



Social protection and labour market policies for vulnerable groups from a social investment perspective

The case of welfare recipients with mental health needs in England

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Executive summary

This study examines the impact of welfare reform on claimants with mental health needs in England, in particular the effects of the recent introduction of two social protection measures: Employment and Support Allowance (ESA) and Personal Independence Payment (PIP). Our analysis indicates that reduced access to and adequacy of benefit coverage under these reforms, particularly the elements linked to increased conditionality, have led to diminished levels of social protection for people with mental health needs. We also identify how discriminatory processes in the benefits system have negatively impacted the sense of self-respect and security experienced by claimants. Overall our data suggest that ESA and PIP processes undermine claimants' subjective wellbeing and exacerbate experiences of mental distress. We therefore propose the term 'benefits distress' to describe these forms of suffering that are being institutionally propagated by UK government agencies and the corporations to which state welfare functions are outsourced. The study is part of the wider European RE-InVEST project to investigate the impact of active labour market and social protection policy on marginalised social groups since the financial crisis of 2007.

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List of abbreviations

ALMP	Active Labour Market Policy
DLA	Disability Living Allowance
DWP	Department for Work and Pensions
ESA	Employment and Support Allowance
WRAG	ESA Work-Related Activity Group
SG	ESA Support Group
HCP	Healthcare Professional [employed by ATOS/Maximus to conduct WCA/PIP assessment]
PIP	Personal Independence Payment
WCA	Work Capability Assessment
WP	Work Programme
WHP	Work and Health Programme

1. Introduction

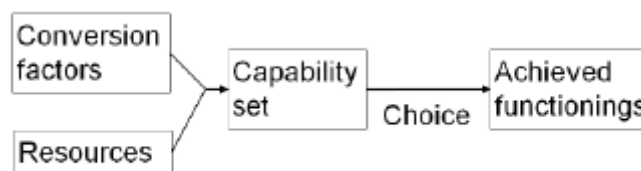
1.1 Brief reference to RE-InVEST project, its content and methodology

RE-InVEST, a H2020 funded project under Euro 3 Europe after the Crisis, involves 19 organizations (universities, research centres and civil society organizations working with vulnerable groups). RE-InVEST aims to investigate the philosophical, institutional and empirical foundations of an inclusive Europe of solidarity and trust. To this end it draws on capability and human rights based participatory approaches to examine how the European Union Social Investment package can be strengthened.

Human rights form a common European basis of values and describe core elements of what constitutes well-being and a good life. Human rights are the basic rights and freedoms that belong to everyone. International law, including treaties, contain the provisions which give human rights legal effect. Specific groups are protected in specific treaties such as women, children, and people with disabilities, minorities, and migrants. Human rights are transformative. For vulnerable groups the usage of a rights-terminology has changed perspectives, by empowering people, by increasing awareness and creating tools to address compromises of these rights.

Capability approach as developed by Sen (1999) and Nussbaum (2011) defines a person's well-being in terms of 'what a person can do' or 'the beings and doings (the functioning's) a person achieves and her capability to choose among different combinations of such 'functioning's'. Resources and conversion factors are preconditions or necessary for leading a life one values and has reason to value. Resources refer to the material conditions of a person: her income, the goods and services she disposes of. Conversion factors help her to convert resources into 'doing and being well'. Both the achieved functionings as well as the freedom to choose a life one values matters.

Figure 1.1 Resources, conversion factors, capability set and achieved functionings



1.2 Background

Since the 1980s there has been a shift in UK welfare policy from Keynesian to neoliberal principles (Grover, 2006) with an increased emphasis on supply-side interventions in the labour market (Peck & Theodore, 2000). In the UK, as elsewhere, an important element of this policy agenda has been a focus on 'activation' or welfare-to-work strategies comprised of two interacting elements: reformed social protection measures and active labour market policies (ALMPs). These two dimensions will now be addressed in turn.

Social protection measures include benefits in cash or in kind (e.g. personal social services) usually provided by public bodies to help with particular needs. The total spend on social protection measures by the UK government in 2014 was £495 billion, a real terms fall of 0.3% from 2013 (Carolan, 2017). Two

primary dynamics are visible in recent reforms to social protection measures in the UK: increasing welfare conditionality and reductions in eligibility for and levels of social security support (Patrick, 2017).

The first of these, increased conditionality, emerged during the New Labour era to eclipse the principles of rights-based citizenship underpinning more universalist approaches to social security in the post-war settlement in the UK. This further intensified under the Conservative-led Coalition government with, for instance, conditions extended to in-work benefit recipients a situation characterized as ‘ubiquitous conditionality’ (Halpern et al., 2004; Dwyer & Wright, 2014). If, as Frericks (2014) notes, the major normative principles underpinning social security institutions are solidarity and self-responsibility, UK welfare reforms embody a transition from the former towards the latter. Overall these conditionality measures represent a marked individualization of claimants’ responsibility (Wright, 2016).

However, this escalation of responsabilising conditionality has been combined with sanctions for non-compliance, and this increasingly ‘punitive turn’ in UK welfare provision has embedded and exacerbated social divisions and undermined social cohesion (Wacquant, 2009; Taylor-Gooby, 2016). Moreover, policy interventions drawing on behavioural psychology and economics have become an increasingly integral feature of coercive conditionality in welfare-to-work regimes (Friedli & Stearn, 2015; Jones et al., 2013). Dubbed ‘psychocompulsion’ such practices seek to impose ‘psychological explanations for unemployment, together with mandatory activities intended to modify beliefs, attitude, disposition or personality’ in order to activate the unemployed (Friedli & Stearn, 2015: 42). This development has raised concerns about the ethics of applying psychological methods in public policy (Rhodes, 2015).

The second main trend in social protection has been to limit access to and levels of welfare support. Examples include the below inflation uprating of benefits under the 2010 Coalition government, followed by freezing of benefit rates under the 2015 Conservative administration (Beatty & Fothergill, 2016). Another is the restriction of access to cash benefits by redrawing eligibility boundaries, for instance the Coalition government’s prediction in 2013 of an eventual one quarter reduction in those eligible to access disability benefit Personal Independence Payment (PIP) when it replaced Disability Living Allowance (DLA) (Roulstone, 2015; Kennedy, 2017).

The other core dimension of the UK government’s activation strategy is ALMP. The purpose of this policy agenda is to integrate unemployed welfare recipients into the labour market. One of the most prominent ALMPs in the UK is the Work Programme (WP), involving a range of employment services targeted at specific groups of welfare claimants, including people with mental health needs, in receipt of either Jobseeker’s Allowance (JSA) or Employment and Support Allowance (ESA). Within this, a key aim has been to reduce the disability employment gap (DEG) that stood at 49% of disabled people aged 16–64 in work compared with 81% of non-disabled people in mid-2016 (Work and Pensions Committee, 2017). Over the period 2011-2017 around 2 million claimants were referred to the WP, and of these 590 thousand spent 3-6 months in employment (DW, 2017a). A Parliamentary committee was highly critical of WP performance with only 30% of participants finding sustained employment (Work and Pensions Committee, 2015). The WP is currently in a period of transition to a much-scaled down successor, the Work and Health Programme (WHP), to be launched late 2017 (Mirza-Davies & McGuinness, 2016).

