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Incapacity Benefit, employment transitions, and health: evidence from longitudinal data and a qualitative study

Kathryn Skivington, MA, MSc.

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Unit, University of Glasgow

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Abstract

Background: UK welfare reform endeavours to reduce out-of-work health-related benefit receipt and support people into employment. Such reforms assume that work is good for health and that targeting welfare-to-work interventions at individuals will result in moves from benefit receipt to employment.

The research in this thesis tackles two questions associated with UK welfare reforms: (1) Is work always good for health? And, (2) Is the focus on motivating individual Incapacity Benefit (IB) and Employment and Support Allowance (ESA) recipients appropriate, or are there barriers to return to work that this approach cannot address?

Methods: Three approaches were taken to address the aims:

1) Longitudinal analysis, using Generalised Estimating Equations, of the West of Scotland Twenty-07 Study (Twenty-07), to explore transitions from worklessness to employment. The analyses looked at both employment and health outcomes (self-rated and anxiety or depression) and took account of the psychosocial quality of the jobs obtained.

2) A systematic review of qualitative studies that explored the barriers and/or facilitators to employment from the perspective of people out of work because of health conditions or disabilities. A qualitative synthesis, using meta-ethnography, of the included studies was conducted.

3) A primary study utilising in-depth interviews with IB and ESA recipients, General Practitioners (GPs), and Employment Advisors (EAs) in Glasgow, to gain more understanding about barriers and facilitators to work and to fill the gaps identified in the qualitative synthesis. The interviews were analysed using Framework Analysis methods.

Findings: Findings from Twenty-07 data showed that only 6.6% of those out of work because of ill health returned to work within the follow-up period. After a transition from worklessness to employment those in low-quality jobs had higher odds of poor health than those who moved to high-quality jobs, even after taking account of prior health. Those who remained workless had higher or similar odds of poor health as those who had moved to low-quality jobs.

Nine studies were synthesised in the systematic review. Participants in the studies identified similar barriers and/or facilitators to return to work. Barriers and facilitators were related to health, workplace factors, the need to change job, financial issues, life stage and social circumstance, support, and self-construct. Synthesis and interpretation of the studies led to themes that were then further explored. These themes were: the complex pathway of return to work; competing participant and author narratives, and a difficulty of interpretation; the distinction between expected and experienced barriers to work; differences in barriers and facilitators by participant characteristics; job quality; and work-role centrality, adaptation, and financial risk.

Seventeen IB or ESA recipients, six GPs, and six EAs participated in the qualitative study. Their barriers and facilitators to work confirmed the findings of the systematic review. All IB/ESA recipients had multiple and interacting barriers that were not limited to their motivation but also related to wider labour-market and social-context issues. Those with complex social situations and mental health conditions had lower expectation that they would successfully return to work. All participant groups were concerned that the policies of the welfare system did not match up with the labour-market or the social context.

Conclusions: A very low proportion of those out of work because of ill health transitioned into employment. This is concerning because current policy is to reduce the number of people receiving IB and ESA. The research showed that there is a significant challenge to support this group into employment and that policies focusing on motivating individuals may miss important barriers to return to work. There appear to be health benefits from return to work; however, job quality is important, and the potential for health improvement is limited if the job is of poor quality. Supporting people into work has the potential to improve health, but more effort is required to determine how to improve support and target where it is most needed. Further research is necessary to explore the results of the current welfare reform i.e. whether IB/ESA recipients move into work, what helps them do so, and whether they experience a change in health.

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Author's declaration

I declare that, except where acknowledged, all work has been undertaken by myself.

Kathryn Skivington

Abbreviations

CI: Confidence interval

CMD: Common mental disorder

DWP: Department for Work and Pensions (previously DSS: Department for Social Security)

EA: Employment Advisor

ESA: Employment and Support Allowance

GEE: Generalised Estimating Equations

GP: General Practitioner (family doctor)

HADS: Hospital Anxiety and Depression Scale

HILDA: Household, Income and Labour Dynamics in Australia Study

IB: Incapacity Benefit

JCP: Jobcentre Plus

JSA: Jobseeker’s Allowance

LA: Local Authority

NHS: National Health Service

NS: Not significant

OR: Odds ratio

OECD: Organisation for Economic Co-operation and Development

OPCS: Office of Population Census and Surveys

OWIH: Out of work because of ill health, injury, limiting condition or disability

OWMH: Out of work because of mental ill health

OWPH: Out of work because of physical ill health

PATH: Personality and Total Health through life (Australian cohort study)

PICO: Population, Intervention, Comparison, Outcome

PTW: Pathways to Work

R&D: Research and Development

RR: Response rate

RTW: Return to work

SPIDER: Sample, Phenomenon of Interest, Design, Evaluation, Research type

SPSS: Statistical Package for the Social Sciences

SRD: Stress-related disorder

Twenty-07: The West of Scotland Twenty-07 Study

UK: United Kingdom

WCA: Work Capability Assessment

Chapter one: Introduction

Worklessness is a significant issue in the UK, and a large proportion of those out of employment are in receipt of Incapacity Benefit (IB) or Employment and Support Allowance (ESA). IB and ESA are paid to people who are out of employment because of a health condition, ill health, injury, or disability. The number of people claiming IB rose from 0.74 million in 1979 to 2.78 million in 2003, and although this has levelled off, it has remained over 2.5 million since then. IB/ESA receipt is a particular problem in deindustrialised areas, including Glasgow, where just prior to the introduction of ESA (2008) 13.6% of the working-age population received IB, compared to 9.1% in Scotland, and 7.1% in the UK. Worklessness, employment policy, and welfare policy contribute to population health therefore are themselves social determinants of health. Policy documents make strong links between employment and health and use health to drive policies aimed at moving people from IB and ESA into employment.

The UK Government's response to the increase in IB, since the early 2000s, has been large-scale reform to the welfare system with the main aims of reducing the number of people receiving IB and increasing the employment rate. There are both economic and health reasons for moving people from health-related benefits and into employment. The Department for Work and Pensions (DWP), which controls welfare benefits, is the biggest spending government department and there is pressure to reduce costs. The Government is also committed to tackling poverty and social exclusion, both of which are strongly associated with ill health. One route out of poverty is employment. Health improvement is repeatedly stated as a benefit and a driver of the welfare reform because of the accepted positive association between employment and health in the general population.

The main policy response to reduce the rate of IB/ESA receipt has been to 'activate' people into employment. 'Activating' benefit recipients refers to policies that have been introduced to reduce individual-level barriers to employment. These policies include both 'demanding' interventions, e.g. placing job search requirements on benefit receipt, and 'enabling' interventions e.g. in-work benefits and support for finding a job. A crucial part of activation has been to make benefits conditional on individual participation in job search activities and employability schemes.

1.1 Clarification of terms

There are many different forms of work, but for ease of exposition when discussing 'work' in this thesis it is referring only to paid employment. Similarly the term 'return to work' is often used for different purposes e.g. to describe an intervention, pathway, or outcome. This thesis uses 'return to work' to talk about an outcome unless otherwise stated. Additionally, it is recognised that not all those who receive IB or ESA were previously in work, but the term 'return to work' is still used to describe the outcome of moving into work.

1.2 Over-arching research questions

This thesis tackles two over-arching questions that lead from the issue of IB/ESA receipt and the associated welfare reform:

1) Is the focus on activating IB/ESA recipients appropriate, or are there barriers to return to work that this approach cannot address?

2) Is work always good for health?

The thesis sought to address these questions with three studies:

1) Longitudinal analysis of the West of Scotland Twenty-07 Study data to examine the employment trajectories of those initially out of work and to investigate the health effects of transitions into employment.

2) A systematic review of qualitative literature to explore and synthesise existing research on barriers and facilitators to employment from the perspectives of people with health conditions or disabilities.

3) A primary qualitative study of IB and ESA recipients, General Practitioners (GPs), and Employment Advisors (EAs) in Glasgow to address gaps in research

identified in the systematic review.

1.3 Thesis outline

Specific research questions are detailed in the introduction sections of Chapters three, four, and five. An outline of each of the chapters of the thesis is set out below.

Chapter two provides background information about the size of the IB/ESA problem and the policy response, and summarises the evidence on predictors of return to work and on the relationship between employment and health. The chapter identifies the gaps in research that are addressed in the rest of the thesis.

Chapter three presents analysis of data from the West of Scotland Twenty-07 Study. First, the analysis looks at factors associated with transitions from worklessness to employment in order to explore whether predictive factors of return to work are tackled in the current welfare reform i.e. whether support to activate benefit recipients seeks to improve the factors associated with positive employment outcomes. Second, the analysis explores the health outcomes of return to work to examine whether a transition into work is always beneficial for health.

Chapter four presents the systematic review of qualitative studies. The objective was to synthesise the existing research that explored perspectives of people with health conditions or disabilities on their barriers and facilitators for return to work. This was done to determine whether current welfare reform addresses these barriers and facilitators to return to work and whether there were any gaps in the literature pertaining to people’s experiences of being out of work because of ill health.

Chapter five introduces the primary qualitative study that was conducted to address the research gaps identified in the systematic review and to explore the perspectives of professionals who support those who are out of work because of ill health. Perspectives of IB recipients, GPs, and EAs were collected using in-depth interviews. Chapters six and seven present the findings and a discussion of the study.

Chapter six discusses the findings from the analysis of IB participant data. It explores whether perceptions of barriers and facilitators to work differed by participants with mental/physical health conditions and investigates participants' motivation to return to work. Data on barriers and facilitators to work and motivation to work were analysed using concepts from participatory action theory: capacity, opportunity, and preference to return to work. These concepts were used to determine where the main barriers and facilitators to work lie and therefore which areas should be targeted in return-to-work support.

Chapter seven follows a similar structure to Chapter six, using the same concepts from participatory action theory to look at barriers and facilitators to work for IB recipients, but from the perspective of the GP and EA participants. GPs' and EAs' perspectives on their role in the welfare system were also explored to identify areas where they felt that support for IB recipients was either not appropriate or not available.

Chapter eight brings together all of the evidence from the thesis to address the two over-arching questions set out in the introduction. The implications of the research are considered and issues for further research set out.

Chapter two: Background and literature review

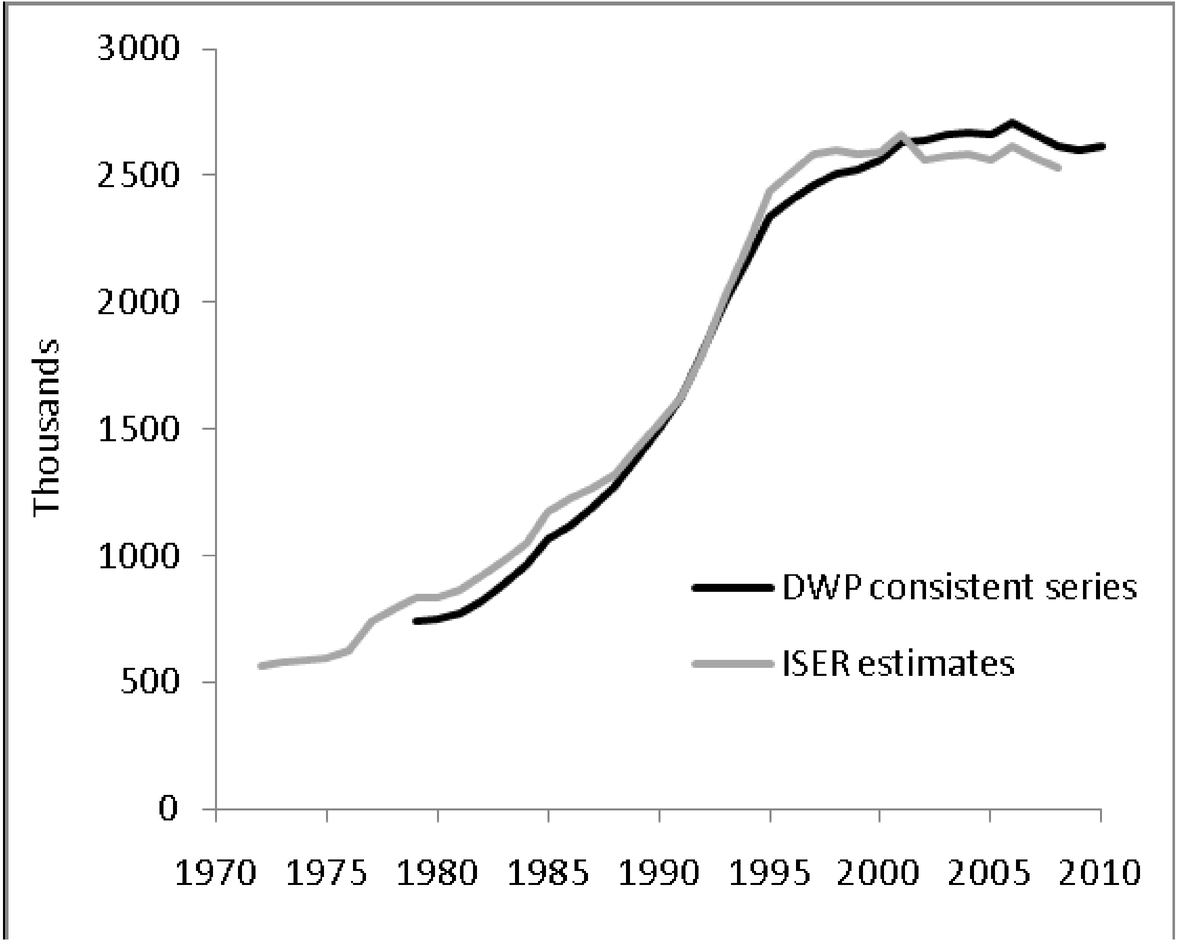
This chapter begins by providing background information about the group of people claiming Incapacity Benefit and Employment and Support Allowance (IB/ESA) in the UK and the associated welfare policy. Two issues that follow from welfare policy are then explored further. First, the evidence on the factors that are associated with return to work is reviewed. Second, the evidence on whether work is good for health is reviewed. The chapter ends by identifying the gaps in the available evidence, leading on to Chapter three, which aims to address some of these gaps.

2.1 The size of the problem and the policy response

The number of people out of work because of ill health is a substantial problem for population health (Alexanderson and Hensing, 2004; Henderson *et al.*, 2005). It is broadly acknowledged that features of work and welfare provision, such as the amount and the coverage, directly impact upon socioeconomic position and, therefore, changes to these features have the potential to impact on a person's physical and/or mental health (Acheson, 1998; Bartley *et al.*, 2006; Eikemo and Bambra, 2008; Townsend and Davidson, 1982). Additionally, health problems lead to more severe negative employment outcomes in those with lower socioeconomic position, meaning that worklessness is likely to exacerbate population health inequalities (Whitehead, 2010).

