodates for the additional costs of living with a disability during this period. However, young people with chronic health conditions and disabilities since childhood will not have access to this additional payment (aged 18-22) regardless of if they can find suitable employment or not, placing additional burden on the transition from child to adult services. Both cases present scenarios where "hidden disabilities" which have intermittent, impact on daily functioning or arbitration conditionality linked to age become exclusionary. While we recognise that this may be the intent of the proposed changes, "in rebalancing disability benefits" it nonetheless fosters distrust in the Social Security system for anyone in this position. It is difficult to see how this situation provides the opportunity to access "good jobs" which can accommodate the specific needs of the individual while allowing for them to make a meaningful contribution to the role. Rather it forces the acceptance of any job, regardless of if it is fit for purpose or problematic of the management of their long-term condition. New Economics Foundation's research on 'Rethinking Conditionality to support more people into better jobs' has shown that Government needs to recognise the direct tension between compliance and engagement. The instinct to resort to conditionality is wrong and ineffective; people disengage and less move into work and wellbeing. The idea is that conditionality 'sets a minimum floor' when it 'sets a ceiling'.

Compounding socio-economic vulnerabilities in addition to disability will invariably create an increasingly precarious position for disabled people. The evidence above outlines how these cuts will disproportionately impact people from socially deprived communities, plunging people further into poverty. Poverty and financial, food, housing insecurities increase the likelihood of mental ill-health and crisis regardless of the presence of disability. The additional stress places increased pressure on persons who already experience mental illness. The loss of financial support distinctly communicates that while their disability is recognised by health professionals and previous governments, it has been devalued in the current hierarchy. In turn this means the loss of mobility entitlement which further limits a person's mobility and decreases potential employment options. This will increase the sense of hopelessness and there is a genuine fear it will result in despair and suicidality. This sense of hopelessness was reflected in the comments by attendees of the JRF event with lived experience who felt the UK Government was setting the bar extremely low, where only food and shelter was seen as essential for disabled people (without recognising that food and housing insecurity remain unacceptably high). They felt this was based on an assumption that 'disabled people only deserve to exist but not to live.'

Anyone still in receipt, or who will lose PIP entitlement, needs support to engage with the employment market. Additionally, the needs of carers, who also stand to lose financial entitlement need access to similar support. The support should include:

- Timely access to healthcare and on-going treatment essential for condition management
- Access to effective wellbeing and crisis services
- Access to appropriate treatment and psychological therapies for those experiencing or at risk of developing mental illness
- Educational and training pathways that are inclusive and accommodate the health needs of the individual
- Money and benefit advice to ensure people can claim everything they are entitled to, to support themselves and their families
- On-going employment support for themselves and their employer to increase access to "good jobs"

These supports are not consistently available within regions, or equitably available across regions. Enforcing the cuts before these supports are adequately robust enough to meet the increased demand these measures will place on them, is unnecessarily punitive and cruel.

3. How could we improve the experience of the health and care system for people who are claiming Personal Independence Payment who would lose entitlement?

There needs to be recognition of the disparate nature of the health and care systems across the UK and acknowledgement that the increased in waiting lists and demand on services felt across the UK, are felt more acutely in NI. The long-understood need for reform in the NI health and care service has been restricted and implementation stagnation and exasperated by governance volatility. Timely access to primary care, diagnosis and on-going treatment is essential for condition maintenance and to avoid deterioration or development of co-morbidities.

For people experiencing mental illness, or at risk of developing mental illness, the experience of the health and care system can be improved if it is transformed to meet the needs of this population. The NI Mental Health Strategy outlines how this needed reform can be achieved, with a fully outlined and costed action plan. It aims to tackle the social inequalities that drive mental illness and which link to economic inactivity. It is a vital support structure which can reduce the burden and impact of these cuts. Regrettably is has not been fully funded since its implementation in 2021. While the overall spend on Health in Northern Ireland is 7% higher than in England, the total planned investment in the mental health programme of care in

2019-20 was just under £300 million. With an overall health and social care budget for 2019-20 of some £5.2 billion, mental health represented 5.7% of the overall health budget. Also, at just under £300 million, and with a total population in Northern Ireland of around 1.89 million, this equates to nearly £160 per person, a sum that is substantially lower than per capita spend dedicated to mental health across all regions of the UK and Ireland.