Whilst UK ALMPs have evolved over the last three decades there has been a degree of continuity in their iterations from New Labour to Conservative-Liberal Coalition and more recent Conservative governments (Berry, 2014). One particularly consistent feature has been the emphasis on the role of the market in welfare-to-work policy delivery (Wright, 2016). For instance, important elements of WP (and now WHP) provision have been secured via competitive procurement with an anticipated total value of up to £5 billion. Services were contracted out to prime providers, including for-profit transnational corporations such as G4S, Maximus and Ingeus, who were given scope for further sub-contracting under a payment by results system based on employment outcomes achieved by claimants (Maddock, 2012). Private sector involvement is also prominent in the delivery of social protection measures with assessment of disabled claimants or those with ill health also contracted out to transnational for-profit providers: Maximus in the case of ESA (the Work Capability Assessment), and Capita and Atos Healthcare (the latter renamed Independent Assessment Services) for PIP. Atos Healthcare was also formerly contracted to deliver the WCA but due in

significant part to protests and resistance by disabled people withdrew from this arrangement early in 2014 (Grover, 2014; Warren et al., 2014).

The emphasis on ALMPs and conditions and restrictions on social protection have been justified by recent UK governments on the basis of the need to reduce so-called ‘welfare dependency’ cultures amongst recipients (Wiggan, 2012). However the notion of widespread and pervasive cultures of inter-generational worklessness has been challenged (Shildrick et al., 2012a) with much stronger evidence for claimants churning between poorly-paid work, unemployment and (for some) receipt of benefits at the margins of the labour market, the so-called a ‘low-pay, no-pay’ cycle (Shildrick et al., 2012b; MacInnes et al., 2012). Furthermore, the UK’s government’s claim that its welfare reform programme was assisting claimants, including disabled people, to escape from dependency was strongly challenged by the United Nations Committee on the Rights of Persons with Disabilities in 2016. In a report that was unprecedented in the extent of its criticisms, the Committee found that UK welfare reforms had resulted in ‘grave or systematic violations of the rights of persons with disabilities’ (UNCRPD, 2016: 20). This was a result of the adverse and disproportionate effects on disabled people of reduced support and social protection, a discriminatory lack of accommodation of particular needs in assessment procedures, and minimal evidence of improved employment outcomes for this group.

Whilst the responsabilising and punitive direction of UK welfare policy under recent governments has had detrimental impacts on claimants with a variety of types of need and protected characteristics its effects have been particularly pronounced for those with mental health needs (Barr et al., 2016). This provides the rationale for our selection of two social protection measures frequently claimed by people experiencing mental distress: ESA and PIP. In the next section we will outline these measures and the focus of the present study in greater detail.

1.3 Rationale for the selection of measures

Our study examines the impact of benefit reform over the last decade that has seen the introduction of two new social protection measures: Employment and Support Allowance (ESA) in 2008 and Personal Independence Payment (PIP) in 2013. Our data collection considered the impact of the introduction of both ESA including its component WCA, and of PIP on claimants with mental health needs. In the first section these two measures will be briefly summarised. We will then explain the rationale for their selection.

Employment and Support Allowance (ESA)

ESA is an out-of-work benefit introduced in 2008 for people experiencing illness or incapacity. This is the main income replacement benefit for sick and disabled claimants. This has both contributory and means-tested elements.

The implementation of ESA involves claimants being subject to a form of medical test known as the Work Capability Assessment (WCA). The nominal rationale for this process is to focus on the claimant’s capability for employment rather than incapacity. As noted above, the administration of the WCA is contracted out by the government to Maximus. The WCA seeks to make a distinction between claimants who can work, those who could work at some point with the right support, the Work-Related Activity Group (WRAG), and those who cannot work, the Support Group (SG). A number of work-related conditions are associated with receipt of this benefit, particularly for claimants placed in the WRAG. Failure to comply with these conditions can lead to the application of sanctions, which involves the non-payment of all or part of the claimant’s benefit entitlement. There has been what Adler (2016) describes as a ‘spectacular’ growth in the use of sanctions across the benefits system as a whole, with some evidence that ESA claimants with mental health needs are disproportionately subjected to sanctions (Mind, 2015).

Personal Independence Payment (PIP)

In addition to ESA we have examined the impact of the introduction of Personal Independence Payment (PIP) which began to replace Disability Living Allowance (DLA) for claimants aged 16-64 in 2013. This is

a non-means-tested extra-costs benefit for people with a long-term physical or mental health conditions or impairments. PIP is intended to address the additional daily living costs faced by disabled people including those with mental health needs.

Rationale

ESA was developed to align with active labour market policy and promote the labour market re-engagement of claimants with the aim of reducing the cost and number of disability benefit claims (Piggott & Grover, 2009). However claims that ESA would prove successful in moving people with mental health needs closer to employment have not been borne out either by the DWP's own data or research conducted with claimants (Hale, 2014). Moreover the robustness and validity of a central element of ESA assessment, the WCA, has come under question because of the high proportion of assessment decisions overturned on appeal (typically 40-50% in recent years) (Shakespeare et al., 2017; DWP, 2017b). We therefore wished to examine in greater detail the effects of this measure on claimants with mental health needs.

Though PIP was not specifically designed as an activation measure, when first introduced, the Minister for Disabled People argued that it would 'create a new, more active and enabling benefit' (DWP, 2010: 1). Moreover the Coalition government made clear that a primary goal of the transition to PIP from Disability Living Allowance (DLA), the benefit it replaced, was to produce financial savings and reduce the number of recipients with an initial estimate of 28% fewer claimants by 2018 (Kennedy, 2017). As mental health needs are currently the most commonly recorded disabling condition for PIP claimants at 36% this reform has significant implications for claimants experiencing mental distress (DWP, 2017c).

In summary, as the primary social protection measures available to people with mental health needs, we considered examination of the impact of both PIP and ESA on claimants to be timely. Moreover this enabled us to build on data collected and analytic themes emerging from WP3 that highlighted the detrimental impacts arising from the introduction of these measures.

1.4 Theoretical and Methodological Approach

Following completion of the RE-InVEST Work Package 3 (WP3), the Liverpool Hope team decided to continue data collection with people experiencing mental distress. However for this work package our particular focus was the two welfare benefit measures outlined above: ESA and PIP. Our research questions were as follows:

- What has been the impact on claimants with mental health needs of the introduction of two 'activating' welfare benefit reforms: ESA and PIP?
- Are these benefits accessible to and adequate in meeting the needs of this claimant group?
- Do these benefit reforms enhance the human rights and capabilities of claimants with mental health needs?

To address these research aims we decided to extend our sample to include welfare rights advocates supporting claimants of ESA and PIP. Four of the respondent group for WP3 decided to continue their involvement with the project into WP5, while other new claimant participants were recruited to the research study. The recruitment, methods and sampling strategy for WP5 will now be outlined in more detail.

Process for recruitment

Before commencing data collection for WP5, the Liverpool Hope team decided to organize a one-day conference in Liverpool on the impact of current 'active' welfare reforms for people with mental health needs. In line with the participatory methodology of RE-InVEST, three members of the WP3 service user participant group chose to become involved (one further WP3 group member later became a participant in WP5 though did not attend the conference). The aim of the conference was to draw attention to the social costs of recent social protection and labour market activation reforms and develop collective responses and

networks of support to this policy agenda. However it was also our intention to deepen our contacts and establish a broader group who could take part in the second phase of the Re-InVEST research.

The conference was a key link between WP3 and WP5, and a successful event in itself. It was attended by 120 people including: claimants and service users with mental health needs, welfare rights workers, mental health professionals, NGOs, trade unionists and campaigners. Two of the WP3 participants were speakers at the conference. Feedback from the event indicated that participants valued the opportunity to share their experiences of the welfare system and develop their campaigning and support networks.