Around 6.5% of the working-age population in the UK receive IB or ESA (as of 2012) (Office for National Statistics, 2013). The number of claims for IB/ESA has changed considerably since the 1980s. Using two different data sources, Berthoud (2011) explored trends in health-related benefit receipt since the 1970s; a chart taken from this work is shown in Figure 2-1 (Berthoud, 2011, p. 4). Since 2010 the number of people receiving IB or ESA has decreased slightly, from 2.42 million in February 2010 to 2.34 million in August 2012 (DWP, 2013). Those who receive IB/ESA have all been judged to have health limitations that preclude their ability to be in paid employment. However, there was a shift in the type of health limitations recorded as reasons for IB/ESA claims between the 1990s and 2000s.

Figure 2-1: Number of working-age claimants of benefits on the grounds of incapacity for work, 1972-2010*



*Includes Invalidity Benefit pre 1995, IB post 1995, ESA post 2008, Invalidity Pension 1977-83, Severe Disablement Allowance post 1984, Supplementary Benefit pre 1986, Income Support 1987-1999). ISER: Institute for Social and Economic Research. Source: taken from Berthoud, 2011 (page 4).

2.1.1 Shift from musculoskeletal health to mental health

Until the late 1990s, musculoskeletal conditions were the most common reason for IB receipt; since then, mental health conditions have been the leading reason for receiving IB (Waddell, 2006). Brown *et al.* (2008) analysed data on the reasons for IB receipt in Scotland between 2000 and 2007. Thirty-three percent of IB receipt was down to mental and behavioural disorder in Scotland in 2000, and this proportion had increased to 44.2% by 2007. The majority of the increase in mental health conditions as reasons for receiving IB has been caused by increases in mild to moderate conditions such as stress, anxiety, and neuroses, with only a small proportion of IB recipients with serious psychiatric illnesses, for example schizophrenia.

A greater proportion of people with mental illness rely on state benefits than those with other health conditions, and the employment rate for people with mental ill health is much lower (21% compared to 47% of all people with a disability overall) (Lelliott *et al.*, 2008). However, it has been shown that a larger proportion of people with mental illness who are out of work want to work than those with other health conditions (Sainsbury *et al.*, 2008). There is still thought to be limited evidence about what actually supports people with a mental health condition into employment (Anyadike-Danes, 2010; Lelliott *et al.*, 2008). It has been suggested that rather than concentrating on reforming the benefit system more effort should be put into building the evidence base on how people with mental health conditions can be best supported (Anyadike-Danes, 2010).

2.2 Welfare reform

Moving working-age people off welfare benefits and into work is part of the Government's employment and public health agendas. A joint strategy programme between the Department for Work and Pensions (DWP) and the Department of Health was announced in 2005 under the Labour Government (DWP *et al.*, 2005) and continued under the 2010 coalition Conservative-Liberal Democrat Government. As well as reducing the cost of the welfare bill and increasing the employment rate, welfare reform aims to move people from IB/ESA to employment in order to improve population health. DWP reports have repeatedly cited that work is good for health and have used this as one driver of reforms (Black, 2008; DWP, 2008a, b; Freud, 2007; Gregg, 2008).

Unlike in Nordic countries—where much effort has been put into improving the employment environment, or the demand for employment—the UK policies have largely placed the emphasis on the individual and therefore on improving the quality of the supply of potential workers (Whitehead *et al.*, 2009). UK welfare reform bills focus on the need to motivate IB/ESA recipients to work and emphasise that individuals need to take increased responsibility to move towards work (Gregg, 2008; HM Government, 2007, 2009). One major limitation of having the policy concentration on the individual is that it takes little account of potential demand-side interventions to support people into employment e.g.

engagement with employers, inward investment (Green and Hasluck, 2009), and flexible jobs (Kvist *et al.*, 2008) (although some of these things have been done in the UK the major focus of welfare-to-work policy is on the individual).

Following the 2007 Welfare Reform Act the major supply-side intervention in the UK was the introduction of ESA in 2008. ESA is paid at two rates—for those judged able or unable to move towards work. Those who are judged as able to move towards work are required to engage with certain return-to-work activities that aim to support them into employment. Those who were receiving IB prior to 2008, unless they moved off of the benefit for any reason, kept receiving IB rather than ESA up until at least 2011. At the time of conducting the current research those who were receiving IB faced being reassessed for ESA with a new Work Capability Assessment. Most of those who were reassessed were required to take part in some return-to-work activity; only 9% of people who were assessed for ESA between September and November 2009 were placed in the ESA Support Group and not required to participate in the welfare-to-work interventions (DWP, 2010b).

The following two sections explore the evidence behind two assumptions of welfare reform related to the concentration on individual-focused interventions and the premise that work is good for health.

2.3 What predicts return to work?

One question arising from the issue of IB and ESA receipt and the associated welfare reform is: Is the focus on activating IB/ESA recipients appropriate, or are there barriers to return to work that this approach cannot address? It is important to know what the predictive factors of return to work are, in order to be able to target support. The first sub-section introduces a conceptual framework for return to work to provide context for the second sub-section, which reviews empirical evidence for factors related to return to work.

2.3.1 Conceptual model of return to work

Over time, return-to-work interventions have drawn on various different models of disability. Table 2-1 details the main models that have been used to understand the concept of disability in relation to return to work. Each of the models has been applied to interventions or policies to support people into work. However, there are limitations with basing interventions or policies on these models.

Table 2-1: Models of disability related to return to work (RTW)

Model	Discipline	Draws on	Aspects/focus	Implications for action	Examples applied to RTW*	Limitations of the model
Biomedical	Biomedicine	Medical model of disability.	RTW requires improving the individual's health condition & functional capacity for work.	Medical/surgical intervention.	Back pain interventions, physiotherapy (Hagen *et al.*, 2003; Rossignol *et al.*, 2000).	Focusing solely on the individual's health issue neglects any wider factors that may impact upon RTW e.g. social/economic factors (& assumes full recovery or at least assumes the workplace will be accessible).
Social	Sociology, social policy	Social model of disability.	People are disabled by their disabling social environments.	Cultural & environmental changes.	The 1995 Disability Discrimination Act, Disability Living Allowance & Department for Work & Pension's (DWP) Access to Work intervention (Dewson *et al.*, 2009) were each grounded in the social model.	Focusing solely on the social neglects that that there may be medical or psychosocial barriers to RTW.
Psychosocial	Psychology	Behaviour change, social learning theory, cognitive behavioural theory.	RTW requires changing the individual's behaviour.	Individual behaviour change.	Theory of Planned Behaviour (Brouwer *et al.*, 2009), Transtheoretical model (Krause *et al.*, 2001).	Focusing solely on the individual's behaviour neglects that RTW may be affected by medical, social & economic factors.
Biopsychosocial	Medicine, psychology, sociology	Medical, psychological & social models of disability.	RTW requires changes related to the individual health condition, behaviour & workplace factors.	Work disability is multi-factorial & therefore RTW interventions require a multi-factorial approach.	World Health Organisation International Classification (World Health Organisation, 2001), DWP: various RTW interventions (House of Lords, 2012).	Not fully developed for RTW & has been criticised for concentrating too much on factors within the individual & neglecting environmental factors e.g. workplace.

* Some of the examples were interventions for those temporarily absent from work rather than out of work without an employment contract.

The medical model of disability asserts that the disabled person needs to be treated medically; the disability is located within the individual and the social consequences emerge from functional or psychological limitations (Albrecht *et al.*, 2001). In contrast, the social model takes account of individuals' social environment and suggests that it is the environment that is disabling, placing disability as a problem of the context rather than the individual. It asserts that people experience physical or mental impairment because of a medical condition, but experience disability when they are excluded from society, and the experience of disability is what leads to being disabled (Oliver, 1990).

Behaviour change is another dimension of disability that has been tackled in some return-to-work interventions. Such interventions draw on psychosocial models of disability. Although psychosocial models go further than biomedical models—in that they see return to work as a more complex phenomenon—as with the biomedical model there is still an over-reliance on locating the disability within the individual, meaning these interventions largely target the psychological rather than psychosocial.

In theory, the biopshychosocial model appears to overcome the criticisms of the biomedical, psychosocial, and social models because it considers each domain and interactions between them. However, there is widespread criticism from disability activists about the way the biopsychosocial model has developed within government reform of health-related welfare benefits. Proponents of the social model of disability have argued that the biopsychosocial model has been adopted by the DWP as a behavioural model, entirely unconnected to the social model, whereby beliefs and attitudes are emphasised as the dimension that requires change (Morris, 2011; Rutherford and Davison, 2012). Despite criticisms of its application, the idea behind the biopsychosocial model is useful when considering the multitude of barriers that people may face. There are various accounts of biopsychosocial models, each slightly different, with no single model yet developed as standard (Schultz *et al.*, 2007). One example of a biopsychosocial model of disability is Verbrugge and Jette's (1994) 'disablement process'. Three areas are highlighted as leading to disability:

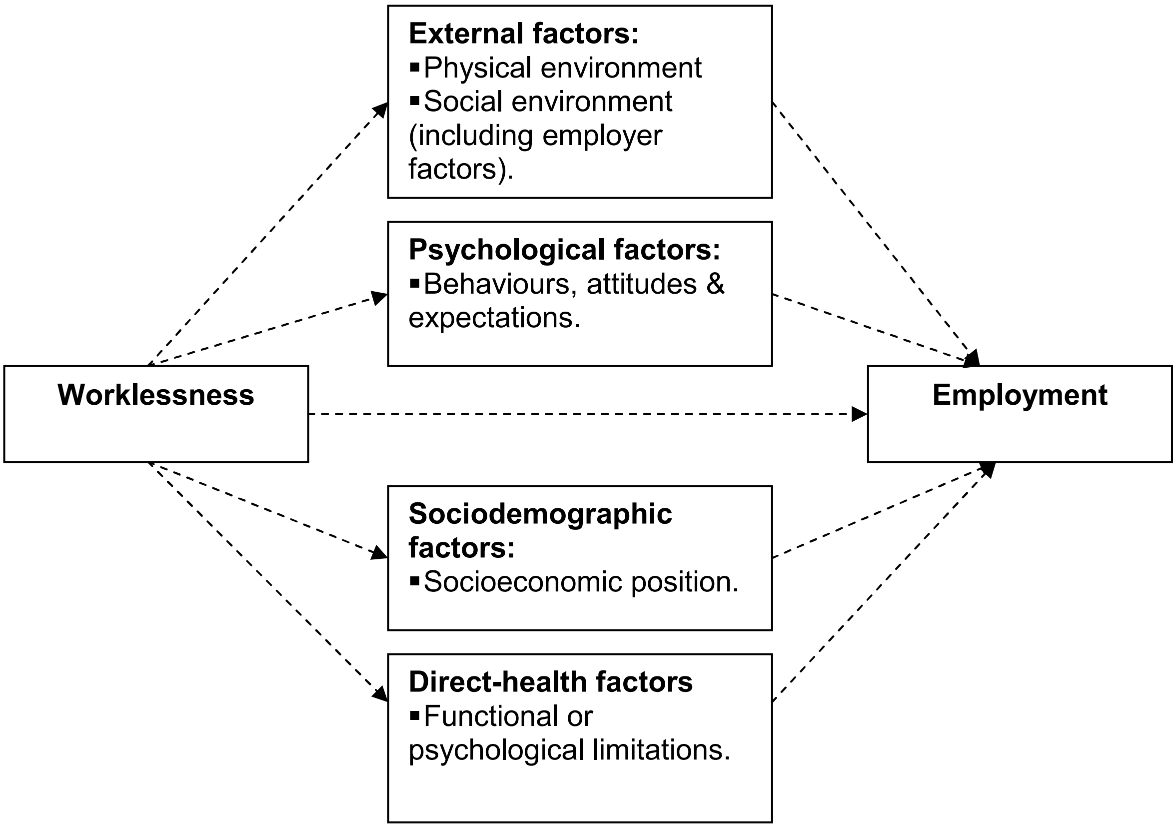
Risk factors: those present prior to the 'disabling event' e.g. socioeconomic position and biological factors.

Intra-individual factors: those that function within the individual e.g. health behaviours and attitudes.

Extra-individual factors: contextual factors that operate outwith the individual e.g. the physical and social environment.

The identification of these factors builds upon Nagi's (1965) influential disablement model, further detailing the role of the physical and social environment, and adding intra-individual factors. The disablement process also extends Nagi's model to view disablement as a changeable rather than a static condition, reflecting that it can fluctuate across the life course. Using the literature, factors from the 'disablement process', and the key aspects of each of the models of disability, Figure 2-2 shows a framework of return to work highlighting each of the domains that have potential to impact on an employment outcome for disabled people.

Figure 2-2: Conceptual model of factors that may be important for a transition from worklessness to employment



The following section reviews previous research that has analysed the worklessness to employment pathway, showing the evidence for the significance of factors in each domain of the model illustrated in Figure 2-2.

2.3.2 Evidence for factors that predict return to work for those out of work because of ill health

It has been observed that there is little information on return-to-work outcomes for those who are out of work because of ill health or disability and do not have an employment contract (Audhoe *et al.*, 2012; Vermeulen *et al.*, 2009). This section reviews the available literature that does analyse factors associated with return to work for this group. Evidence is drawn from studies that sample benefit recipients but also those including samples of people who self-classify as being out of work because of ill health, a health condition, injury or disability. For ease of exposition, this distinction will not be made again throughout the thesis; people are described as being 'out of work because of ill health' (OWIH), unless discussing a particular benefit receipt.

It is recognised that there is a wider literature on return to work for those on sickness absence from work. Primary research has been evaluated in a number of systematic reviews (Blank *et al.*, 2008; Cornelius *et al.*, 2011; de Croon *et al.*, 2004; Dekkers-Sánchez *et al.*, 2008; Fadyl and McPherson, 2008; Franche *et al.*, 2005; Iles *et al.*, 2008; Steenstra *et al.*, 2005). However, this is not drawn upon here because participants in these studies retain an employment contract while out of work, making the barriers to work different to those experienced by people who are OWIH.

To review the evidence on sociodemographic, health, and psychological factors, studies were included if they provided individual-level information on transitions from OWIH to employment. Criteria for reviewing studies are shown in Table 2-2.

Table 2-2: Criteria for including studies in literature review

INCLUSION	EXCLUSION
Participants were out of work because of ill health (OWIH)–either in receipt of out-of-work disability benefits or self-identified as OWIH.	Participants had an employment contract, or were unemployed rather than OWIH participants.
Studies included individual-level follow-up for employment outcome.	Where the outcome was stopping benefit receipt rather than moving into employment.
Studies provided information on factors that predict return to work.	Population studies that gave employment rates over time rather than outcomes of individual transitions from OWIH to employment.
	Evaluations that did not provide multivariate analysis to give evidence on predictors of return to work other than the intervention.