Chapter Three of the green paper recognises the significant impact of mental health and the need for investment in this area. It outlines ring-fencing funding through the Mental Health Investment Standard, but it is unclear how this will translate to other regions. It states a commitment to continuing to expand access to NHS Talking Therapies for adults with common mental health conditions in England. This is expected to increase the number of people completing courses of treatment by 384,000 and increase the number of sessions. Currently over 90% of NHS Talking Therapy Services in England also provide access to Employment Advisers, with an aspiration that by March 2025, 100% of NHS Talking Therapies services in England will offer employment support as part of their service. Again, while the Mental Health Strategy aims to achieve similar outcomes and increase the availability of psychological therapies, NI is behind in achieving this goal. It highlights a provision gap in NI comparative to other regions, which needs to be addressed before these proposals move forward.

4. How could we introduce a new Unemployment Insurance, how long should it last for and what support should be provided during this time to support people to adjust to changes in their life and get back into work?

Unemployment Insurance is a welcome consideration to assist people who have lost employment to access enhanced financial support over and above the standard UC allowance. It rewards previous National Insurance contributions and buffers against the cliff edge of moving from the income level they had during employment and UC amounts. This is particularly important for the 18-22 age group who will not be able to access the health element of UC, regardless of having additional health needs.

During this time, people will need access to recruitment and employment opportunities and training and education services to enhance their skills. There should be access to budgetary advice and signposting to support services which can assist with the adjustment period. However, before that there needs to be an understanding of why employment was not maintained. The assumption would be that it is due to increased acuity of symptoms caused by disability or recurrence of illness. The additional financial support attached to the unemployment insurance should be in place until:

- A person has been able to access suitable work if that is possible given their current health needs
- A person who is unable to return to work has been reassessed to account for their current health needs and is in receipt of all appropriate disability benefits.

5. What practical steps could we take to improve our current approach to safeguarding people who use our services?

Fundamentally safeguarding approaches, policies and procedures need to be informed and designed alongside people with lived experience. Consideration for the assessment criteria, reassessment process and medical evidence requirements needs to reflect the real-life impactions for those living with illness or disabilities. Where conditions or diagnoses are unlikely to change, consider if reassessment is needed or if it causes undue stress. Avoid duplication of services and assessments by securely sharing relevant health related information between allied professionals. At all times, remember that a person is seeking support and avoid assumptions of their capacity or circumstance based on a generalised option of their diagnosis or disability.

Consider the real-life implications for young people 18-22 who will be excluded from the health element of UC and ensure that alternative supports are available:

- Is holding long-term employment an achievable outcome while they manage their condition without additional financial support?
- Consider additional risk factors such as being a care leaver, having experienced childhood adversities, living in areas of deprivation, having limited or no family support
- How will the transition from child to adult services impact their access to support and how will this affect employment opportunities?

The Government's own narrative appears to be changing and contradicting itself around supporting people into work. For example, the 'Get Great Britain Working White Paper' (November 2024) had a positive tone and included commitments to a devolved approach/support, a focus on good jobs, and a commitment that conditionality would be 'backgrounded'. The recent Green Paper has some continuity with this approach, but these are largely overshadowed by the cuts it initiates and the extension of conditionality. Research from the New Economics Foundation highlighted that the whole system should be focused on fostering genuine engagement and supporting people into 'good work'; as within a genuine, strong relationship there can be more push/challenge and receptiveness to change than in conditionality-led relationships. Unfortunately, at the JRF/UU event representatives from Disabled People Against the Cuts Northern Ireland (DPAC, NI), shared how this local group are campaigning against the proposals in the Green Paper, after having engaged extensively during the white paper consultation period, yet not seeing that engagement reflected in the green paper. He warned these choices will cause the tragic loss of lives and huge mental health impacts. Engagement and co-design efforts need to be enhanced throughout this process to effectively safeguard people.