Furthermore, as a consequence of the event, the Liverpool Hope team were able to gain access to a number of networks of claimants and welfare rights workers in the region. Two particular groups of respondents were approached to participate in the study and these will be described in the next section.

Sampling

The study used a combination of non-probability sampling techniques including purposive, convenience and snowballing. The purposive sample was oriented to those with knowledge or experience of ESA and PIP assessment processes for people with mental health needs, and for this reason we selected two groups. The first were adults (aged 16-64), resident in the North West England region, experiencing mental distress who were claimants of Employment and Support Allowance (ESA) and/or Personal Independence Payment (PIP). The second were welfare rights advocates working with disabled clients including people mental health needs claiming Employment and Support Allowance (ESA) and/or Personal Independence Payments (PIP). These advisors were also located in a variety of advocacy organisations in the North West England region, working in either a formal paid (n=4) or voluntary capacity (n=2). Convenience sampling involved the utilization of WP3 participants from the Liverpool Hope service user group with additional contacts from the conference. Snowball sampling was also utilized with advocates asked to approach their clients regarding participation in the study.

The total number of participants recruited was as follows:

- 19 claimants of ESA and/or PIP (10 female, 9 male);
- 6 welfare rights advocates (3 female, 3 male).

Methods of data collection

The project uses a qualitative methodology, with data collected via two methods: group interviews and/or individual in depth semi-structured interviews.

- Group interviews

We initially collected data via group interviews and then selected a sample of respondents to invite to an individual interview to explore salient themes in more detail.

Table 1.1 Data set

Format	Code	Type of participant	Number of participants	Gender of participants
Group interview 1	GRP01	Claimants	2	1 Female, 1 Male
Group interview 2	GRP02	Claimants	4	3 Female, 1 Male
Group interview 3	GRP03	Claimants	11	6 Female, 5 Male
Group interview 4	GRP04	Advocates	4	2 Female, 2 Male
Individual interview 1	INT01	Advocate	1	Male
Individual interview 2	INT02	Advocate	1	Male
Individual interview 3	INT03	Advocate	1	Female
Individual interview 4	INT04	Advocate	1	Female
Individual interview 5	INT05	Advocate	1	Male
Individual interview 6	INT06	Advocate	1	Female
Individual interview 7	INT07	Claimant	1	Female
Individual interview 8	INT08	Claimant	1	Male
Individual interview 9	INT09	Claimant	1	Male

- *Individual in-depth qualitative interviews*

- Benefit claimants

We conducted three individual in-depth interviews with claimants who had chosen this format in preference to a group interview. One of these respondents subsequently agreed to participate in a group interview.

- Welfare rights advocates

We conducted six individual in-depth interviews, with the four group interview participants and two further advocates who had been unable to attend the group interview.

An overview of the data set is presented in Table 1. The four group interviews and nine individual interviews took place between February and July 2017.

2. Analysis of policy measures

This part of the paper will present data on the impacts of recent UK welfare reforms on claimants with mental health needs by utilizing the following structure. It is presented in four sections. Part one will focus on two core elements of the right to social security¹: accessibility and adequacy, and evaluate the extent to which, according to the data collected from our participants, the selected welfare benefit measures appear to meet these criteria. Part two will consider the impact of the reforms in relation to their propensity, according to our respondents, to advance or undermine non-discrimination and equality. In part three we will present key themes regarding the effects of these policies on the subjective wellbeing of claimants with mental health needs. The section will conclude with brief consideration of implications for the enhancement of claimants' capabilities. Names of all participants and places have been changed to preserve confidentiality and anonymity.

The relevant rights include the right to social security (social protection) and the right to work. While the International Covenant on Economic, Social and Cultural Rights Article 9 articulates the right to social security, these do not specify particular individual rights. Moreover while rights to social security are not explicitly mentioned in the European Convention on Human Rights, some social rights do fall within its area of application (Gómez Heredero, 2007). Another important area of relevance to the discussion concerns the rights pertaining to disabled people. Most relevant here is the UN Convention on the Rights of Persons with Disabilities which outlines standards of protection for the civil, cultural, economic, political and social rights of disabled people on the basis of inclusion, equality and non-discrimination, and The Equality Act 2010 in the UK.

2.1 Core elements of the right to social security

There are two dimensions of this right: accessibility and adequacy. We begin with accessibility, which is broken into a five further component elements: participation and information; affordability; physical access; coverage; and eligibility². Respondents articulated concerns across each of the categories and these will now be described in turn.

2.1.1 Accessibility

There was remarkable level of agreement across all the focus groups and interviews regarding the detrimental and damaging nature of many features of the ESA and PIP reforms, in particular the role of increasing conditionality. These will now be set out in more detail.

2.1.1.1 Participation and information

When initially coming into contact with the system, respondents described scant sources of reliable information about benefit entitlements, processes and outcomes and decried a lack of transparency in the system. Matt (claimant) recounted that:

¹ These two criteria are elucidated in UN Economic and Social Council (2008). We have not included a third, availability, as this refers to the need for states without welfare systems to establish social security institutions.

² These criteria also align with UN Economic and Social Council (2008).

[T]hey never, ever told me what I was entitled to or what claims I could make, it was always up to me to find out and if they decided that you weren't entitled to it, you were never given an explanation, or if you were, it was obtuse and you never met decision makers, you always meet people who are just passing messages on, so you can't respond. You might have to, they would say, fill in another form to respond that way and of course, it exhausts you mentally. (GRP02: 5)

This also draws attention to the intensive and stressful 'work' of claiming and maintaining benefit entitlements identified by Patrick (2014).

2.1.1.2 Affordability

Claimants in the UK benefits system are not subject to specific charges³. However our respondents identified two financial costs in the process. Firstly, the DWP encourages potential benefit recipients to make their initial claim via freephone numbers. However this requires the claimant to own a phone and, until mid-2015, such numbers were not necessarily free to call from mobiles: the type of phone most accessible to people on a low income (Karagiannaki, 2009). At the time this caused financial difficulties for at least two members of the claimant cohort, Louise and Star, who did not have a landline telephone. Secondly, the cost of travel to attend appointments and assessments can be prohibitive. Further aspects of physical access will be considered in greater detail in the next section.

2.1.1.3 Physical access

The spatial organization of the benefit system presents access problems for claimants and is experienced by them as remote and opaque. Louise described the barriers typically encountered as claimants sought to navigate and interact with this institutional complex:

[The] DWP is hiding behind, yeah, internet and payphone numbers [...] They've hidden themselves behind a lot of walls now, they're moving all their services online and that's a two tier society, 'cause access to the internet is not consistent and that's creating another class division [...] all these walls are put up for contacting them. They will jump on you at any time, any place, but you cannot get hold of them very easily.

This was echoed by advocate Aaron, who expressed concern that:

[I]t's all call centres now, it's not as personal as it used to be, it's not as local as it used to be, everything is like, you know, you've got to go through certain systems to get an answer and it's waiting. I mean, I have to say to people [claimants] now, if you need to ring benefits, you need to come in first thing of a morning, 'cause after one o'clock, I just can't get through to them. (INT11: 21)

Following initial phone contact the claimant would be required to attend the DWP offices for assessment. However the physical location of offices often presented access problems for claimants. This was exacerbated, Aaron noted, by some local benefit offices closing due to DWP restructuring and cuts. Though, as advocate Evelyn noted, disabled claimants could request home visits for assessment these were frequently turned down by the DWP. Consequently expectations could be placed on claimants to travel as far as the neighbouring town of Eastville for assessment. However Dave (advocate) described advising his clients to contact the DWP to alert them that they would be unable to attend the venue due to the distance. He explained:

[I]f you go over to Eastville, I know someone [claimant] who went over there, I mean, obviously she went to Eastville, [the DWP] said, 'thank you very much, you're not getting it [benefit]. (GRP01: 25)

For Dave the invitation functions as a form of entrapment presenting a dilemma for claimants with mental health needs. If they attend the assessment it is regarded as evidence of the capacity to travel long distances thereby undermining their illness claim. However, if they do not travel their claim may be delayed or rejected.