A wider literature was drawn on to look at external factors. National return-to-work interventions are part of welfare reform in the UK and as such can be thought of as a factor related to macro-level context in the return-to-work process. A series of systematic reviews brought together evidence regarding the effectiveness of return-to-work interventions and evidence from these is considered in the section on external factors (Bambra *et al.*, 2005; Clayton *et al.*, 2011a; Clayton *et al.*, 2011b). Specific evaluations included in these systematic reviews and those published since are also included in the other sections where they provide information on other predictive factors of return to work from multivariate analysis.

2.3.2.1 Return to work for those out of work because of ill health

Nine studies were identified that focus on return to work for those OWIH, they are summarised in Table 2-3. Two studies collected baseline and follow-up data from a cohort of benefit recipients (Audhoe *et al.*, 2012; Kemp and Davidson, 2010), two studies used longitudinal analysis of existing records or data (Magnussen *et al.*, 2009; Popham and Bambra, 2008), and five included cross-sectional analysis of surveys with cohorts of participants OWIH and retrospective data on demographics and length of time OWIH (Bailey *et al.*, 2007; Hales *et al.*, 2008; Hayllar *et al.*, 2010; Sejersen *et al.*, 2009; Vermeulen *et al.*, 2009). Four studies were evaluations of the roll-out of the national (UK) mandatory return-to-work intervention Pathways to Work (PTW) (Bailey *et al.*, 2007; Hales *et al.*, 2008; Hayllar *et al.*, 2010; Sejersen *et al.*, 2009). PTW encompasses a series of different interventions e.g. mandatory work-focused interviews, condition management (using cognitive behavioural therapy), return-to-work credit (£40 per week for the first year in work), and a range of other interventions termed the ‘Choices package’. Some aspects of PTW are mandatory, but the level of engagement varies. All evaluations of PTW reviewed in this section included a control group that did not engage with PTW.

Across the studies considered, the proportion of those who returned to work ranged from 1.6% to 35%. There appears to be a relationship between the length of time spent OWIH and the return to work: the highest proportions of return to work (18-35%) came from the studies that included those who had been OWIH for fewer than 18 months (Audhoe *et al.*, 2012; Bailey *et al.*, 2007; Hayllar *et al.*, 2010; Kemp and Davidson, 2010; Vermeulen *et al.*, 2009). Those with participants OWIH more than two years reported return-to-work rates of 1.6-9%. Other factors were also associated with the proportion of those who returned to work e.g. intervention effects, different samples in terms of health conditions, benefit receipt etc. These predictors of return to work are considered in the following sections. It should be kept in mind in the following sections that the variation in effect sizes across studies is likely to be related to the heterogeneity of studies, highlighted in Table 2-3, e.g. different countries (and therefore benefit systems), study populations were sampled at different stages of their period out of work, there were different follow-up periods, and different study-design and analysis features. Dichotomisation of the return-to-work outcome is simplistic, and does not take account of the fact that risk factors for remaining out of work may differ in the first three months of worklessness to risk factors for people who, for example, have been workless for over a year. In saying that, these studies provide the available evidence for the population of interest and they do give some information as to what is associated with a positive return-to-work outcome.

Many of the factors from the four domains illustrated in the conceptual model in the previous section were included in the studies to determine important indicators of return to work for those OWIH. The following sections review the factors, organised by the four categories set out in the conceptual model: sociodemographic, health, psychological, and external. Magnussen *et al.*’s (2009) study is not used in the following sections as so few of the sample returned to work that predictors of return to work could not be determined.

Table 2-3: Studies looking at return to work (RTW) outcomes for those out of work because of ill health who do not have an employment contract

First author, country	Study design & source of data	Initial n (RR: response rate)	Follow-up n (response rate)	Length of time between start of period out of work because of ill health & follow-up	Proportion RTW at follow-up	Comments
Kemp (2010), UK	National administrative data. Sample: nationally representative sample of new Incapacity Benefit (IB) claims identified (n=3291). Data: two-stage face-to-face survey.	1843 (56% RR).	801 (43.5%) 6 months after initial data point.	1 year	26%	Includes a representative sample of new IB claimants & considers the role of various factors in RTW. However, does not include prior health as a predictor of RTW (presumably because the only measure is presence of a health condition & 96% report having a health condition at baseline). Excludes those who describe themselves as permanently out of work because of ill health (OWIH), therefore the proportion RTW is likely to be higher than that of all new IB claimants. The sample size for multivariate analyses was not given.
Audhoe (2012), The Netherlands	National administrative data. Sample: all those sick-listed with psychological problems without an employment contract prior to their sick listing. Data: three-stage postal survey.	932 (part of a larger study with RR 42%).	476 (51%) 8 months after initial data point.	18 months	18%	It is not clear whether RTW as the dependent variable includes those who had the ability to RTW & were not sick-listed anymore (i.e. had not RTW because there was no employer available) or if it only included those who had actually RTW. There was further analysis between 18 & 27 months but this included employed at 18 months as a predictor; it would have been interesting to see results of analysis with the group who were still out of work at 18 months separately.

First author, country	Study design & source of data	Initial n (RR: response rate)	Follow-up n (response rate)	Length of time between start of period out of work because of ill health & follow-up	Proportion RTW at follow-up	Comments
Magnussen (2009), Norway	National administrative data. Sample: all aged <55 who had been on Disability Pension for >1 year because of a musculoskeletal disorder. Data: longitudinal analysis of registry data.	899	887 1 year after initial data point; 877 3 years after initial data.	Mean time ~10 years.	1.6%	Few variables could be tested as predictors of RTW as only registry data were used. However, so few returned to work that it would not have been possible for reliable statistical analysis into predictors of RTW anyway (although the fact that so few returned to work is a finding in itself).
Vermeulen, (2009), The Netherlands	National administrative data. Sample: random sample of those without an employment contract who had been sick-listed >13 weeks. Excluded full Disability Pensioners. Data: admin records at baseline & follow-up postal questionnaire.	3,500	1,179 (34% RR) 4-6 months after initial data point.	7-9 months	19%.	No further information on demographics (treated as confounders only) as the main aim of the study was to analyse whether participation in RTW interventions was associated with RTW. Baseline data were only demographic information.
Popham (2008), Scotland	Scottish Longitudinal Study (representative sample of Scottish population). Sample: all aged 25-49 who reported that they were economically inactive because of ill health in 1991. Data: longitudinal record linkage.	3,748	2,774 (74%) 10 years after initial data point.	N/A	12.9%	Provides information on a representative sample of the population. However, only looked at sociodemographic characteristics' associations with RTW. There was information on presence of health condition, but this was not analysed as a predictor of RTW, presumably because the entire baseline sample had a health condition.

First author, country	Study design & source of data	Initial n (RR: response rate)	Follow-up n (response rate)	Length of time between start of period out of work because of ill health & follow-up	Proportion RTW at follow-up	Comments
Hales (2008), UK	National administrative data. Sample: random sample of IB recipients living in Pathways to Work (PTW) pilot areas & called to PTW. Data: admin records initially & follow-up face-to-face survey.	4,246	2207 (52%)	2-5 years	9%	Only retrospective information on health. No odds ratios were reported. The aim of the research was to analyse the impact of PTW interventions but this was difficult to assess because of the selection to the interventions in the first place.
Bailey (2007), UK	National administrative data. Sample: IB recipients living in PTW pilot areas–random sample of those who had taken up some of the intervention, plus a matched sample of those who had not & a random sample of those who had not. Data: admin records initially & follow-up face-to-face survey.	6,785	3507 (52%)	~14 months	35%	As above.
Sejersen (2009), UK	National administrative data. Sample: Random sample of IB recipients living in a PTW pilot area & had been called to attend PTW. Data: admin records initially & face-to-face survey.	3,657	1,692 (46%)	5-10 years	6%	As above.
Hayllar (2010), UK	National administrative data. Sample: Random sample of IB recipients living in PTW expansion area & called to attend PTW. Data: admin records initially & follow-up face-to-face survey.	5,361	2679 (50%)	~13 months	26%	As above.

2.3.2.2 Sociodemographic factors

Using the studies identified in the previous section, Table 2-4 details the sociodemographic factors that were included in multivariate analyses of return-to-work outcomes for those OWIH.

Those over age ~50 were found to have lower odds of return to work than younger age groups. However, in studies that categorised rather than dichotomised age the middle-age group (around 30-50) had highest odds of return to work rather than the youngest.

Gender has usually not been found to be predictive of return to work for those OWIH; it was only significantly associated with return to work in one of the studies. In that study a higher proportion of women said they were not looking for work (52% compared to 40% of males). It is possible that gender is associated with looking for work rather than acting as a barrier to work in itself. However, although Kemp and Davidson (2010) did not report whether gender was significant in predicting return to work they showed findings separately for males and females and found different factors to be important. It is possible that different factors interact differently with the return-to-work process for males and females. For example, marital status was found to be significant for both, but females had higher odds of return to work if they were single (rather than in a couple or a lone parent), whereas males had higher odds of return to work if they were in a couple. The fact that a higher proportion of females than males are lone parents is likely to have an impact on this relationship.

Ethnicity was only significantly associated with return to work in one of the six studies that included it. In this study 95% of participants described themselves as white and specific numbers of different ethnic groups returning to work, odds ratios and confidence intervals were not provided, making it difficult to appraise this result.

Socioeconomic position is an important factor and has been measured by education, housing tenure, car ownership, driving licence, and occupational social class. Most of the studies that included at least one measure found that lower socioeconomic position was associated with lower odds of return to work (and none found an association between any of the measures of socioeconomic position and employment in the opposite direction). Popham and Bambra (2008) included measures of socioeconomic position in separate models (adjusted for other demographics) and found all were significant. Other studies adjusted for multiple measures of socioeconomic position in the same model. It is therefore difficult to determine whether one particular measure of socioeconomic position is more important for transitions from OWIH to employment.

Employment history was included in analysis models in two of the studies and both found that steady employment before the period OWIH was associated with higher odds of return to work (Bailey *et al.*, 2007; Kemp and Davidson, 2010). In another study, when analysis was restricted to those who had worked in the ten years prior to the initial data point, a higher proportion had returned to work at follow-up (19%) than the full sample (13%) (Popham and Bambra, 2008). Previous employment is an important predictor of return to work for those OWIH.

In summary, sociodemographic factors consistently shown to be significant predictors of return to work for those OWIH were age, socioeconomic position, and prior employment. However, it is unclear how best to measure socioeconomic position for return-to-work analysis. The relationship between gender and return to work—or between gender and other factors that are important for return to work—is also unclear. Again, it should be kept in mind that the variability in the effect sizes presented in Table 2-4 are likely to be partly related to the heterogeneity of the individual studies.

Table 2-4: Evidence on individual factors and their association with return to work (RTW)

Barriers to work	Evidence from: Study author (year)	Multivariate results: RTW (reference category)	Odds Ratio[+]
Age	Kemp (2010) males	>55 (16-24)	0.10*
	Kemp (2010) females	Age categories	0.61-1.86 (ns)
	Audhoe (2012)	<45 (>45) [++]	2.5*
	Vermeulen (2009)	>55 (categories <55)	<1*
	Popham (2008)	Age categories >29 (25-29)	0.27-0.75*
	Sejersen (2009)	>55 (<55)	<1*
	Hales (2008)	18-30 or >54 (30-54).	<1*
	Bailey (2007)	18-30 or >54 (30-54).	<1*
	Hayllar (2010)	18-25 or >49 (25-49)	<1*
Gender	Audhoe (2012)	Male (female)	ns
	Vermeulen (2009)	“	ns
	Popham (2008)	“	1.09 (ns)
	Hales (2008)	“	ns
	Bailey (2007)	“	>1*
	Sejersen (2009)	“	ns
	Hayllar (2010)	“	ns
Ethnicity	Kemp (2010) m/f	Other ethnic backgrounds (white)	1.22/0.81 (ns)
	Hayllar (2010)	“	ns
	Hales (2008)	“	ns
	Bailey (2007)	“	ns
	Sejersen (2009)	“	<1*
	Audhoe (2012)	Native Dutch (non native)	ns
Marital/household status	Kemp (2010) males	In a couple or lone parents (single)	4.73 - 10.24*
	Kemp (2010) females	In a couple or lone parents (single)	0.21-0.77*
	Audhoe (2012)	With partner (single)	ns
	Hales (2008)	With partner (single)	>1*
	Bailey (2007)	With partner (single)	>1*
	Hayllar (2010)	With partner (single)	>1*
Housing tenure	Kemp (2010) males	Social housing tenants (non social housing tenants)	0.42*
	Kemp (2010) females	Social housing tenants (non social housing tenants)	0.46 (ns)
	Popham (2008)	Social renters (owner occupiers).	0.55*
	Bailey (2007)	Renters (home owners)	<1*
	Hayllar (2010)	Private renting (ref not given)	>1*
Education: qualifications	Popham (2008)	Low (high)	0.59*
	Vermeulen (2009)	Low, average (high)	ns
	Audhoe (2012)	Low (high)	ns
	Sejersen (2009)	Low (high)	<1
	Hales (2008)	No qualifications (qualifications)	<1
	Hayllar (2010)	No qualifications (qualifications)	<1*
	Kemp (2010)	No qualifications (qualifications)	ns
Education: Basic skills	Kemp (2010) m/f	Basic skill problems (no problems)	0.83/3.74 (ns)
	Hales (2008)	Basic skill problems (no problems)	<1*
	Sejersen (2009)	Basic skill problems (no problems)	ns
Driving licence	Kemp (2010) males	Drivers (non drivers)	2.57*
	Kemp (2010) females	Drivers (non drivers)	2.69*
Car ownership	Popham (2008)	Car ownership (no car ownership)	1.92*

Barriers to work	Evidence from: Study author (year)	Multivariate results: RTW (reference category)	Odds Ratio[+]
Previous employment	Kemp (2010) males	Most of adult life spent in steady jobs (most not spent in steady jobs).	3.13*
	Kemp (2010) females	Most of adult life spent in steady jobs (most not spent in steady jobs).	0.72 (ns)
	Bailey (2007)	Significant work 2 years prior to OWIH (not significant work)	>1*
	Popham (2008)	Manual / not worked in 10 years (non-manual).	0.78/0.27*

+ Specific ORs were not reported in all studies, therefore <1 or >1 is given to reflect where authors reported a significant association & ns is used where they reported that there was no significant relationship. * Statistically significant (p<0.05). ++ Only significant between 18 & 27 months, not at first follow-up.

2.3.2.3 Health factors

Measures of health included self-rated health, limitation of daily activities, and type of condition (Table 2-5). All of the studies that included a measure of health reported that it was either strongly associated with or was the most important predictor of return to work (Audhoe *et al.*, 2012; Bailey *et al.*, 2007; Hales *et al.*, 2008; Hayllar *et al.*, 2010; Kemp and Davidson, 2010; Sejersen *et al.*, 2009; Vermeulen *et al.*, 2009). However, only one study had available data to also include a measure of health to control for starting position (Audhoe *et al.*, 2012).