Chapter 3: Supporting people to thrive our new support offer

6. How should the support conversation be designed and delivered so that it is welcomed by individuals and is effective?

The support conversation is a welcome addition to the proposed plan. It outlines that time will be taken to understand a person's barriers to work and link to relevant support organisations such as community services, housing support, condition management and social prescribers. I would suggest that these supports also include wellbeing and mental health support for anyone that needs it, not just with a diagnosis of mental illness. The focus should be on a person's strengths and aspirations, rather than their limitations. As with all these measures they should adopt a dynamic, trauma informed approach, and be co-designed to ensure the flexibility to respond to the needs of the individual and recognising the impacts of adversities. It should not become another "tick box" exercise that people must comply with in order to access a benefit they are entitled to.

7. How should we design and deliver conversations to people who currently receive no or little contact, so that they are most effective?

The principals of trauma informed practice should be applied; these are equality, transparency, collaboration and empowerment and a recognition of historic adversities and cultural factors. The goal should be the creation of a safe space for individuals to explore their strengths. This would start with engagement with people who fall into this category and ask them how they would want to be contacted. If the reason for receiving little or no contact is because entering the workforce is not a feasible option due to the nature of their illness or disability, consider if the supports which can be provided are tailored to their needs. If the answer is no, or not really, then avoid presenting options of support which are unattainable. If, however, the supports can be utilised to improve quality of life and allow a person to reach personal goals, without the expectation of entering the workforce, then approach the conversation with that mindset and explanation. I welcome the intent to engage in a flexible manner, conducting the conversation at home or in a place/time that is convenient for the person seeking support, not restricted by the working office or times of the service.

A new baseline expectation of engagement

8. How we should determine who is subject to a requirement only to participate in conversations, or work preparation activity rather than the stronger requirements placed on people in the Intensive Work Search regime.

If the support conversations are conducted in the way which is outlined, then it should become evident who can and should avail of work preparation activities. This should entail accessing training and skills development, exploring the appropriateness of available jobs and the supports contained within to maintain that employment. It is essential that a person's full circumstances be considered in that process. It is insufficient to consider the type of work a person would like to undertake even when it has appropriate supports embedded, if that employment opportunity cannot be accessed due to limited transportation options for example.

9. Should we require most people to participate in a support conversation as a condition of receipt of their full benefit award or of the health element in Universal Credit?

No. It should be available to everyone but never a requirement for accessing the benefit they are otherwise entitled to. Making a condition of benefit entitlement is coercive and fosters an environment of compliance, not engagement, which will not achieve the anticipated outcome of supporting the individual.

10. How should we determine which individuals or groups of individuals should be exempt from requirements?

It should not be a requirement for anyone. It should be offered to everyone, unless previous health assessments have indicated that entering the workforce is unattainable at present and that this is unlikely to change in the future due to the nature of their illness or disability. Subjecting people in that position to multiple assessments or conversations as a conditionality of their benefit entitlement is unjust and creates needless duplication within the service.

Delaying payment of the health element of Universal Credit

11. Should we delay access to the health element of Universal Credit within the reformed system until someone is aged 22?

No. A young person with an illness or disability incurs the same cost of living with their condition as anyone older than 22 will. They should be supported to engage with education and training as outlined in the youth guarantee, but they should not be forced to endure additional financial burdens solely on account of their age. The lives and circumstances young people experience are multifaceted; this blanket change will disadvantage certain high-risk groups more than others. Care experienced, young people without family or community support, young people living or attempting to live independently.

Raising the age at which young people start claiming adult disability benefits

12. Do you think 18 is the right age for young people to start claiming the adult disability benefit, Personal Independence Payment? If not, what age do you think it should be?

The child disability payments stop at 16 when a reassessment is triggered. Adult disability payments should start as soon as the assessment concludes that continued financial support is warranted. These two systems need to align to ensure there is no gap in provision.