³ However one advocate expressed concern that there is currently discussion amongst policymakers about the introduction of charges to access the Social Security Tribunal system to appeal decisions.

Claimants encountered further obstacles at the offices themselves. The offices were depicted as forbidding environments, and Louise's vivid description is worth quoting at length:

[M]y impression of the two places we've been to have been the most dilapidated cheapest places they could find to rent, nothing welcoming, a very small waiting room awaits you, crowded with other people who've already been waiting there a long time, [...] you can see people running in and out, panicking, you're looking for a quiet space yourself, often you're just packed like cattle into the one waiting room, so it's not a place to spend hours. It's small, it closes in on you, it's dirty, it's intrusive, you're in full view of many people, you feel like you're on display in some kind of bizarre show, you can see assessors walking in and out, looking at you, you wonder if you're being watched on CCTV and usually you are [...] the hours dragging on, there's no clocks in view anyway, so it becomes a kind of timeless sinkhole, where time takes on its own relative crawl. Everything that you'd built yourself up to get yourself there in the first place, like I can do this, I can remember this and I will be calm, it slowly eats away at that armour that you've encased yourself in, so by the time you get into the assessment, you're pretty raw already, so that's my experience of these places.

The issue of covert surveillance of claimants, perceived as another 'trap', was also described by Jack (advocate) who noted:

[C]ameras as you're walking in, you go in the waiting room and there's cameras. [...] Now, I cannot think of any other reason that those cameras were there apart from observing the claimants, you know.

Dave (advocate) agreed, adding: 'yeah, you used to see things [on the assessment] like, 'observed to walk briskly to the assessment', you know what I mean' (GRP01: 26). Consequently, Dave advised one particular client not to attempt to keep up with a receptionist at the centre who walked quickly as she escorted them to the assessment room. These forms of perceived entrapment were considered by advocates to constitute a significant abuse of due process and procedures.

2.1.1.4 Coverage

While the previous section noted *traps* for claimants, the next two sections will examine the construction of significant *gaps* in coverage and eligibility. We will begin with examination of a prominent theme articulated by both claimants and advocates, that the reform programme was designed not to support claimants but to disentitle them by reducing the scope of coverage. Two particular aspects of this were articulated.

Redrawn disability category excludes mental illness

The first concerned the extent to which the boundaries of the disability category are being redrawn to exclude and limit claims relating to mental illness/distress.

For advocate Jack:

I think that these new benefits, PIP and ESA are so destructful for people with mental health conditions, you know, the number of times I see no points [awarded] whatsoever and it's getting even more difficult now. (GRP01: 1)

Gill, another welfare rights advocate, identified the limiting 'tick box' categories that are utilized to invalidate mental health-related claims:

[P]eople who were on [ESA], who were awarded it completely validly and then given no points the next time they went for reassessment, because they just didn't tick the boxes and it's the lack of wriggle room as well, it's like, if you can see that they're obviously ill but they don't tick the boxes. (INT03: 33)

Gill elaborated, explaining these restrictions as underpinned by the contrasting ontologies of physical illness and mental distress:

[Mental illness] is such an individualised condition [...] no two people have the same mental health problem, whereas, you know, go on a ward for hip replacements, you know, your body's a machine, isn't it, your mind's just, there's so many little aspects to it and everything and also it's so dependent on your circumstances, which your physical needs aren't necessarily dependent on your circumstances. (INT03: 37)

As a consequence, Gill explained, it is more difficult to provide evidence:

Mental health is not an easy fix and it's not an easy thing to seek a fix for, so there's far less medical evidence to start off with, which is the stumbling block really, I think, for getting awarded. (INT03: 33)

Minimisation and invalidation of common mental health needs

The second mechanism of disentitlement related to the nature and extent of the condition. Here, certain types of more common mental health needs were increasingly minimised and invalidated by the benefits system as a basis for ESA and PIP claims. Advocate Dave described this in relation to certain diagnostic categories:

Depression is the 'bad back' of the mental health world [i.e. non-serious], no-one believes you've got depression but depression is a killer, but no-one believes it and when you go to a [Benefits] Tribunal [...] they don't, depression is not taken seriously. (GRP01: 5)

This was similar, he explained, for other more widely experienced conditions:

An awful lot of the depression and anxieties though, you don't [get a benefit awarded] and you know, a lot of them, OCD [Obsessive Compulsive Disorder] and you know, things like that, unless they're getting full on specialist help. (GRP01: 19)

The advocates did note however, as the latter part of this quote suggests, that claimants receiving clinical support due to so-called severe and enduring mental health conditions at the acute stage (e.g. schizophrenia) were more likely to be awarded these benefits though there were also limits and exceptions to this (ADD). These trends in reduced coverage created significant *gaps* in the benefits system for people experiencing certain types of mental distress.

2.1.1.5 Eligibility

The gaps outlined above were intensified by a number of mechanisms seemingly designed to further reduce eligibility. These various processes seemed to coalesce in a wider pattern of *disentitling proceduralism* that will now be described.

Redefining eligibility criteria

Several participants noted the redrawing of eligibility criteria to reduce entitlements. Matt (claimant) described the DWP as:

[R]aising the bar to get into the groups that require more support, where they're saying, you not only have to have these disabilities, but now you have to have this issue or this issue. (GRP02: 10)

One example was restriction of access for people with mental health needs to the higher rate 'enhanced mobility' payment in the transition from DLA to PIP. Advocates agreed that, when supporting people with mental health needs through reassessment they encountered what appeared to be systematic and widespread exclusion of this claimant group from receipt of the enhanced payment. The DWP subsequently acknowledged the redrawing of the boundary via new descriptors to restrict eligibility to those whose mobility was restricted by physical impairments and not those with functional limitations due to the impact of mental distress e.g. anxiety (Mind, 2017).

Increasing proceduralism

Several participants noted that these restrictive criteria were accompanied by an intensifying proceduralism in the assessment process. This was apparent in a reductive rule-bound approach by healthcare professionals (HCPs) who lacked specialist knowledge of mental health and failed to use their professional discretion in the assessment process. Aaron (advocate) described this as follows:

[I]t's all tick boxes, how do you feel today, oh, I feel fine, he said he was fine and that's, you know, well, I'm fine [...] they're not looking at [the claimant's] ongoing situation or where they've been in the past and where they may go in the future. (INT11: 4)

Likewise, with Louise (claimant):

It seemed like they were looking for a tick list of certain symptoms and certain phrases and seeing if their questions would result in those phrases and symptoms, that they already had a preconceived idea of what the mental health problem should be and how it should be described, rather than evaluating the individual capacity and incapacity [...] it was almost symptom bingo, that key phrases and words were being looked out for. (GRP02: 22)

These quotes evoke an procedural and inflexible assessment process that is distant and disconnected from claimants' lived experiences, echoing the spatial remoteness of benefits institutions described earlier.