Table 2-5: Evidence on health factors and their association with return to work (RTW)

Barriers to work	Analysis from studies: First author (year)	Multivariate results: RTW (reference category)	Odds Ratio^{+}
Self-rated health	Hales (2008)	Improving health trajectory (not improving)	>1*
	Bailey (2007)	Improving health trajectory (not improving)	>1*
	Sejersen (2009)	Improving health trajectory (not improving)	>1*
	Audhoe (2012)	Moderate/good (poor)	4.2*
	Vermeulen (2009)	Good (bad)	>1*
	Hayllar (2010)	Improving health trajectory (declining)	>1*
		Not limited in daily activities (limited in daily activities)	>1*
	Kemp (2010)	No health condition at follow-up (health condition at follow-up) males/females	3.06*/ 4.98*
Type of condition	Sejersen (2009)	No mental health condition (has mental health conditions)	>1*
	Bailey (2007)	No mental health condition (has mental health condition)	>1*
	Hayllar (2010)	No mental health condition (has mental health condition)	>1*
	Hales (2008)	No mental health condition (has mental health condition)	ns
	Sejersen (2009)	Having learning difficulties (no learning difficulties)	<1*
	Bailey (2007)	Having learning difficulties (no learning difficulties)	>1*
	Hayllar (2010)	Having learning difficulties (no learning difficulties)	ns

+ Specific ORs were not reported in all studies, therefore <1 or >1 is given to reflect where authors reported a significant association & ns is used where they reported that there was no significant relationship. * Statistically significant ($p<0.05$).

There were some conflicting findings about the presence of learning difficulties. Small numbers of participants with learning difficulties in all three studies, as well as a lack of odds ratios, make the differences in results difficult to interpret.

Three of the studies that explored type of health condition found that those with mental health conditions had significantly lower odds of return to work than those without (Bailey *et al.*, 2007; Hayllar *et al.*, 2010; Sejersen *et al.*, 2009). The fourth study that included presence of a mental health condition in the analysis model found that it was not significantly associated with return to work (Hales *et al.*, 2008). It is not clear why this study had a different finding as the four studies were similar in design and use of covariates. This study showed that participants with mental health conditions were younger than those without. The authors therefore went on to explore employment outcomes by age for those with and without a mental health condition. It was found that in the under-50 age group a lower proportion of those with a mental health condition were in work (6-8%) than those without a mental health condition (12-

14%). It is possible that there is a condition type and age interaction, but this was not included in multivariate models. One possibility relates to the change in prevalence from musculoskeletal health to mental health as reasons for being out of work. It is likely that the prevalence of musculoskeletal conditions was higher in the older group than the younger group, and the prevalence of mental health was higher in the younger group than the older group.

Comparative analysis of those with mental health conditions and those without showed that there were differences in relation to sociodemographic factors e.g. people with mental health conditions were less likely to own their own homes and more likely to live alone and report having 'personal troubles' (Sejersen *et al.*, 2009). Also, people with mental health conditions were more likely to describe their health as changeable and report that they were lacking in confidence (63% compared to 9% of those without mental health conditions). However, when all of these factors were tested in multivariate models, mental health remained significantly associated with return to work, therefore it is possible that other factors were involved (Sejersen *et al.*, 2009).

In summary, health is an important factor for return to work for those OWIH. Lack of information on health beyond self-rated health hinders further conclusions, but there is some indication that those with a mental health condition are disadvantaged in terms of a positive employment outcome.

2.3.2.4 Psychological factors

Psychological factors included in analyses of return-to-work outcomes are shown in Table 2-6.

Table 2-6: Evidence on psychosocial factors and their association with return to work (RTW)

Barriers to work	**Analysis from studies: First author (year)**	**Multivariate results: RTW (reference category)**	**Odds Ratio+**
RTW expectation	Audhoe (2012)	Positive expectation (negative expectation).	1.7*
Work commitment	Kemp (2010)	Attitudes to paid work: high/medium/low	ns

+ Specific ORs were not reported in all studies, therefore <1 or >1 is given to reflect where authors reported a significant association & ns is used where they reported that there was no significant relationship. * Statistically significant ($p<0.05$).

Return-to-work expectation at baseline was found to be a significant predictor of employment at follow-up (eight months later) in one study (Audhoe *et al.*, 2012). Kemp and Davidson (2010) also asked ‘potential workers’ (those who did not describe themselves as employed or permanently OWIH) about their expectations for return to work (not in table). They found no significant difference in initial return-to-work expectation between those who were in work and not in work at follow-up. However, it is not clear whether this analysis controlled for other sociodemographic factors or not. Perhaps if the analysis had included those who described themselves as permanently OWIH at baseline, return-to-work expectation would have been significant, as found in Audhoe *et al.* (2012).

Kemp and Davidson (2010) also found that there were no significant differences between those who they termed ‘potential workers’ and those who were employed at follow-up on their work commitment. Work-commitment was assessed based on questions related to attitude to work. Those who described themselves as permanently OWIH were not included in this analysis, but it may have been interesting to compare the work commitment of all three groups.

Return-to-work expectation and commitment to work are different constructs. Commitment to work was based on a general attitude towards employment rather than rooted in participants’ expectations for their own return to work. Return-to-work expectation is specifically about each participant’s feelings about their own return to work. In answering whether they expect to return to work participants may weigh up all of the factors that they believe will act as barriers or facilitators to their doing so. In contrast, work commitment may reflect how participants feel about work outwith the context of their own situation, which may be one reason for the different results.

All of the DWP evaluations of PTW (national intervention) asked participants what their biggest barriers to work were (Bailey *et al.*, 2007; Hales *et al.*, 2008; Hayllar *et al.*, 2010; Sejersen *et al.*, 2009). Although the most frequently cited barrier was health (70-88%), around 40% of participants cited lack of confidence and around 20% said they were not motivated to work. Since these studies did not collect information from participants for the initial data point they only had data on these barriers to work at one point in time, the same point in time as the employment outcome was taken. Lack of confidence and motivation were not included in these multivariate models owing to issues with the study design surrounding temporality i.e. it would not be possible to tell whether confidence or motivation came before or after return to work. It is therefore difficult to assess, from these studies, whether confidence and motivation are factors related to employment outcome in their own right or whether they are associated with other factors e.g. people may lack motivation to work because they believe they would be worse off financially or because they do not think it would be good for their health, and people may lack confidence because they do not think that they would be able to get a job because of their health, age etc.

In summary, the role of psychological factors in return to work is difficult to determine. Further research is required to ascertain whether positive or negative attitudes precede or follow return to work. The two studies that included psychological factors in multivariate models had different findings, in that one found psychological factors to be significantly associated with return to work and the other did not. However, as discussed, the psychological indicators were also quite different. Additionally, other aspects of the two studies differed. The most important difference to point out is that that one of the studies included benefit recipients generally (Kemp & Davidson, 2010) and the other included those receiving OWIH benefits specifically for psychological conditions (Audhoe *et al.*, 2012). Therefore, it is not really possible to say whether psychological factors, independent of health conditions, are significantly associated with return to work for those OWIH.

2.3.2.5 External factors

This section moves from considering return-to-work barriers related to the individual to looking at wider-level factors that may be associated with return to work. In the studies used in the previous sections external factors included in the analysis of return-to-work outcomes were area of deprivation, whether the area had a high level of unemployment, and the Jobcentre Plus (JCP) area (Table 2-7). JCP is a public employment service that is part of the DWP; it provides services nationally that aim to support people from welfare to work.

Where there was an association between area of deprivation and employment outcome it was that residence in more deprived areas was associated with lower odds of return to work than residence in less deprived areas (Table 2-7). However, this was not a consistent finding across studies as some found no association between area of deprivation and return to work. Area of deprivation can be seen as a measure of individual socioeconomic position as well as a marker of employment opportunities in the area. All of these studies included other measures of socioeconomic position (discussed in sociodemographic section above) so it is possible that lack of association between area of deprivation and return to work was related to associations with other variables in the model e.g. housing tenure and JCP area.

Table 2-7: Evidence on external factors and their association with return to work (RTW)

Barriers to work	Analysis from studies: First author (year)	Multivariate results: RTW (reference category)	Odds Ratio^{+}
Area	Kemp (2010) males	High unemployment area (low unemployment area)	0.46*
	Kemp (2010) females	High unemployment area (low unemployment area)	2.15 (ns)
	Hales (2008)	Area of deprivation	ns
	Bailey (2007)	Area of deprivation	ns
	Hayllar (2010)	More deprived areas (less deprived areas)	<1*
	Hayllar (2010)	Certain Jobcentre Plus areas	<1*
	Sejersen (2009)	Certain Jobcentre Plus areas	ns
	Bailey (2007)	Certain Jobcentre Plus areas	<1*
	Hales (2008)	Certain Jobcentre Plus areas	<1*

+ Specific ORs were not reported in all studies, therefore <1 or >1 is given to reflect where authors reported a significant association & ns is used where they reported that there was no significant relationship. * Statistically significant (p<0.05).

Other examples of external factors relate to employer attitudes, suitable employment, and ergonomic environment (not shown in table). Kemp and Davidson’s (2010) survey asked participants who were employed at follow-up about whether they were offered workplace adjustments. Workplace adjustments, such as number and flexibility of hours, were reported by 37 (25%) of those employed at follow-up. Of those who had experienced a workplace adjustment, nine out of 10 said it had helped them to keep their employment. However, the authors noted that the sample size was too small for further analysis to determine whether workplace adjustment was a statistically significant factor for initial return to work.

Another external factor is availability of support to return to work. Although many national interventions provide individual-level support i.e. those stimulating the supply of labour, such as improving the confidence, providing training etc. such interventions can be thought of as being part of the external factors as they relate to the welfare system, led by national government. Participation in return-to-work interventions was included in some of the studies looking at employment outcomes. Return-to-work interventions have not been included in Table 2-7 because there were numerous interventions that concentrated on different aspects of support e.g. condition management, job search support etc. There were therefore different findings regarding whether return-to-work interventions were important for employment outcomes. In some cases participation in interventions was associated with lower odds of return to work e.g. those who attended the Condition Management Programme and those who attended work-focused interviews (Bailey *et al.*, 2007). This was perhaps because of selection to certain interventions for some groups i.e. those with lower likelihood of return to work in the first place (Vermeulen *et al.*, 2009). It was difficult to tease out what aspects of the interventions were related to positive return-to-work outcomes independent of other factors.

Some of the studies asked participants about their barriers to return to work. External barriers were identified in all of these studies. For example, participants were concerned about other people's attitudes to their health condition (29-35% cited this as a major barrier to work), difficulty with accessibility and transport to work (21-28% cited journey to work as a major barrier), few job opportunities in the area (20-42%), and that they may not be financially better off in work (14-23%) (Bailey *et al.*, 2007; Hales *et al.*, 2008; Hayllar *et al.*, 2010; Kemp and Davidson, 2010; Sejersen *et al.*, 2009). Responses to the questions on barriers to work could not be compared by employment outcome in any of the studies because they were asked at the same time that employment outcome was recorded. However, even if it was possible to analyse perceptions of barriers as predictors of return to work this would not tell us whether they were barriers to work in the sense that the perceptions were realised or whether they were barriers to work because they affected participants' attitudes or confidence about return to work. One way of exploring external barriers to work is to look at return-to-work evidence from evaluations of interventions that focus on the demand side of employment rather than the supply side.

Three comprehensive systematic reviews provide more information about return-to-work interventions and associated employment outcomes (detailed in Table 2-8). These reviews were linked; the first covered publications in the period 1990-2002 (Bambra *et al.*, 2005) and the second two 2002-2007 (Clayton *et al.*, 2011a; Clayton *et al.*, 2011b), and aimed to answer the question ‘does welfare to work work?’ in terms of employment outcomes. The reviews from 2002-2007 were split into two publications: one focusing on interventions aimed at the individual and the other on interventions aimed at the employer.

Evaluations have shown that there are potentially positive employment outcomes of individual-focused support e.g. education, vocational advice, work placement (Bambra, 2005), personal advice, and financial incentives (Clayton, 2011a). Likewise, Clayton *et al*’s (2011b) systematic review on effectiveness of employer-focused interventions for return to work for those OWIH has shown that some interventions e.g. workplace adjustments, wage subsidies, and involving employers in return-to-work planning may be promising for employment outcomes. However, authors of the systematic reviews reported that it was difficult to determine whether positive employment outcomes from interventions were down to aspects of the interventions or to characteristics of those participating in them and/or to do with labour-market context at the time. This arose from the inability to control for potentially confounding factors (Bambra *et al.* 2005, Clayton *et al.* 2011a, Clayton *et al.* 2011b).

Table 2-8: Details of systematic reviews of evidence on effectiveness of return to work (RTW) outcomes for those out of work because of ill health

First author (year)	Focus	Inclusion/ exclusion criteria	N & details of included studies	Details of intervention/policies evaluated	Summary of findings
Bambra (2005)	Employment outcomes from evaluations of interventions which aim to support people with disability/chronic illness into work.	UK Government initiatives only, 1990-2001. Quantitative & qualitative studies. Must include an employment outcome.	16: 11 quantitative; 5 qualitative. Observational quantitative studies included a range of sample sizes: two were small scale (n=68 & 150) & the other 10 had 492-2823 participants. All judged to have adequate sample size but 3 did not give response rates & only 2 were controlled.	- Education, training & work placement -Vocational advice & support - In-work benefits - Employer incentives - Accessibility interventions.	11-50% moved into employment – but this was dependent on 'job readiness' in the 1st place & there was evidence of selection bias to interventions. Main conclusion is that there is a dearth of evidence.
Clayton (2011a)	Evaluations of the effectiveness of national UK Government interventions aimed at individuals out of work receiving sickness benefits, to support them into employment.	UK national level government interventions, 2002-2007. Quantitative & qualitative studies. Must include & employment outcome.	31 (27 evaluated 3 national programmes). Mainly qualitative studies. Quantitative studies: 4 controlled cohorts (samples >4783); 2 uncontrolled cohorts (samples >1435); 2 repeat cross-sectional (samples>3452).	- Individualised case management & job search assistance - Financial incentives/ disincentives - Education, training & work trial - Condition management.	An individual approach can work, but there was evidence of selection into these programmes by the most work ready. Dearth of high-quality studies.
Clayton (2011b)	Evaluations of the effectiveness of governmental policies aiming to change the behaviour of employers to support chronically ill or disabled people into employment.	Evaluations of government interventions from Canada, Denmark, Norway, Sweden & the UK, 1990 & 2008.	30: Qualitative (focus groups, interviews & observations) & quantitative studies (8 uncontrolled cross-sectional; 3 case control (two with small sample sizes n=59 & 78); 2 econometric analyses; one randomised controlled trial).	- Anti-discrimination legislation - Workplace adjustments - Financial incentives for employers - Engaging employers in RTW plans.	No impact of population-level effect on employment rates after legislation had been introduced. Concerns about differential take up of other policies—the more advantaged in the first place are more likely to benefit.