Chapter 4: Supporting employers and making work accessible

13. How can we support and ensure employers, including Small and Medium Sized Enterprises, to know what workplace adjustments they can make to help employees with a disability or health condition?

This needs to involve a concerted, targeted effort to address ableism and reduce discrimination across society starting with the education system. In particular, it would increase awareness of “hidden disabilities” which would include the experience of mental illness and disabilities associated with these. When considering accommodations, most employers consider physical accommodations: if their workplace, workspace and the physical requirements of the position are accessible. However, mental illness and the severity of presenting symptoms fluctuate. It is impacted by stress levels, fatigue, an external factor which employers cannot control. However, it results in fluctuation in capacity to engage with work or work-related activities and productivity. Employers need to be aware of this, so that work streams and expectations can be adjusted to meet the capacity of the worker, rather than risk burnout or an increase in symptoms acuity or crisis. Public stigma toward mental illness remains prevalent wherein persons with mental illness perceive negative attitudes among the general public and experience discrimination in their everyday life. This stigma is present in work environments, both from employers and other staff. The ability for staff to access accommodations for their mental illness, or wider mental health is largely impacted by the employer understanding and accepting the fluctuating nature of their condition.

When putting people forward for employment opportunities, DWP should be advocating on behalf of individual regarding their personal health needs. The employer should be informed of what accommodations are required and how these may change over time. There needs to be a pathway for the employee to raise concerns if these accommodations are not met that involves a neutral party (not just the employer HR department).

14. What should DWP directly fund for both employers and individuals to maximise the impact of a future Access to Work and reach as many people as possible?

- Training opportunities to better understand the support needs of disabled persons
- Access to wellbeing support throughout employment, aiding in condition management
- Access to development grants/loans to update physical infrastructure to ensure accessibility (some small and medium size employers may lack the capital to invest in these areas without support)
- Enhanced work support packages
- Expand the Access to Work service so that it can meet the increased demand, and accommodate the further increase these cuts will create

15. What do you think the future role and design of Access to Work should be?

The level of support that people need to maintain and thrive within employment while managing a long-term illness or disability is wide ranging. The current level of support offered is not sufficient and disparate across the region. Access to Work should be able to bring together all the support options in one centralised area. This ensures that there is a single point of access people can be directed to, with any/all additional supports organised through this service. Where additional supports through pilot programmes or external services are available, on-ward referrals should be made on behalf of the applicant. Fragmented support systems create gaps in provision when people do not know where to look or what to search for. Access to Work should have that wider view and be able to help people navigate an already complex system. Chapter Four outlines bringing it together all resources and professionals in this space which is encouraging. However, it also mentions taking responsibility from DWP and hiring a third party or private sector service to deliver on this enhanced Access to Work programme. There is a concern that that approach would dilute the offer of support available to people, and distance DWP from the realities facing disabled people in the workplace. While I welcome the consideration of allowing a regional approach to its development, I caution that unless the funding allocated is ringfenced for this purpose that regional disparity in the scale and scope of support will persist.

16. How can we better define and utilise the various roles of Access to Work, the Health and Safety Executive, Advisory, Conciliation and Arbitration Service and the Equalities and Human Rights Commission to achieve a cultural shift in employer awareness and action on workplace adjustments?

Engage with people who have experienced navigating this complex support network, across the widest range of illness and disabilities. Seek to understand how they view each of those bodies, their expectations of how they should function compared to their direct experience of interacting with them. Map out how they intersect and identify all potential gaps where people in need of their support are prevented from doing so. Candidly define who these services are designed for, what is there intended purpose and abide by that definition so that people accessing support can trust what is being offered.

17. What should be the future delivery model for the future of Access to Work?
Other

An open access inclusive resource advertised and accessible to anyone in receipt of a disability benefit or with a long-term health or disability need not covered by the new assessment criteria. A single point of contact accessible through multiple formats, i.e. physical location facilitating in-person contact, digital resource, print or alternative format information. The network of support available may be complex but if Access to Work can assist individuals as they navigate that network it can only enhance that experience. It needs to be more than a funding body, incorporating access to training, development and support for employees and employers.

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