For Dave (advocate) proceduralism is also endemic in the Tribunal system, with members who are:

[R]eally scared to make decisions, like, they stick to the letter of the law. If you can put a good argument and it can fit in, like, unless it goes within the parameters of these points systems, they just won't do it. (GRP01: 4)

Paul (claimant) concurred:

It seems it's got to be done on computer, it's not the person using their judgement, skill and knowledge and ascertaining, it's what the computer says. (INT05: 3)

As a consequence of these restrictive methodologies, claimants who are deemed not to meet the required eligibility criteria are disentitled. This restriction on professional discretion in the benefits system is not limited to HCPs and Tribunal staff, but also Job Centre workers. Gill described how JCP workers who felt a claimant should be in the higher-need Support Group rather than more work-focused WRAG were constrained from acting on this judgement:

[T]he work coach in the Job Centre, who knows you [the claimant] on ESA, thinks you should be in a support group because you're not, you know, they can just see you're not alright for this, they can't put in a recommendation, they have to say, we think you should apply and they [claimant] have to then come to us and we try and apply for them to go through to the support group, you don't actually get evidence from anyone in the Job Centre. (INT03: 19)

Some participants expressed concern that excessive proceduralism in the system undermined the realization of wider substantive outcomes related to social justice.

Frequent reassessment

As well as an increase in the intensity of bureaucratic proceduralism, claimants described an increase in its frequency. For instance eligibility periods were circumscribed and claimants subjected to recurrent reassessment processes. Gill explained:

I think a lot of the older claimants as well used to be on the lifetime awards or the 10 year awards [of DLA] and now it's, you know, even if you get a three year, you're getting reassessed in two years. (INT03: 18)

Louise (claimant) described such constant bureaucratic demands as being like a 'hamster wheel' (GRP02: 5). These generated insecurity and uncertainty for claimants.

Discounting of medical evidence

Another aspect of this disorienting proceduralism was, for Gill (advocate), the invalidation of forms of supporting evidence. She described the DWP consistently:

[L]ooking to find a way that you're not [eligible] even when you've got the evidence, even if it's just like doctors letters and hospital letters and... whoever the medical assessor is ignoring it. (INT03: 19)

The discounting of supporting evidence from professionals also drew comment from claimants, with Louise noting:

[A]ll medical evidence is now being disregarded, your own GPs and your own specialists, who've known you for years, it carries very little weight now. The only weight that carries is the assessors in the employ of the DWP. (GRP02: 11)

Assessment outcome targets

Participants' questioned the veracity of benefit test procedures, in particular the WCA, and whether they constituted a valid assessment of levels of illness and disability when outcomes were regarded as determined by wider governmental and financial exigencies rather than the process itself. Matt (claimant) argued that WCA outcomes were:

[N]ot based purely on the value you have as a person, it's based on the book keeping [...] they've got to keep the numbers right, you know, they've got to kick a certain amount of people off [...] so it's number, it's balancing the books, that's what it is, I can't put any, you know, it's not based purely on whether you're deserving of a claim or not really. [...] Exactly, it's a target culture. (GRP02: 21)

Gill (advocate) made a similar point drawing on testimony from a colleague:

[S]omeone who I used to work with's husband was one [HCP] and they had targets for you to approve, so say they had to approve, you know, or knock off eight in 10, doesn't matter what they've seen, they're just keeping to the numbers, they could have 10 people completely entitled to it. (GRP01: 27)

Consequently the assessment process is:

[T]arget led and the target is to not award a benefit and they don't take the time to understand what's gone on with the claimant. (INT03:18)

Whilst the government has denied defining targets for assessment outcomes, various sources nonetheless point to evidence of covert goal setting (DWP and DH, 2016). Jack (advocate) put his concerns about target-driven disentitlement in even stronger terms:

[T]he system is corrupt, it's designed to take people off benefits, you know, deprive them of what their entitlement is and by doing that, you follow through to what the policy is, that when you take entitlement away, whatever way you take it away, that you then lose entitlement for the people going forward and it becomes, well, look, it's justified. (GRP01: 26)

For Jack, therefore, a consequence of this process of curbing coverage and restricting access for current claimants is a reduction in the perceived legitimacy of the system amongst the wider body of citizens.

Overall there was a consensus amongst participants that, rather than facilitating in-depth understandings of a claimant's mental health needs, superficial and procedural forms of assessment informed by minimal external evidence such as the WCA functioned as a mechanism for reducing or denying claimant eligibility to benefits in order to meet government welfare retrenchment targets.

2.1.2 Adequacy

A further consideration from a rights perspective is that of adequacy of benefit levels to meet subsistence needs. Welfare policy in the period since 2010, in particular the below inflation 1% uprating of many benefits post 2013 and benefits freeze post 2015, has led to significant financial losses to and increased poverty for welfare recipients, with claimants in regions such as North West England disproportionately impacted (Beatty & Fothergill, 2016). Moreover the government has recently withdrawn the enhanced rate of ESA to those in Support group, reducing this to lower WRAG group rate. In doing so it is de-recognising the additional costs experienced by disabled claimants and those experiencing mental distress (Lord Low of Dalston, Baroness Meacher, Baroness Grey-Thompson, 2015). This section will present data examining the impact of benefit rates and poverty on claimants experiencing mental distress.

Claimants' experiences of poverty were a significant theme in many accounts. In a particularly poignant account, Gill (advocate) described three cases of suicide amongst welfare recipients known to her welfare rights service in 2014-15, which though unconnected came in quick succession. These were men whom she regarded as having mental health needs, though these were not formally diagnosed and treated:

[T]hey were on Jobseekers [Allowance], sanctions, you know. If you're on Jobseekers generally, their gas and electric is £40 a week, gives them £30, you know, some of them have kids and obviously they can't afford maintenance, but they're still wanting to see their kids, but then they have no money to do anything with them or anything else like that and you know, you can just see they were depressed and everything else like that, wouldn't access any services and you know, you're just there to try and help them through wherever you can. Then I think it was down by the docks in Northtown, killing themselves and stuff, not knowing each other or anything and it's just, it was horrible [...] I think an awful lot of the depression side of it is just poverty, you know, which is rife at the minute, particularly in men. (INT03: 45-6)

Star (claimant) referred to similar experiences:

I know a few people have took their life because of the impacts [of benefit reforms] and I've been to their funerals and that's heart breaking, that you've lost friends, they're already poorly [mental health], but with the extra added on debt or bills or threat of homelessness or losing your dole and all stuff like that, it's just cruel, like, really and I think it's wrong, I do think it's wrong to do that to people who are already vulnerable and hurting and struggling anyway. (INT06: 11)

For Jack (advocate) the disentanglement of claimants with mental health needs was a widespread phenomenon leaving large numbers in destitution:

[T]here must be thousands, tens of thousands of people out there who have got mental health problems who have been through the system and been left with nothing. (INT01: 14)

Matt described just such an experience, when he was forced to rely on help from friends for two years because the process of reinstating benefits after a psychiatric hospital admission became so stressful that he decided to withdraw:

It's surprising what you can survive, I mean, you can go without for a long time [...] I know what it's like to go without stuff [...] I know what it's like to go without food for three, four days. (GRP02: 32)

Food poverty linked to benefit rejections, delays, sanctions was a common theme amongst participants, with several claimant respondents recounting their experiences of foodbank use and most advocates describing the need to refer clients. Aaron noted the detrimental impact of poverty for one of his clients, following the rejection of her ESA claim:

[I]t's affecting her by that, I've been referring her to food banks. I've also referred her to the [homelessness centre], you know, for clothing. There's little things there for her but it does take away her dignity. (INT11: 3)

Star described the difference to her quality of life that the increased income from award of PIP had made:

I've had to do without gas and leccy a few times [...] What has helped now is with the PIP money, I'm able to get extra gas and leccy [electricity], so I don't, through the winter, have to be without, you know what I mean. (INT06: 9)

Having examined respondents' accounts of the effects of poverty and distress arising from inadequate benefit levels, we will now turn to wider themes of discrimination and inequality related to the benefits system and their consequences for claimants.