In summary, ‘external factors’ covers a wide range of variables e.g. local employment opportunities, employer attitudes, workplace adjustments, accessibility, health and return-to-work services, welfare policies etc. How those OWIH view these factors is also likely to have an impact upon their motivation and expectation for return to work. Although there are promising results from some interventions, the main conclusion of the systematic reviews analysing effectiveness of return-to-work interventions was a lack of good quality evidence. There therefore remains a level of uncertainty regarding the impact of such interventions and which aspects of them are likely to benefit those OWIH.

2.3.3 Evidence from population studies

Factors related to changes in the labour market, welfare policy, and population health may also be associated with return to work for those OWIH. Research that explores these factors does not usually show individual-level predictors of return to work, but provides evidence of how they associate with employment and benefit-receipt rates.

2.3.3.1 Macro-context: welfare benefits (external factor)

Welfare policies, such as changes to eligibility requirements of OWIH welfare benefits and the generosity of OWIH benefits in five OECD countries, were systematically reviewed by Barr *et al.*(2010). Sixteen empirical studies from 1990-2009 were reviewed. There was a lack of evidence regarding whether changes to eligibility rules had an effect on employment outcome. Generosity was shown to be negatively associated with employment, although there was concern about the quality of the studies.

2.3.3.2 Macro-context: labour-market demand (external factor)

Studies looking at trends in rates of IB over time have related rises and falls to macro-level influences e.g. recession and deindustrialisation (Holland *et al.*, 2011a), labour market policies (Holland *et al.*, 2011b), and labour market trends more generally (series of studies by Beatty *et al.* and Webster *et al.*, 2010). Beatty *et al.*’s (2000) influential theory on hidden unemployment suggests that the rise in IB claims from the early 1980s to late 1990s represented a rise in the rate of unemployment, which was disguised as sickness absence i.e. in the weakened labour market in the 1980s those with health problems or disabilities who lost their jobs were eligible to move on to sickness benefit. The incentive to claim sickness benefit rather than unemployment benefits was that it was paid at a higher rate (Beatty and Fothergill, 2005). The part of the hidden unemployment theory most relevant to return to work, is the explanation of the "queue for jobs" (Beatty *et al.*, 2000, p. 621). IB recipients are seldom in the best position to get a job when in competition with unemployed people or others looking for work; they "are generally towards the back of the 'jobs queue'" because of poor health, but also because of lack of recent work history, lower qualifications, and not being of 'prime working age' (Beatty *et al.*, 2010, p. 145). Beatty *et al.* have researched this extensively with a series of quantitative and qualitative studies and have shown the existence of hidden unemployment with studies throughout the UK (e.g. Beatty and Fothergill, 2002, 2004, 2005, 2007; Beatty *et al.* 2010). Drawing on data from different countries over time, Benitez-Silva *et al.* (2010) found that both regions and times of high unemployment had higher OWIH benefit receipt and lower off-flow from it. Webster *et al.*'s (2010) research demonstrates evidence for hidden unemployment in Glasgow.

There is strong evidence that the number OWIH is higher in areas with, and at periods of, high unemployment. This shows that labour-market context plays a role in employment of those with health conditions or disabilities and is likely to have an impact on individual return to work for those OWIH. However, this does not suggest that those who are capable of work do not have health conditions that stopped them working in the first place. Rather that there are barriers to work beyond health conditions or disabilities that preclude employment for those OWIH, many of which cannot be overcome by the individuals themselves.

2.3.3.3 Health

Owing to the increase in the rates of people receiving IB/ESA there has been some debate about whether this can reflect any actual differences in health. Research has been conducted to explore whether claiming IB and/or ESA or being OWIH is in fact a measure of poor health.

Norman and Bambra (2007) compared administrative data on IB receipt as a measure of population health and compared this with 2001 census measures of health (limiting long-term illness, self-rated health, and economic activity ‘permanently sick or disabled’) at the local government district and sub-district levels. They found a high correlation between the two, suggesting that IB receipt is a good measure of health within areas. Similarly, Akinwale *et al.*(2010) looked at whether people who were economically inactive in the 2000s differed in health status to those economically inactive from the 1970s onwards. They found no evidence that those who were OWIH were any less sick in the 2000s than in previous decades.

Popham *et al.* (2012) explored differences in mortality outcomes between those employed, unemployed, and OWIH in a cohort of people followed up from 1987 (age 55) to 2012. Mortality was higher among those who were OWIH at baseline than those who were unemployed and employed, but differences in survival could mostly be explained by differences in health at baseline. This suggests that those OWIH had real health problems that resulted in significantly higher death rates by age 75.

Receiving IB/ESA is a marker of poor health, and those OWIH have poorer health than those in other employment statuses. Concentration on labour-market issues has the potential to overlook the health problems faced by those OWIH and the fact that there are associated issues for population health. This is in line with the research from individual studies that showed that an improvement in health may lead to return to work.

2.3.4 Summary: predictors of return to work and gaps for further study

The reviewed studies have given some information about the rate of return to work over time for those OWIH and of factors that play a role in whether people transit from OWIH to employment. However, there are some limitations regarding the evidence they provide about the important factors for transitions from being OWIH to employment.

The group of studies reviewed for return-to-work outcomes related to the sociodemographic, health, and psychological domains were limited in what they could conclude about factors that are important for return to work because many only had one data-collection point. Although some details from records and retrospective information were sought, some factors could not be included in analyses and many were limited in that they could only really give information on sociodemographic predictors of return to work. Therefore, none of the identified studies included factors from all four domains of the conceptual model in multivariate analyses of return-to-work outcomes. This is important because one factor may have been shown to be important because others had not been included. For example, confidence may be significantly associated with return to work, but once an analysis controlled for health and other individual and external factors, it may no longer be independently statistically significant. Confidence to return to work may be an independent indicator of return to work or it may reflect the fact that people with poor health, or people with poor work opportunities, have low confidence of return to work.

Longitudinal analysis to explore employment outcomes for those OWIH with the data to account for a range of differences between individuals and context would provide more evidence on the factors that are important for return to work. Additionally, psychological factors need to be considered in context and more in-depth research e.g. using qualitative methods may provide better evidence about why people OWIH lack confidence or motivation to return to work.

Additionally, the data for health were often crude, with all of the studies using a dichotomised measure of self-rated health and none using objective measures or validated scales for mental or physical health. Analysis of longitudinal data that can account for baseline measures of health is required. There was some indication that those with a mental health condition had poorer outcomes than those without; however, it is not clear why this was the case. Again qualitative methods may provide more in-depth information about why this occurs.

Research that has analysed the health, labour-market, and welfare-policy context provides further evidence that those OWIH have a health disadvantage and that macro-level factors related to labour-market trends and welfare benefits have an impact upon the rates of people OWIH in certain periods and places. Although these studies do not analyse individual return-to-work outcomes they provide further evidence that health and macro-level context are likely to create barriers to return to work for those OWIH.

The rest of the chapter turns to review the literature relating to the second over-arching question leading from welfare reform tackled in this thesis: Is work always good for health?

2.4 The work-health relationship

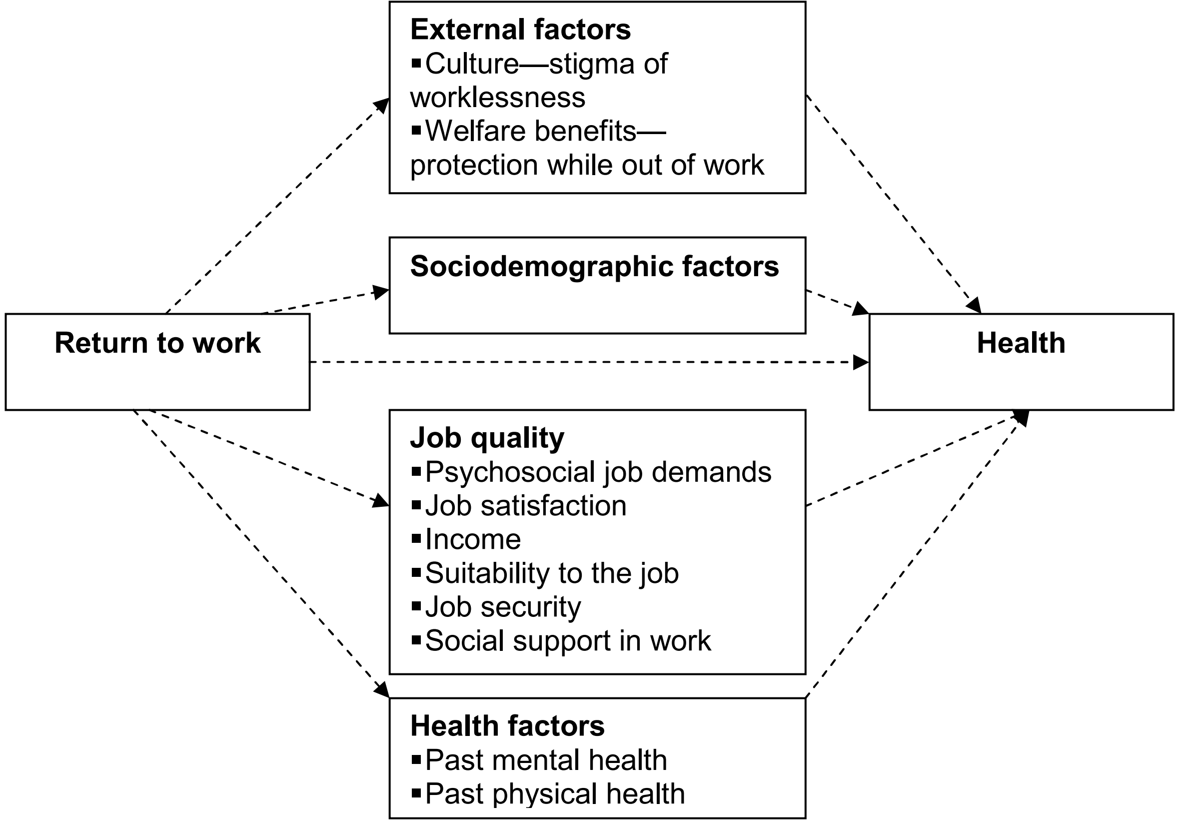
2.4.1 Is work always good for health?

There is little evidence on the health impact of transitions from OWIH to employment, largely because the numbers making this transition are low. For example, Thomas *et al.*(2005) explored employment transitions and the association with changes in health using data from the British Household Panel Survey. The analysis included 13,359 employment transitions, but such a small proportion of transitions from long-term illness to employment occurred (0.6%) that this analysis was not presented. Although there is little research on the health impact of a transition from OWIH to employment, the relationship between employment and health is well-established from studies using data on transitions from other forms of worklessness to employment. Systematic reviews are drawn upon in this section in areas where the literature is extensive.

There is a well accepted positive relationship between employment and health; generally people who are unemployed are in poorer health than those who are employed, even after controlling for other sociodemographic characteristics (Bartley, 1994; Waddell and Burton, 2006). Several systematic reviews have looked at the relationship between unemployment and health (e.g. Jin *et al.*, 1995; McKee-Ryan *et al.*, 2005; McLean *et al.*, 2005; Murphy and Athanasou, 1999; Paul and Moser, 2009). Paul and Moser (2009) conducted a comprehensive review in order to fill gaps left by previous reviews i.e. to consider potential moderator variables; to attempt to provide further evidence on causality; and to assess selection effects. This systematic review included 87 longitudinal studies and 237 cross-sectional studies. There was evidence showing that people with poorer mental health were more likely to lose their jobs in the first place. However, a move into (or back to) employment was also found to be beneficial for mental health, similar to findings of other systematic reviews and meta-analyses (McKee-Ryan *et al.*, 2005; Murphy and Athanasou, 1999; Rueda *et al.*, 2012).

A number of mechanisms are thought to explain the association between unemployment and poor health. The association has been conceptualised in theoretical models, which show the benefits of employment that are missed out on when unemployed e.g. time structure, social contact, income, status, activity, common goals, finance (for example, Ezzy, 1993; Fryer, 1985; Jahoda, 1981; Nordenmark and Strandh, 1999; Warr, 1987). These models attempting to explain the relationship between unemployment and health vary in how they view the individual as an agent, how they view other contextual factors, and how they consider the actual work that an individual may move into (Ezzy, 1993). Theories of employment and health have also emphasised that not everyone has a positive health experience when moving into employment and likewise not everyone has a negative health experience when moving out of employment. It has therefore been questioned whether all employment is good for health (Dooley *et al.*, 1996; Ezzy, 1997). One of the major caveats to the positive work-health relationship is the ‘quality’ of the work obtained. The potential for health benefits from moving into employment is likely to be dependent on the type of work, the suitability to the job, job satisfaction, and individual-level factors such as age and existing health status (Bartley *et al.*, 2006; Paul and Moser, 2009; Waddell and Burton, 2006). Figure 2-3 shows a conceptual model of the relationship between return to work and health, constructed using different factors that have been discussed in the relevant literature informing the relationship. The following section explores job quality in more detail: what it is, how it is measured, and evidence of its role in the relationship between work and health.

Figure 2-3: Conceptual model of factors that may play a role in the health impact of employment



2.4.2 Job quality

Quality of employment is multi-dimensional, and there are different models to assess 'job quality' in terms of psychosocial factors. The job strain model (Karasek, 1979) is the most commonly used, and when compared with other models has been shown to be the most "precise in describing the relationship" between job characteristics and symptoms of anxiety and depression (Griffin *et al.*, 2007, p. 345). Research using the job strain model bases measures on Karasek's Job Content Questionnaire (Karasek *et al.*, 1985), but the constructs used varies between studies. In this section, 'job quality' refers to psychosocial measures of employment generally, although the specific measures often differ.

The main components of Karasek's job strain model are job demands and job control. Job demands are factors of the job such as the amount of work that there is to be done, the time there is to do it, how hard it requires a person to work, and whether there are also conflicting demands. Control over performance at work (decision latitude) is split into two sub-dimensions: skill discretion e.g. how much a job uses a person's skill and creativity; and decision authority e.g. how much freedom a there is in terms of what happens in work. The model hypothesises that job strain is experienced in jobs that are high in psychosocial job demands and provide low control over work tasks.

Chandola (2011) makes the distinction between workplace stressors i.e. aspects of the job or workplace that may cause stress, and stress reactions i.e. the response to the workplace stressor. Stress reactions can result in clinical illness such as mental health conditions and/or physical responses to stress such as cardiovascular disease and ulcers (Woo and Postolache, 2008). Karasek's model assumes that psychosocial dimensions of jobs—such as job demands and control over work—are mechanisms through which work could be detrimental to health and therefore this model measures workplace stressors rather than stress reactions.

2.4.2.1 Evidence for the relationship between job quality and health from employed populations

There is evidence from different countries showing that people in better quality jobs have better health than those in low-quality jobs. Longitudinal evidence has shown job quality as a risk factor for various measures of health, for example, cardiovascular disease (e.g. Bosma *et al.*, 1997; Kivimäki *et al.*, 2012; Kuper and Marmot, 2003), musculoskeletal conditions (e.g. da Costa and Vieira, 2010), mental health (e.g. Rugulies *et al.*, 2006; Stansfeld *et al.*, 1999; Strazdins *et al.*, 2011; Virtanen *et al.*, 2011), and self-rated health (e.g. Grzywacz and Dooley, 2003; Virtanen *et al.*, 2011). A vast amount of research has been done using Karasek's job demand-control as a predictor of mental health; Table 2-9 summarises four systematic reviews that included only longitudinal research (Bonde, 2008; Netterstrøm *et al.*, 2008; Nieuwenhuijsen *et al.*, 2006; Stansfeld and Candy, 2006). Much of the primary research included in the systematic reviews comes from the Whitehall study; the initial study that explored why those in lower employment grades had poorer health than those in higher employment grades (University College London, 2013). Some of the individual systematic reviews contain the same studies but were slightly different in aim. The three later reviews stated that they aimed to review something more specific than Stansfeld and Candy's 2006 review: clinically significant psychiatric disorder (Bonde, 2008); depression (as well as updating results since 2005)

(Netterstrøm *et al.*, 2008); and stress-related disorders (Nieuwenhuijsen *et al.*, 2006). These reviews generally provide support for the demand-control model of work stress, showing that demand and control and the combination of the two relate to increased odds of common mental disorders. However, inconsistent evidence was found for the relationship between job control (decision latitude) and depression (Netterstrøm *et al.*, 2008), and one review found that job strain was only predictive of depression for males, not females (Bonde, 2008). Other workplace stressors that do not fall into the demand or control dimensions are also related to job quality. Poor work relationships, social support (Bonde, 2008; Netterstrøm *et al.*, 2008; Nieuwenhuijsen *et al.*, 2006; Stansfeld and Candy, 2006), and job insecurity (Stansfeld and Candy, 2006) were found to be predictive of mental health problems, but not in all studies that tested for them (Netterstrøm *et al.*, 2008).

It is clear that there is an association between aspects of employment and individual health. However, the studies reviewed have explored health outcomes of employed populations; they do not compare the health of those out of work with those in low- and high-quality jobs. Although the previous section showed that the employed population is generally healthier than the unemployed population, it is not clear whether those out of work are healthier than those in low-quality jobs. Therefore, in turn it is not clear whether a transition from worklessness to employment has a positive effect on health if the quality of the job obtained is poor.

Table 2-9: Summary of systematic reviews of psychosocial job quality as predictors of mental health problems

First author, year	N, design & follow-up	Predictors	Outcomes	Findings for job demand & job control	Odds Ratio (95% confidence interval)
Stansfeld, 2006	11 longitudinal studies with follow-up of at least 12 months.	Work characteristics	New onset of common mental disorders (CMD).	Meta-analysis found that the strongest predictor of CMD was job strain (combination of demand & control), from 3 studies.	Meta-analysis 1.82 (1.06, 3.10)
				Associated with ‘moderate’ risk of CMD:	
				Low decision authority (4 studies)	1.21 (1.09, 1.35)
				Low decision latitude (6 studies)	1.23 (1.08, 1.39)
				High job demands (8 studies)	1.39 (1.15, 1.69)
Bonde, 2008	16 longitudinal studies, with follow-up of at least 12 months.	Job-related psychosocial factors	Major depressive disorder or depressive symptoms.	‘Elevated’ risk of depression for those with:	Meta-analysis:
				High-demand jobs (7 studies)	1.31 (1.08, 1.59)
				Low decision latitude (9 studies)	1.20 (1.08, 1.39)
				Increased risk of depression for males: Job strain (3 studies)	
Netterstrom, 2008	14 longitudinal studies, follow-up of at least 12 months.	Work-related psychosocial factors	Depression by clinical diagnosis, by validated diagnostic interview of by validated rating scale for depression.	‘Moderate’ evidence for increased odds of depression for:	(No formal meta-analysis)
				High job demands (3 studies)	Around 2.0
				Relationship between decision latitude & depression was found to be inconsistent.	
Nieuwenhuijsen, 2010	7 prospective cohort studies or patient-control studies (where exposure was recorded before onset of the stress-related disorder (SRD)), follow-up of at least 12 months.	Work-related psychosocial risk factors	SRDs mainly measured by General Health Questionnaire.	‘Strong’ evidence for association with increased odds of SRD:	Pooled effect estimate:
				High job demand (from 3 studies)	1.35 (1.22, 1.50)
				Low job control (2 studies)	1.22 (1.10, 1.36)

2.4.2.2 The health impact of transitions from worklessness to employment, taking account of job quality

Although there is considerable evidence on the relationship between job quality and health in employed populations there is less evidence to show whether or how the health of people who are unemployed or out of the labour force differs from those who are in poor- and high-quality jobs. Cross-sectional research provides some evidence that sub-optimal working conditions are associated with similar (Butterworth *et al.*, 2012; Grzywacz and Dooley, 2003) or lower (Broom *et al.*, 2006) levels of poor health to unemployment, when compared to optimal working conditions. However, cross-sectional evidence is not able to take prior health into account, therefore does not rule out the possibility of health selection i.e. people may be in poorer quality jobs because they had poorer health in the first place, rather than the actual job being bad for their health.

Two Australian studies provide the available longitudinal evidence on health and job quality compared to unemployment (Butterworth *et al.*, 2011; Leach *et al.*, 2010). Leach *et al.* (2010) conducted analysis using the Personality and Total Health through life (PATH) study, a cohort study in Australia. As well as unemployment, the employment status category in this analysis was split by job quality, whereby high-quality jobs were defined as those with no or one adverse condition and low-quality jobs as those with two or more adverse conditions. Adverse conditions were measured by job strain, job insecurity, and ability to get another job. It was shown that those who were unemployed or employed in jobs with adverse conditions had significantly higher odds of being depressed, anxious, and in poor physical health than those employed with no adverse job conditions, when prior health and employment status were adjusted for. Those in the most adverse job conditions (those in employment with high job strain, low job insecurity, with low ability to get another job) did not have significantly different odds of depression, anxiety, or physical health to those who were unemployed. Follow-up of those who were unemployed at baseline showed that those who moved into low-quality jobs had higher odds of depression than those who remained unemployed. There were no significant differences in anxiety or physical health between those who remained unemployed and those who moved into low-quality jobs. However, the sample for the analysis on transitions from unemployment was small and confidence intervals were wide; only 15 people remained unemployed and 21 moved into low-quality jobs.

Using a larger sample, and with more follow-up points, Butterworth *et al.*(2011) presented longitudinal analysis from the Household, Income and Labour Dynamics in Australia (HILDA) study. They found that a transition from unemployment to a high-quality job was associated with improved mental health. Transitions from unemployment to low-quality jobs were associated with a greater decline in mental health when compared to remaining unemployed. However, both those who moved to low-quality jobs and those who remained unemployed showed a decline in mental health and confidence intervals overlapped for the difference in means.

The existing evidence that has compared those who are unemployed with those in low- and high-quality jobs is from Australia, and the first study (PATH) was conducted in an area of relative affluence (Broom *et al.*, 2006). It is possible that there are differences in the relationship between job quality and health depending on country, because of different cultures and different systems of welfare benefits (Broom *et al.*, 2006; Laszlo *et al.*, 2010). Further longitudinal research is needed from other countries regarding transitions into different 'quality' employment. Also, fewer people move from receiving sickness benefits into employment and as yet there is no longitudinal evidence considering this transition, the quality of work obtained, and the impact on health. The number of people receiving sickness benefits has increased since the 1980s and is a significant category of the wider group of economically inactive. Although not part of their conclusion, Waddell and Burton's (2006) review did acknowledge that there was little evidence to support any conclusions about the impact of work on the health of sick or disabled people; they present only a "non-scientific consensus" that people are better off in work than on sickness benefits (Waddell and Burton, 2006, p. 20). So, despite the broad acceptance of a positive relationship between work and health more generally, there is little evidence of whether a move from sickness benefits into employment has a positive impact on health. This is likely to be partly because the off-flow from OWIH welfare benefits into employment has been low (Adams *et al.*, 2012; Brown *et al.*, 2010), with those moving off the benefit not necessarily moving into work, but cycling between other out-of-work benefits and often moving back on to IB (Kemp and Davidson, 2010). Research with those OWIH is important, as they may differ from other workless or employed groups. For example, it is thought likely that those moving from OWIH benefit into work may be employed in ‘below average’ standards of work in terms of pay and conditions, satisfaction with work etc. (Equality and Human Rights Commission, 2008; Konle-Seidl and Eichhorst, 2008). This is because they are competing with people in full health and with more consistent employment history for the same jobs. One example of this is the difference in salary for those who move from ESA to employment compared to the general population salary. The mean salary for those who moved off of ESA to start employment in 2011 was £12,350 (£16,800 for those in full-time work with an employer) (Adams *et al.*, 2012). Although slightly different (ONS use the median rather than the mean as they state it is a better measure of ‘typical pay’), the median salary at the same time was £26,100 for full-time employees (Office for National Statistics, 2011).

2.4.3 Summary: is work always good for health?

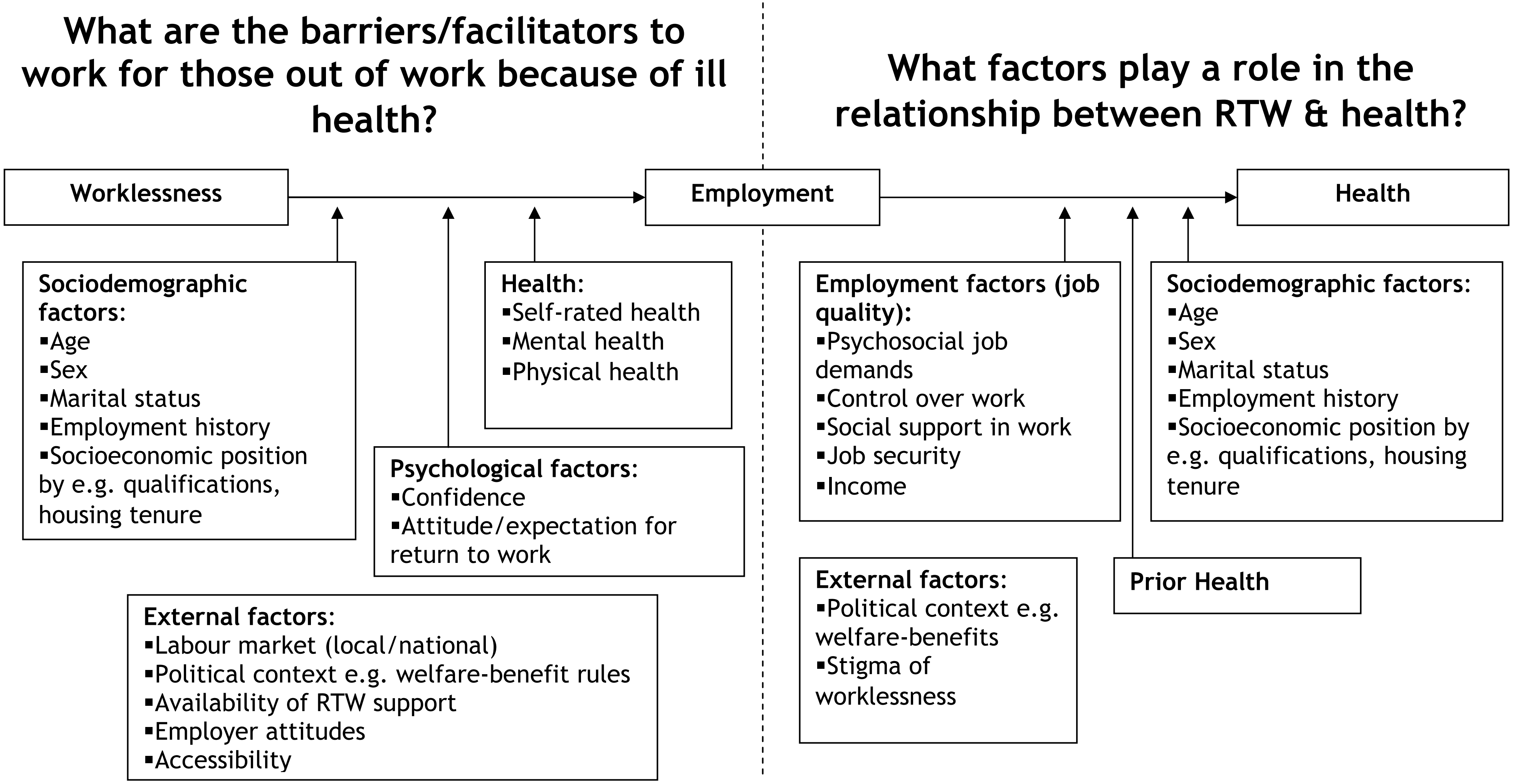
There is an established and evidenced relationship between work and health. At a population level those who are employed are healthier than those who are unemployed. Rather than treating employment as a single outcome it can be broken down to reflect that different jobs bring various levels of benefits and harms depending on certain factors. There is some evidence that being unemployed is associated with similar or poorer levels of health as being employed in a low-quality job. Likewise, there is some evidence that moving from unemployment to a low-quality job is not beneficial to health. However, there is limited evidence, from one country, on the health impact of transitions into high- or low-quality employment from worklessness. More longitudinal evidence is required about the health impact of transitions from worklessness to employment that is able to consider the employment outcome by job quality.

2.5 Conclusions

A range of different factors related to individual characteristics and health, but also to the wider context, have been shown to play a role in return to work and the health impact this can have. Figure 2-4 illustrates the factors that are important in the relationship between worklessness and employment and between return to work and health. Some factors are better evidenced than others e.g. individual-level predictors of return to work, and some are evidenced for certain populations e.g. job quality largely in the employed population.

The rest of the thesis presents analyses and discussion of quantitative and qualitative data to explore some of the identified gaps in evidence. The following chapter presents longitudinal analyses of employment and health outcomes, taking account of the role of job quality.

Figure 2-4: Return to work (RTW): factors influencing the employment and health outcome



Chapter three: Transitions into employment

The previous chapter reviewed the literature and found several gaps in research relating to return to work. There is some evidence that barriers to work relate to sociodemographic, health, psychological, and external factors. However longitudinal evidence that is able to control for each of these domains is lacking. There is an accepted positive association between employment and health; however, research has shown that the quality of the job plays a role in this relationship. There has been little research that has used this evidence when looking at the health impact of return to work from unemployment or other forms of worklessness.

In this chapter, employment and health outcomes for those initially out of work are investigated using quantitative analysis of longitudinal data from the West of Scotland Twenty-07 Study: Health in the Community (Twenty-07 Study).