2.2 Non-discrimination and equality

The previous section has outlined the impact of various restrictions on eligibility and the effects of poverty and distress arising from inadequate benefit levels. This section will consider data examining various forms of discrimination and unequal treatment within the benefits system with a particular focus on ESA and PIP. There were three primary areas in which our participants described oppressive processes and outcomes as

a result of discriminatory and unequal aspects of these policy measures: invalidation of testimony; benefits stigma; and ‘psychocompulsion’.

2.2.1 Invalidation of testimony

The first oppressive process was the invalidation of claimants’ testimonies of their lived experiences. Gill (advocate) recounted how DWP officials frequently disregarded with responses such as:

We haven’t got a letter signed from the doctor, you haven’t got this evidence, it’s on hearsay [...] so it’s like a, well, we don’t believe you. (GRP01: 2)

Jack (advocate) described the potentially distressing impact of this institutional invalidation on claimants with mental health needs:

That’s one of the points over adults with mental health problems who’ve been sexually abused as kids [...] [I] say, ‘look, we will put this in [the form], but you might get refused, that doesn’t mean they don’t believe you, I do and it’s the important thing, that I believe you and if need be, we’ll go to tribunal and we can prove it there’. But that actual decision where they [DWP] said no, as much as you try to reassure them [...] that should not be happening to people who have been abused as children, because it compounds it, doesn’t it, makes it worse. (GRP01: 24-5)

However respondents noted this process of invalidation by the DWP was now sometimes extended to encompass supporting evidence from professionals. While Dave (advocate) noted that psychiatric diagnosis and evidence could be a ‘big weight behind someone’ (GRP01: 20), with diagnostic labels operating as gateways to welfare entitlement (Dobransky, 2009), our data suggested a weakening of this function. For instance Louise noted that:

[O]ur own doctors aren’t valid anymore, even if you’ve got a specialist [...] any specialist evidence you bring in is disregarded if their [DWP] doctors or their lay people at the tribunal say, we don’t believe this or, no, looking at you, I don’t think so, [...] your own specialists, who’ve known you for years, it carries very little weight now. The only weight that carries is the assessors in the employ of the DWP. (GRP02: 11)

These structural processes of invalidation represent a form of ‘symbolic violence’ inflicted on people with mental health needs (Bourdieu, 1992). As an already marginalized and oppressed social group this process of *non-recognition* of lived experiences, a form of epistemic injustice, has the potential to leave people with a further diminished self-esteem, self-respect and emotional/ontological insecurity (Fraser, 2000; Lewis 2009; Lakeman, 2010).

2.2.2 Benefits stigma

The second oppressive structural mechanism visible in participants’ accounts relates to stigma. Star (claimant) described in stark terms how, even in comparison with unhelpful interactions with family or friends who were insensitive to mental distress, the most powerful forms of stigma in her life arose from the ‘Dickensian’ benefits system:

[I]n my recovery, I’ve never felt so ashamed, so excluded and so out of sync with how I’ve been treated by the benefits system and my shame and the sense is that you’re not worthy predominantly comes from how we access our benefits systems [...] the system that’s supposed to be helping us to feel less ashamed and more included is excluding us and knocking us back to miles gone back to centuries ago, like. I was thinking it’s a bit like Charles Dickens times, isn’t it, worse, you know, food banks and everything. (INT06: 18)

Matt also moved beyond interpersonal level explanations of stigmatization when explaining how, in his own experience: ‘the [benefits] system kind of encourages that self-loathing’ (GRP02: 6). Central to this form of structural stigma (Link & Phelan, 2001) is what Jack describes as the ‘vilification of disabled people, of ill

people' (GRP01: 1) in the benefits system and a remobilization of what Gill (advocate) identified as a 'deserving/undeserving poor' discourse:

Now, I don't believe that there is a deserving and an undeserving, I think they [DWP] think everybody is undeserving at the moment.

Dave (advocate) explained in more detail how this structural or more specifically benefits stigma (Baumberg et al., 2012) was operationalized in assessment and Tribunal processes. He described officials who, due to limited understanding of mental distress or unwillingness to acknowledge its impacts, conflated typical experiences during episodes of anxiety or low mood such as feeling unable to leave the home with negative popular stereotypes of the welfare claimant 'sitting there on their arse watching the telly' (GRP01: 24).

2.2.3 Psychocompulsion

Such demeaning constructions also underpin a third oppressive dimension of welfare reform: psychocompulsion. As noted earlier, this term has been coined to describe the embedding in welfare institutions of supply-side explanations for and solutions to unemployment under neoliberal capitalism. This is operationalized in the welfare system via the construction of 'worklessness' as underpinned by individual-psychological deficits to be rectified via behavioural and positive psychology techniques to engender labour market re-engagement (Friedli & Stearn, 2015).

The tenets of this philosophy are inculcated through courses offered to welfare claimants. For instance Paul described being offered a number of courses through his Job Centre on 'how to motivate yourself, how to be positive'. He was however highly critical of these, describing them as 'patronizing' and explaining:

[M]y own perception of it was as well, you're at fault for being unemployed, you're at fault for being ill, you have to change the way you are, you have to be more positive. It's like this nudge⁴ fairy that, well, you're at fault, you need to correct yourself, which doesn't seem right. No matter what the circumstances are of how I've come to this, if they're of no fault of my own, then how can I change it? (INT05: 10-11)

Louise had a similar critical perspective on this approach describing such courses as 'blame workshops' (GRP02: 34). She raised concerns about related proposals to co-locate mental health services and Job Centres in order to deliver work-related psychological interventions to claimants, in particular the potential with more integrated outcomes for benefits conditionality and therapeutic outcomes to be aligned:

But the psychiatrists in the Job Centres and the point of, if they made you see a psychiatrist now for six weeks and at the end, would you feel better for it, what would you tell them, you know, it's just would they cut your benefits if you don't have a positive result at the end, this is scary stuff [...] I don't believe [in] employment centred psychiatry, it's got to be more holistic than that. (GRP02: 18-9)

Dave (advocate) contextualised this trend within wider processes of claimant responsabilisation under neoliberal welfare reform:

[E]verything is the responsibility of the individual [...] It's like taking the state away from being responsible for anything, like and you know, putting it on the individual, so you become out of work, it's your problem. (GRP01: 5)

By articulating these dynamics of psychocompulsion and structural stigma together as manifestations of responsabilisation our analysis appears to support Scambler's (2009) thesis that new constructions of marginalized groups of welfare recipients are becoming visible. These are generated by neoliberal welfare reforms and characterized in terms of a shift 'from deficits to deviance', whereby the *shame* formerly associated with an ontological deficit (mental illness) is being transformed into *blame* attributed to the claimant because of the perceived moral deficit associated with 'worklessness'. In summary these

4 This refers to the concept popularised through the book by Thaler and Sunstein (2008).

experiences of blaming and the processes of invalidation noted earlier fundamentally challenge claimants' self-esteem and sense of ontological security. The consequences of these intersecting dynamics for the mental wellbeing of claimants will be explored in the next section.

2.3 ESA and PIP reforms: effects on claimants' mental health

The previous sections have focused on two overarching themes. The first is the way that reduced access to and adequacy of benefit coverage, particularly elements linked to increased conditionality, has led to diminished levels of social protection for people with mental health needs. The second is the way in which discriminatory processes in the benefits system have negatively impacted the sense of self-respect and security experienced by claimants. This section will now draw together various strands from the earlier discussion to examine the impact of challenges in navigating the system on the mental health of claimants

Our data suggest that the ESA and PIP processes potentially undermine claimants' subjective wellbeing and mental health recovery⁵ via a number of mechanisms which will now be summarized:

2.3.1 Retraumatization

Evelyn (advocate) explained that disclosure of traumatic experiences required by the claims process can be highly distressing:

They're not prepared to say what their worst days are, because they don't want to relive those thoughts. (GRP01: 24)

Matt described the focus of the line of questioning at his WCA and its effects:

Yeah, when I was, was it early 20 or something, I made a suicide attempt and I had to go in quite a lot of detail about that [...] I feel really sick after that, really sick. (GRP002: 7-8)

For Louise, who had accompanied Matt, the mode of examination by the assessor:

[C]aused [Matt] to relive some of the worst experiences of his life [...] it's as if they were almost trying to really uncover the most appalling events of your life and see if they could push some buttons, it was shocking, I thought. [...] It felt like a personal attack, didn't it, but done with a smile. (GRP002: 8)

There is growing evidence that questions regarding topics such as suicide attempts are routinely posed to claimants with mental health needs in WCAs. There is significant concern that inquisitorial examination of such intensely sensitive personal experiences are highly inappropriate, particularly when the claimant is neither offered therapeutic support within the assessment process nor rendered eligible for it on the WCA's completion (Pring, 2017). Moreover, the increasingly recurrent expectation on claimants to reprove their entitlement means that claimants are forced to recount these experiences ever more frequently.

2.3.2 Invalidation

We have already described the extent to which the disregarding and undermining by the DWP of the veracity of the testimony of claimants with regard to their experiences. This is a form of epistemic injustice, elaborated by Fricker (2007) as 'testimonial injustice', whereby the credibility of evidence from marginalized groups such as mental health service users is undermined. This, as Jack noted in relation to childhood abuse survivors, causes harm and tends to exacerbate the mental distress of claimants.

5 Though we utilize this term, we recognize and support the concerns about the use of the concept of recovery articulated by survivor movements such as Recovery in the Bin. Though the recovery model was originally developed by service user movements this critique addresses the appropriation of the concept to inform neoliberal activation-oriented welfare reform.

2.3.3 Fear

A constant theme in respondents' accounts was *fear*. One common instance related to the 'fear of the brown envelope'. As Dave explained, 'people who are starting to feel okay, you know, starting to look forward and then, bump, the brown envelope lands [...] and next minute it's back down' (GRP01: 25). Dave described the intensity of this for one of his clients:

[S]he's, like, exasperated, why are they still after me and you know, she does, she really had near enough a breakdown over it [...] It's a trigger, like, if she gets anything like that [forms], [...] it really stresses her out to the point where there's a danger of her going back into hospital. (INT02: 26-7)

Another was the fear of sanctions. Even though claimant Paul has not yet been sanctioned he expressed anxiety that this may happen if he did not meet various job search requirements placed on him when temporarily claiming JSA:

I had that fear of sanctions, it wasn't the fact, it is just the regimentality of what, you've got to produce so much for, to say that you're looking for work. (INT05: 9)

2.3.4 Mistrust

Dave (advocate) articulated a consensus view amongst respondents that: 'the whole system is based on mistrust really' (INT02: 16). Previous sections have elaborated in some detail the challenges faced by claimants in the WCA and PIP assessment processes, and 'traps' experienced by claimants. Paul (claimant) summarized this when expressing his view that the WCA was 'designed to trip up [applicants]' (INT05: 13).

This was elaborated in more detail by Jack who described a claimant with debilitating fibromyalgia whose husband had put up shelves so she could tend to some plant pots: 'That translated into the report, 'does the garden three times a week''. He argued:

Because she was honest and truthful with that answer, that's then turned on its head [...] Now, you say to yourself, well, is that a lie, no, it's not a lie, but it's certainly grossly inaccurate. (INT01: 7)

In a similar vein, Gill (advocate) described the relationship between the invalidation described above, the misrepresentation of claimants' experiences by assessors and the harmful effects of these distortions on claimants' mental health:

[I]t's this sort of element of just disbelief and the whole way that the healthcare, the ATOS reports [WCA] and everything are then sent out and they're just full of, you know, blatant lies and it makes everyone go far worse then, you know, they have relapses. (GRP01: 2)

Matt (claimant) described the effects of restrictions and disentanglements in the welfare system and how these created pressures on claimants to engage in 'gaming' in order to access support:

[I]t's not just an inefficient system, it's also, you know, it's a very degrading system as well because it penalises honesty... And it encourages dishonesty. [...] well, what they're doing at the moment, they're raising the bar to get into the groups that require more support [...] I would have been in the position where I'd be entitled to make a claim in regard to... they've changed the rules and so you can't and of course, people see that and they think, well, I want to stay in the group I'm already in, so they'll fill in the criteria [...] It's encouraging deception [...] dishonesty and fraud. (GRP02: 9-10)

2.3.5 Double binds

This paper has drawn attention to respondents' descriptions of a number of 'traps' and conflicting messages in the benefits system (for instance, the personal attack combined with the smile, detected by Louise in the Matt's assessment). Some of these take the form of 'double binds', or contradictory injunctions from powerful others, that were theorised by Bateson and Laing as potential causal mechanisms of mental distress (Gibney, 2006). For example, we referred above to the claimant who was requested by the DWP to attend

Eastville for WCA assessment of their mental health needs, but presentation at Eastville was perceived to invalidate their claim to be mentally distressed due to their capacity to travel.

2.3.6 Shaming and blaming

In the quote presented earlier Star discussed how the debilitating sense of shame she felt was directly linked to her experiences of governmental welfare policy. Matt also felt claimants were labelled as ‘useless eaters’ and denigrated in comparison with ‘working people’ (GRP02: 14). Louise (claimant) felt the election of the Conservative-Liberal Coalition government in 2010 marked a significant escalation in such, ‘divide and conquer [rhetoric]... the unemployed and the sick were the target from the off’ (GRP02: 14-15).

These scapegoating and shaming dynamics in benefits stigmatisation intersected and articulated with constructions of blaming in psychocompulsion measures (the ‘blame workshops’ in Job Centres). These processes caused escalating levels of distress for claimants, for instance Louise described them making her ‘feel more and more useless about not fitting in with their model and therefore pushing mental health down further’ (GRP02: 19).

2.3.7 Summary of mechanisms

Based on analysis of our data it is clear that participants’ perceive the pressures exerted on claimants via the six mechanisms outlined in the preceding discussion to play a significant role in exacerbating levels of mental distress. For Matt, demands on claimants are escalated:

[T]o such a degree that it’s, I mean, people who don’t suffer from depression find it exasperating, but people who just find it so difficult to cope with day to day, things like that, it’s simply impossible.