3.1 Research questions

Specific research questions addressed in this chapter were:

How common is moving from being out of work because of ill health (OWIH) into employment?

What factors are associated with return to work for those out of work without an employment contract? And, more specifically for those OWIH?

What type of job, in terms of psychosocial job quality, do people move into from a period of worklessness? And, more specifically from OWIH?

Is return to work associated with a change in health? If so, does the quality of the job obtained affect the health change associated with return to work?

As in other literature, ‘worklessness’ is used in this chapter as an over-arching term to capture people who are out of work for any reason, including those actively looking for employment as well as those who are not, for example, those who are unemployed, out of work because of ill health, early retired, looking after the household etc.

Twenty-07 is a longitudinal cohort study comprising five waves of data collection over twenty years (1987-2007) (Benzeval *et al.*, 2009). It is an appropriate dataset to address the above research questions as it provides data on various measures of health, employment, and other relevant characteristics and it allows analysis of change over time because of its longitudinal design.

The chapter starts with a description of the study before going on to describe the specific analytical methods used. Results of the analyses are then presented and the final section provides a discussion of the findings.

3.2 The Twenty-07 Study

The Twenty-07 Study was set up in 1987 to investigate social processes that produce or maintain inequalities in health (Benzeval *et al.*, 2009). The study initially collected data from 4,510 participants from three age cohorts: the 1930s cohort aged approximately 56 at the first point of data collection; the 1950s cohort aged approximately 36; and the 1970s cohort aged approximately 16. At baseline all participants resided in the Central Clydeside Conurbation in the west of Scotland (a map detailing this area is shown in Appendix A). Questionnaires were mainly completed during face-to-face interviews and topics included health, cognition, life circumstances, education, employment, and behaviours. Table 3-1 shows the number, age, and sex of participants interviewed in each cohort at each wave.

Table 3-1: Descriptive information by cohort and wave

Cohort	Wave	Interview date	N (% of wave 1)*	Mean Age	Female N (%)
	1	1987	1515	15.7	777 (51.3)
	2	1990	1343 (88.8)	18.6	704 (52.4)
1970s	3	1995-1998	916 (60.7)	24.7	496 (54.1)
	4	2000-2004	843 (56.2)	30.1	459 (54.4)
	5	2007/8	942 (63.3)	36.6	517 (54.9)
	1	1986-1988	1444	36.1	788 (54.6)
	2	1991/2	1225 (85.2)	40.4	673 (55.3)
1950s	3	1995-1998	1026 (72.2)	45.1	570 (55.6)
	4	2000-2004	980 (70.2)	50.1	534 (54.5)
	5	2007/8	999 (73.8)	57.0	542 (54.3)
	1	1988	1551	56.1	849 (54.7)
	2	1991/2	1266 (85.1)	59.5	681 (54.1)
1930s	3	1995-1998	1030 (74.3)	64.3	580 (56.3)
	4	2000-2004	838 (67.5)	69.0	470 (56.1)
	5	2007/8	663 (68.1)	76.0	384 (57.9)

* % of baseline n minus participants who had died before the interview date.

There are two study samples of participants in the Twenty-07 Study: the regional (approximately 67% of the total sample at baseline) and the localities samples. The regional sample was selected to be representative of the area, and comparison with census data found this to be the case (Der, 1998). The localities sample was recruited in order to allow an in-depth exploration of how people’s local environment affects health and personal circumstance (MacIver and Macintyre, 1987). This study sample was recruited from two Glasgow City areas; a middle-class and a working-class area. At most waves of the study the two samples were asked identical questionnaires. However, data collection between the study samples differed at wave three when the localities sample was sent a postal questionnaire rather than the usual face-to-face interview.

The full Twenty-07 sample is used in the analysis discussed in this chapter, using all available data to increase statistical power. Therefore, the two study samples were compared to check whether the use of the localities sample was likely to add any bias, in respect that it may differ systematically from the regional sample (and therefore the general population). This analysis is shown in Appendix A.

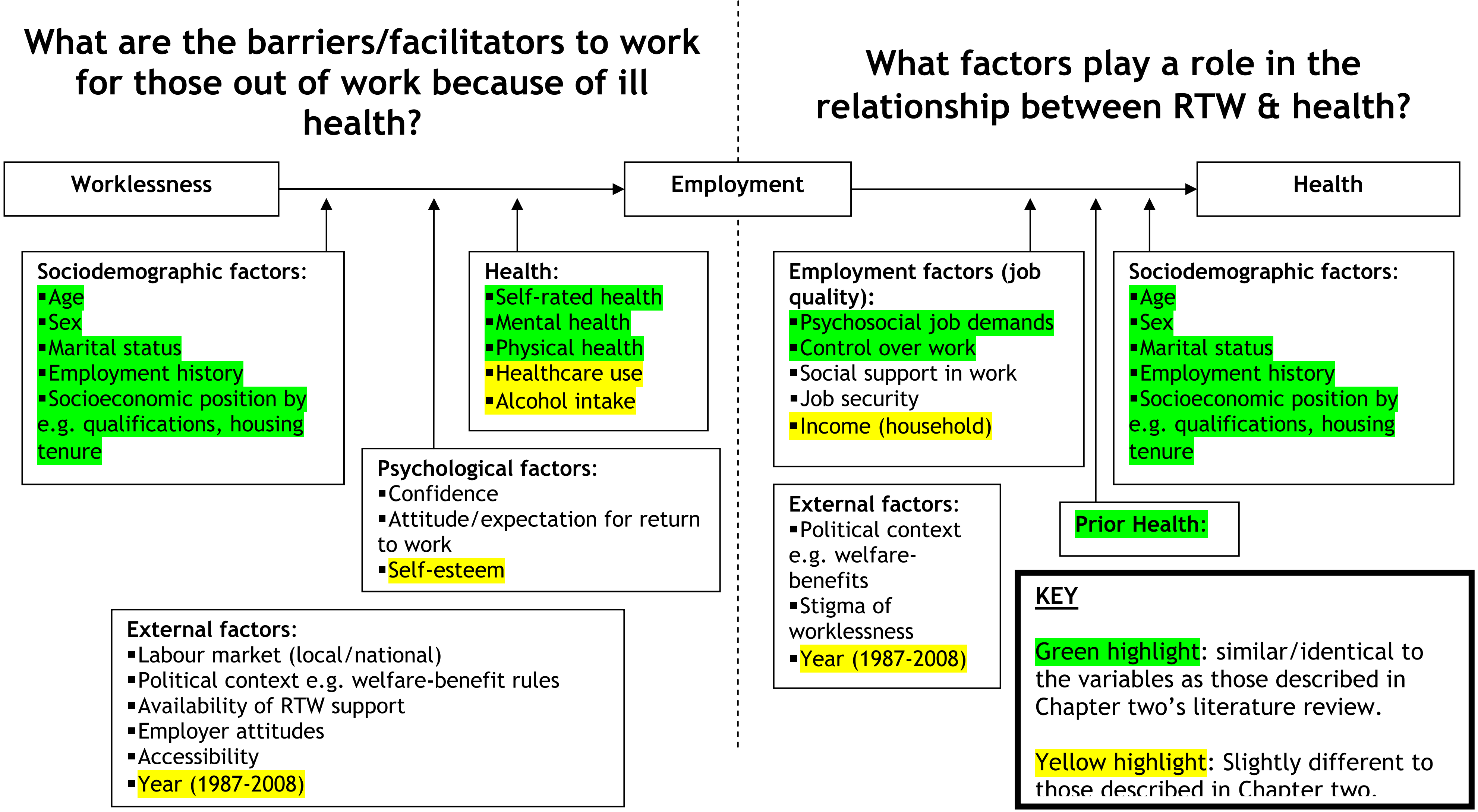
There was a higher attrition rate in the localities than in the regional sample. Although there were no significant differences between the samples in terms of sex, employment status, or cohort, there were significant differences with respect to socioeconomic position, with the localities sample being more deprived than the regional sample. This difference may lead to a bias in prevalence estimates, in that the full sample is likely to be more deprived than the general population. Prevalence of return to work should therefore be treated with caution as it may be underestimated. To adjust for the differences between samples, study sample (as well as other socioeconomic indicators) is controlled for in all of the analyses presented.

3.3 Methods

3.3.1 Measures

This section gives an overview of all of the variables that were drawn upon in the analyses. As discussed in the literature review (Chapter two), previous research has examined the influence of various factors on return to work. It has also examined the influence of various factors likely to be important in the relationship between return to work and health. Such factors were identified in the Twenty-07 dataset and used in the analyses presented here. Figure 3-1 reproduces the figure shown at the end of Chapter two, with highlighting to indicate the available variables from the Twenty-07 data used to conduct the analyses. Those highlighted green are similar or identical variables to those described in the literature review in Chapter two. Those highlighted yellow are slightly different e.g. year is used as an indicator of the labour-market context and self-esteem is used as a psychological measure. Information on healthcare use was available in Twenty-07 and is used as an indicator of health. Data on alcohol intake were also available. Alcohol intake was not included in the studies in the literature reviewed in Chapter two, but is included in the analyses in this chapter because of the high proportion of Incapacity Benefit (IB) claims arising from alcohol use in Glasgow (Brown *et al.*, 2008). Data from all waves of the study were used where available.

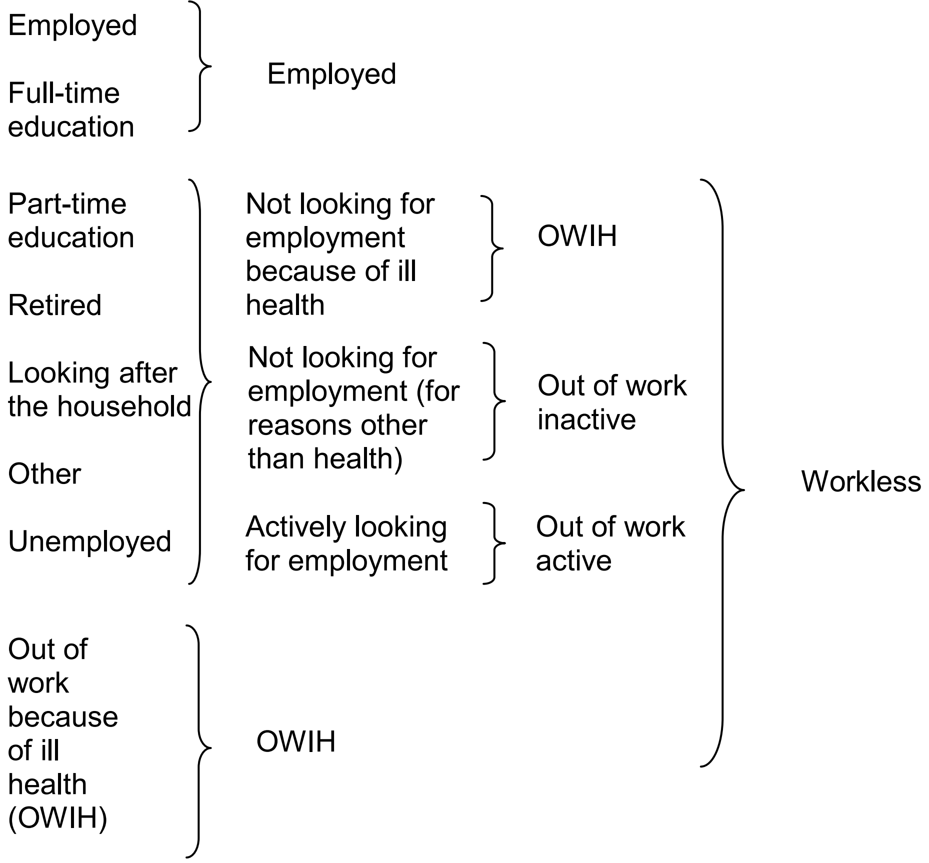
Figure 3-1: Return to work (RTW): factors influencing the employment and health outcome. Variables used from the Twenty-07 Study



3.3.1.1 Employment factors

Employment status: At each wave participants were asked for their employment status. Employment status variables were collapsed into fewer categories for the following analyses (detailed in Figure 3-2). The terms ‘active’ and ‘inactive’ were used to distinguish between participants who were available for work and seeking a job and those who were not. There are some differences between the categories making up the ‘inactive out of work’ group in terms of whether they were likely to move into employment or not. These categories were kept together as they were not the main group of interest. However, additional models were run (with ‘retired’ as a separate employment status category) to ensure that the combination of these groups did not alter the meaning of the results. When looking at employment as an outcome variable, the categories were dichotomised into employed and not employed.

Figure 3-2: Combined employment status categories for analyses



Job quality: This was measured using 14 items from Karasek's demand-control model (Karasek, 1979) and items are shown in Box 3-1. These items were used to assess control over performance at work and job demands. Control was measured by two sub-dimensions of the decision latitude scale (skill discretion and decision authority). Job demand was measured by five questions on the psychological demands and mental workload scale. Participants rated each item from strongly disagree to strongly agree (four options). If one item on a sub-scale was missing, the mean of the valid responses for that sub-scale was used. Where more than one item was missing the variable was coded as missing. Scores were dichotomised at the median to give low and high demand and control (as in D'Souza *et al.*, 2003). Low job demand and high job control are indicators of a high-quality job; high job demand and low job control are indicators of a low-quality job.

Box 3-1: 14 items from the Job-Content Questionnaire used to score job demand and job control (responses: strongly agree, agree, disagree, and strongly disagree)

Job demand items	Job control items
My job requires working very fast. My job requires working very hard. I am not asked to do an excessive amount of work. I have enough time to get the job done. I am free from conflicting demands that others make.	*Skills discretion items:* My job requires that I learn new things. My job involves a lot of repetitive work. My job requires me to be creative. My job requires a high level of skill. I get to do a variety of different things on my job. I have an opportunity to develop my own special abilities. *Decision authority items:* I have a lot of say about what happens on my job. My job allows me to make a lot of decisions on my own. On my job, I have very little freedom to decide how I do my work.

3.3.1.2 Health and psychosocial measures

Mental health: The Hospital Anxiety and Depression Scale (HADS) was designed to identify cases of anxiety and depression in clinical settings. It has also been shown to be a valid measure among the general population (Bjelland *et al.*, 2002). Both seven-item sub-scales were used in this analysis—one for anxiety and one for depression. Each item scored between zero and three with a total maximum score of 21 for each sub-scale (Zigmond and Snaith, 1983). If one or two items on a sub-scale were missing the mean of the valid responses for that individual were used. Participants who scored eight or more on the anxiety section were defined as anxiety cases and participants who scored eight or more on the depression section were defined as depression cases (Bjelland *et al.*, 2002). For the analyses in this chapter, participants were defined as HADS anxiety or depression cases if they scored eight or more on one or both of the sub-scales.