This suggests that even those claimants not initially experiencing mental distress may find the demands created intolerable. This latter point is confirmed by advocate Gill, who describes how:

[P]eople who didn’t have a mental health condition to start with as well, I think [...] The way it goes on, there’s a lot of people who’ve ended up becoming ill, just going through it [benefits claim]. (GRP01: 25)

There was high level of agreement amongst participants of the detrimental impacts of the processes of claiming and maintaining entitlement to ESA and PIP described above. These effects were visible both before as well as during the claim. In combination with the discriminatory effects described earlier, respondents perceived these processes as exacerbating mental distress amongst claimants, with some expressing the view that these processes caused mental ill-health⁶.

In summary, the data presented in the last three sections indicates that the introduction of ESA and PIP have led to a decrease in both access to and adequacy of welfare support via a number of discriminatory mechanisms. For claimants this has led to increased levels of poverty and reduced levels of self-respect and self-esteem resulting in an exacerbation of mental distress. The forms of suffering described above are institutionally propagated by government agencies and the corporations to which state functions are outsourced and consequently constitute a specific example of ‘social harm’ (Lasslett, 2010). In view of the mechanisms underpinning this harmful phenomenon we suggest the term ‘benefits distress’ to describe it.

⁶ It should be noted that the exploratory qualitative methodology of this study is not, on its own, suitable and sufficient for the determination of benefit reform as a mechanism of causation of mental distress, but our findings suggest that further research to determine whether or not benefit reform constitutes such a mechanism seems strongly warranted.

2.4 Implications for claimants' capabilities

In this section we address the extent to which claimants with mental health needs are able to achieve various valued capacities to act. According to the capabilities approach, two important dimensions underpinning the capacity to act are: a) the individual and contextual (e.g. economic and social) means to convert resources into this capacity, and b) the freedom to use such capacity to act in the way one chooses and values (Orton, 2011). We will briefly examine the extent to which these criteria are met in relation to promoting claimants' capacities to engage in paid employment; engage in other forms of social participation; and experience positive mental health and wellbeing.

2.4.1 Paid employment

Testimony from a number of our respondents, both claimants and advisors, indicated a desire on the part of many claimants to find ways to re-engage with the labour market and realize their capacity to work. However participants described individual-level barriers to work, such as PIP mobility cuts reducing travel resources, as well as contextual and structural impediments such as the number of jobs available in the labour market (mentioned by Matt), and a lack of workplace adjustments by employers to meet mental health needs (noted by Star). Respondents were also subjected to administrative expectations from the DWP that meant they were not able to freely choose how to reconnect with work. This took the form, as noted by both Paul and Louise, of employment-based training courses experienced as inappropriate and/or patronizing but which claimants felt compelled to attend for fear of punishment or sanctions.

2.4.2 Other forms of social participation

For many respondents the emphasis on paid employment by the DWP undermined the capacity for participation in other valued social roles such as caring or volunteering (c.f. Patrick, 2014). Such capabilities for care (Orton, 2011) were perceived as less valid within the welfare system. For instance Star placed a high value on her practice as a volunteer art group teacher for people with mental health needs (which acted as a space for both education and care). However her involvement was utilised by the DWP to justify applying pressure on her to return to paid employment. Moreover she described how austerity measures had led to limitations in access to the contextual resources, for instance the rooms provided by third sector organisations, on which she depended in order to be able to provide the classes. Louise also talked of her perception that the government no longer seemed to recognise the value and necessity of informal caring roles, for instance the protective function of the support she offered friends with mental health needs in a context of reduced access to formal mental healthcare. In this way participants felt that their freedom to choose to realize their capabilities for caring and volunteering were constrained and challenged within the welfare system.

There were two further structural barriers to the capacity to engage in forms of social participation noted by respondents: poverty and benefits stigma. Both of these constituted capabilities deprivations, poverty by intensifying claimants' social isolation, and benefits stigma by reducing the self-worth and self-esteem of benefit recipients in relation to families, communities and other networks as well as the self.

2.4.3 Mental health and wellbeing

We noted in the previous section that Star was engaged in voluntary work as a peer coordinator of a mental health survivor art group. Lewis (2012: 527) describes this type of adult community learning project as functioning as a social good in its own right by promoting what is termed, in the capabilities approach, 'human development freedom'. It transcends instrumentalist conceptions such as 'improving employability' by recognizing how participation in collective forms of agency such as educational practice in a destigmatised space serve as a valued end in themselves. This not only promotes empowerment but also

enhances mental wellbeing. Such impacts were confirmed by Star who described how an important element of this coordinator role was its positive impact on her own mental health.

While this combination of resource availability and freedom to choose visible in Star's project promoted her mental wellbeing, our data also indicate that these wellbeing effects were threatened by the potential, noted above, for constraints on the capacity to choose valued roles emanating from the DWP. Similarly, the denial of resources, the lack of transparency and invalidation of experiences in the welfare system placed limitations on the capacity of claimants with mental health needs to recover. As advocate Dave noted, these constraints denied claimants 'room to breathe' (INT02: 18).

2.5 Evaluation of 'effectiveness' at the collective level

The primary goal of these new benefit and ALMP measures was to support the labour market re-engagement of welfare recipients. However because of the challenges for claimants in establishing entitlements (described above), participants considered the risks associated with re-entering the labour market and signing off from claims to be high because of the possibility of employment proving hard to sustain. In this respect the reforms resulted, paradoxically, in disincentives for claimants to seek work or volunteer. Similarly increased levels of stress and mental distress experienced by recipients as a result of draconian welfare assessment procedures and limits on eligibility also seem to be pushing claimants further away from re-engagement with paid employment. Consequently, in view of the data presented here and the broader evidence (e.g. Work and Pensions Committee, 2017), the UK government's current activation strategy of reducing and limiting welfare entitlements does not appear likely to achieve its employment-related goals and close the disability employment gap.

Furthermore, extensive evidence has been presented which establishes the negative impact of these reforms for the capabilities of claimants, with increased social exclusion and poverty, and the erosion of rights and increased stigmatization of some of the most marginalized citizens in the UK.

Our findings suggest that the welfare system retains minimal legitimacy amongst many of those who are closest to its operation: claimants and advocates. Whilst many claimants were sympathetic to the employment-related aims of policy, its draconian means (e.g. sanctions and psychocompulsion) were extensively problematized. Moreover, claimant Louise argued, the government are, 'more likely to get people back into work if they have a kinder system that supports them with long term therapeutic relationships. [That would be] more effective at return to work' (GRP02: 35).

3. Conclusions

Even in the context of austerity measures, states continue to have an obligation not only to preserve the right to social security but also to prevent retrogressive measures (UN High Commissioner for Human Rights, 2013). This study has argued that current ESA and PIP reforms and their mode of implementation do indeed constitute a backward step for social security rights of people experiencing mental distress in the UK, through both the restriction of eligibility criteria and reduction in the level of benefits⁷. The reforms therefore run counter to this obligation. Furthermore there is extensive evidence that the substantive application of the relevant procedures (e.g. the WCA) leads to discriminatory and unequal outcomes for people with mental health needs.

Consequently we contend that these reforms are not consistent with the right to social security and an adequate standard of living for claimants experiencing mental distress in England. The evidence from this study suggests that the current suite of social protection and ALMP measures have not been successful in supporting people with mental health needs to reintegrate into the labour market should they wish to do so. Nor is there evidence, based on the data from our respondents or the wider literature, that these measures are likely to close the disability employment gap in the UK. Moreover, though the right to work is important, the option to engage in alternative valued social roles such as caring or volunteering is supported by claimants but not currently validated by the benefits system.

⁷ The potential for such negative outcomes was recognized by the Human Rights Joint Committee of the UK Parliament in 2011 (Human Rights Joint Committee, 2011).

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