Self-rated health: Self-rated health has been shown to be a reliable measure of morbidity and mortality (Burstrom and Fredlund, 2001; Fayers and Sprangers, 2002). At each wave in the Twenty-07 Study, participants were asked to rate their own health: ‘over the last 12 months, would you say that your health on the whole has been excellent, good, fair, or poor?’. Responses were dichotomised: fair or poor were combined and excellent or good were combined.

Physical disability: The best measure of physical disability available in the Twenty-07 dataset was the Office of Population Census and Surveys (OPCS) disability scale (Martin *et al.*, 1998). In the OPCS disability scale different areas of disability—e.g. locomotion, dexterity, reaching and stretching—each have their own severity scales, and participants are scored on each scale separately. As advised by the authors of the scale, the disability score was calculated by adding together the three highest scores (each from different areas of disability) and applying weighting: worst + 0.4*(second worst) + 0.3*(third worst). Thus as physical disability increased the score increased.

Presence of a health condition: The OPCS disability and HADS anxiety or depression scales were not asked of every cohort at each wave, so for that reason and in order to be comparable with previous research, presence of a longstanding limiting health condition was used as well. This also provided the possibility of coding conditions as mental or physical, allowing another comparison of the impact of different dimensions of health on employment outcome. At each wave participants were asked whether they had ‘a limiting illness’. And if they responded positively they were asked a series of questions about each of their ‘limiting illnesses’ (up to eight conditions were recorded at each wave). For this study participants were defined as having a limiting condition if they responded that at least one of their conditions limited them ‘to a moderate degree’, ‘quite a lot’, or ‘a great deal’, but not if they stated that it limited them ‘a little’ or ‘not at all’. Each condition had been given a condition code based on the Royal College of General Practitioners Morbidity classification (Royal College of General Practitioners, 1986), and for the analyses presented in this chapter, conditions were classified as mental or physical based on their assigned code (further details of classification in Appendix A).

Use of primary healthcare: Participants were asked how many times they had visited their General Practitioner (GP) in the preceding 12 months, and the number of GP visits was used as a measure of contact with health services, which may indicate physical or psychological chronic illness (Westhead, 1985).

Alcohol intake: At each wave, participants were asked about the alcoholic drinks they had consumed in the week prior to interview. Units of alcohol were calculated from the drinks consumed e.g. two units per glass of wine, two units per pint of lager etc. A dichotomous variable was created by calculating whether the individuals had exceeded the recommended alcohol intake for the week (21 units for males and 14 for females).

Self-esteem: This was used as a psychological indicator. The Rosenberg Self-Esteem Scale was the main measure of self-esteem used in Twenty-07 (Rosenberg, 1965). However, for the 1970s cohort at wave two, a different measure of self-esteem was used. In both self-esteem scales if only one or two items on the scale were missing the item was given the mean of the individual’s other valid responses. Scores were then calculated by summing the individual items of the scale. Since slightly different measures were used, standardised z-scores were created for self-esteem.

All of the health and psychological measures were used as covariates in the analysis of return to work. In the analyses where health was the main outcome, HADS and self-rated health were used as the outcome measures. It was expected that these measures of health may be the most likely to improve following return to work.

3.3.1.3 Socioeconomic position

As discussed in the previous chapter, socioeconomic position is associated with health and employment outcomes; however, evidence on specific measures was inconclusive. Socioeconomic position is multi-faceted and there are a number of options for measuring its different constructs (Galobardes *et al.*, 2006). Given that the analyses in this chapter focus on participants who were out of work at baseline, using occupation as a measure of socioeconomic position was considered inadequate. However, prior employment status (employed, inactive, active, or OWIH) was controlled for in all multivariate models. The analyses also used qualifications, housing tenure, and income as indicators of potential employability, assets, and household resources.

Qualifications: Participants were asked about their qualifications, with response options differing at each wave to account for changes in current common qualifications e.g. the 1930s cohort were asked if they had a school leaver's certificate, whereas the 1970s were asked what level of qualification they obtained at high school (Standard Grades, Highers etc.). A variable for educational level was created, based on the highest qualification that the participant had obtained at each wave. The various qualifications were organised into three categories based on the Scottish Qualifications Framework (Scottish Qualifications Authority, 2013): high, low, and no qualifications (more information in Appendix A).

Housing tenure: At each wave participants were asked whether their home was privately owned (with a mortgage or outright) or rented (from council, local authority, other housing association, or privately).

Income: Participants were asked what their weekly household income was at each wave. In order to make income comparable across households and time periods it was weighted for number and age of people living in the household, using the McClements equivalence scale (McClements, 1977), and adjusted for inflation.

3.3.1.4 Other sociodemographic characteristics

Sex, age, and marital status (dichotomised allowing comparison between people who were married or cohabiting and those who were not married or cohabiting) were used as they each potentially relate to employment and health outcomes. Year of interview was adjusted for in the models that were concerned with employment as an outcome, to account for the fact that the unemployment rate varies by year owing to labour market influences. Study sample (region or locality) was also included in all multivariate models.

3.3.2 Analysis

To address the research questions set out at the beginning of the chapter, a mixture of descriptive statistics and regression analyses were used. Descriptive statistics included frequencies and cross-tabulations. Two separate sets of regression analyses were conducted. The first set (hereafter referred to as ‘return-to-work analyses’, relating to the left-hand side of Figure 3-1, page 70) addressed the following research questions:

How common is moving from being out of work because of ill health (OWIH) into employment?

What factors are associated with return to work for those out of work without an employment contract? And, more specifically for those OWIH?

What type of job, in terms of psychosocial job quality, do people move into from a period of worklessness? And, more specifically from OWIH?

The second set of analyses moved from looking at employment as the outcome to explore health as the outcome. The specific research questions (hereafter referred to as ‘health-outcome analyses’, relating to the right-hand side of Figure 3-1) were:

Is return to work associated with a change in health? If so, does the quality of the job obtained affect the health change associated with return to work?

3.3.2.1 Sample inclusion

Initial descriptive statistics to explore the data and describe the pattern of employment statuses over time used the full working-age sample of Twenty-07 participants. Wave 1 data for the 1970s cohort were excluded from analyses as all these participants were still in high school at this time, but were included from wave 2. The 1950s and 1930s cohorts were included in analyses until they were no longer working age; at the time of analyses this was 65 for males and 60 for females.

The main analyses were concerned with change in employment status from worklessness, therefore included participants who were interviewed in at least two consecutive waves and were not employed at the first. Each participant could be included in each model a maximum of four times i.e. if they were present at all five waves. For clarity of description, the follow-up is denoted as t and initial data collection point (approximately five years before follow-up) is denoted as t-1.

3.3.2.2 Regression analysis using Generalized Estimating Equations

Both sets of analyses used repeated measures logistic regression with Generalized Estimating Equations (GEE). GEE is useful for dealing with a large number of small clusters (Zeger and Liang, 1986), therefore is suited to this analysis of the Twenty-07 data, which has 4,510 participants (clusters) each consisting of up to four pairs of responses (repeated measurements). GEE takes account of correlation between repeated measurements for the same individuals. An additional level of clustering in Twenty-07, sampling unit (postcode sectors), was also accounted for in the GEE model. Within-subject variables to define each measurement included a variable to indicate repeated measurement (participant identification number) and one to indicate the primary sampling unit (sample unit number) to take account of clustering. All available information from each participant was used in the GEE models i.e. if a participant was only present in one wave pair, the data from those waves were used in the analyses.

All analyses were conducted using SPSS for Windows Version 19. Odds ratios are reported with a 95% confidence interval.

Table 3-2 provides details about the two different sets of regression analyses and the following sub-sections discuss each further.

Table 3-2: Details of the two sets of analyses

Analyses	Outcome (at t)	Sample	Predictor & co-predictors
Return-to-work	Employed.	Out of work because of ill health at t-1.	Self-rated health, anxiety or depression, presence of a health condition, use of primary healthcare, self-esteem, and alcohol intake (each in separate models), measured at t-1. Adjusted for sample, sex, age, qualifications, tenure, and year.
		All workless at t-1.	As above plus workless category at t-1.
	Job demand & job control.	All workless at t-1 & employed at t.	As above.
Health-outcomes	Fair or poor self-rated health & HADS anxiety or depression case (separate models).	All workless at t-1.	Employed at t (yes/no). Adjusted for age, sex, marital status, sample, HADS/self-rated health at t-1, workless status at t-1, income, and housing tenure.
		All workless at t-1.	Job control (high/low/remain workless) at t. Adjusted for age, sex, marital status, sample, HADS/self-rated health at t-1, workless status at t-1, income, and housing tenure.
			Job demand (high/low/remain workless) at t. Adjusted for age, sex, marital status, sample, HADS/self-rated health at t-1, workless status at t-1, income, and housing tenure.
		All workless at t-1 & employed at t.	Job demand (high or low). Job control (high or low). Adjusted for age, sex, marital status, sample, HADS/self-rated health at t-1, workless status at t-1, income, and housing tenure.

3.3.2.3 Return-to-work analyses

Unadjusted models looked at the relationship between each explanatory variable (at t-1) and the outcome (employment status at t). Health measures that were significant predictors of employment outcomes in unadjusted models were included in multivariate models. Each measure of health was entered into a separate model. Some of the measures of health were only available at certain waves or for certain cohorts, therefore the number of participants in each model varied. These analyses were repeated with two different samples. The first included those who were OWIH at t-1 and followed up at t. Since there were relatively few transitions from OWIH to employment, a second set of analyses with those in any form of worklessness at t-1 was conducted. Here, the odds ratios for being employed at t were compared for different employment categories at t-1. Finally, for those who were employed at t, odds of being in a high-quality job were explored by workless status at t-1.

3.3.2.4 Health-outcomes analyses

Unadjusted and adjusted analyses of fair or poor self-rated health at t and HADS anxiety or depression cases at t by employment status at t were run (separately). Independent variables in the multivariate models were health, workless category, and sociodemographic characteristics at t-1. The models were repeated to include job quality at t as a predictor of health outcome, rather than simply looking at employment status at t. Job quality was only measured from wave three so these models did not include wave pair one/two. Lastly, the models were repeated with those who were employed at t only, taking account of job demand and job control in the same model.

3.4 Results

The results are split by analyses as described in the previous section. Descriptive information about the total sample is shown first followed by exploration of attrition. The return-to-work and health-outcomes analyses are then presented.

3.4.1 Out of work because of ill health and transitions in and out of this employment status: initial descriptive statistics results

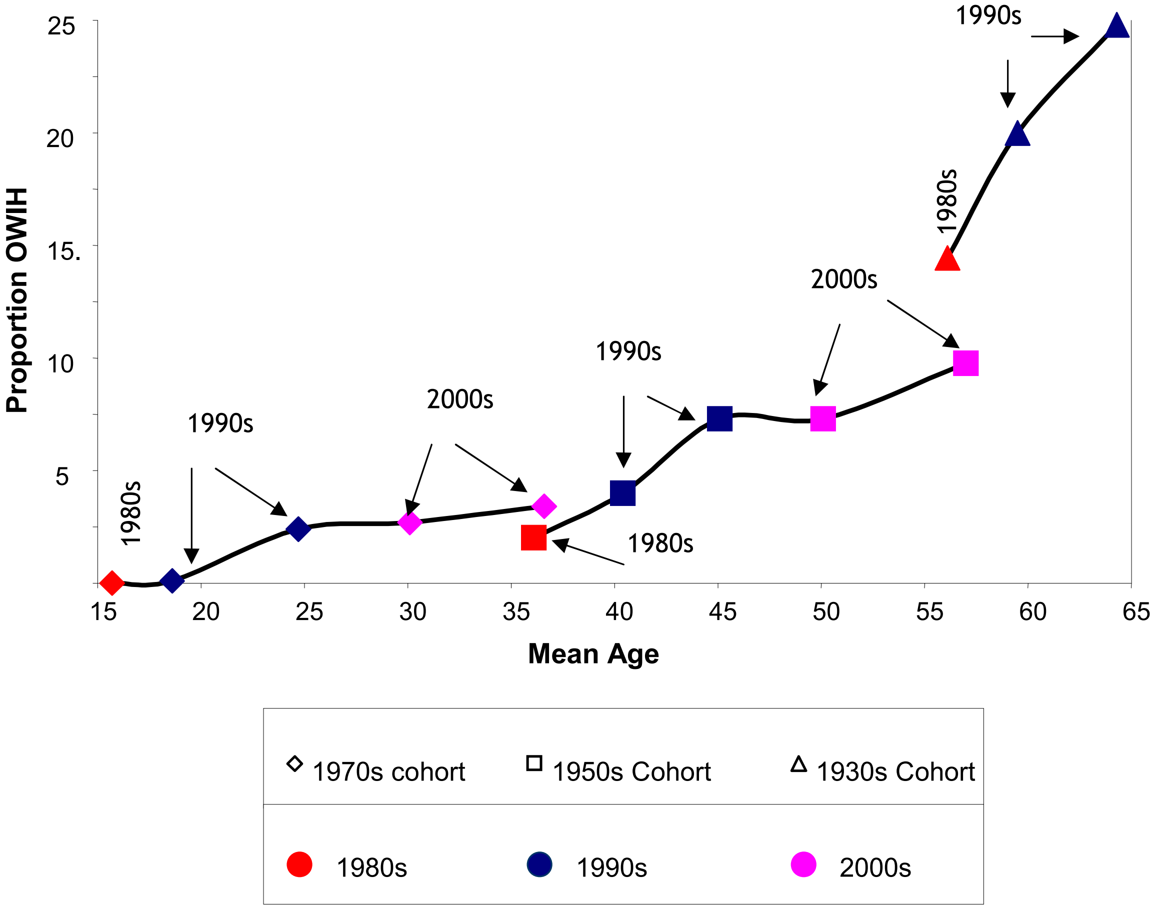
This section provides the results of analyses that used the full working-age

Twenty-07 sample.

3.4.1.1 Proportion out of work because of ill health by cohort and period

The proportion of people reporting they were OWIH increased with age (Figure 3-3). At age 25, 2.4% were OWIH. A steep increase was clear between age 40 and 45, where the proportion rose from 4.0% to 7.3%. At age 65, 24.8% of working age participants reported that they were OWIH (because women were no longer working age at 65, this proportion reflects men only). Figure 3-3 also shows cohort differences when participants were approximately the same age, indicating period effects. The proportion of those experiencing OWIH aged around 56 differed between the 1950s (9.7%) and the 1930s cohort (14.4%). Also, a slightly higher proportion of those aged 35 in 2007 were OWIH (3.4%) than those aged 35 in 1987 (2.0%). However, it is difficult to fully disentangle whether the differences in proportions of people out of work because of ill health are related to age, period, or cohort effects with these data that only have very brief overlaps of ages.

Figure 3-3: Proportion out of work because of ill health by age



3.4.1.2 Participant characteristics by employment status

Table 3-3 to Table 3-5 show the distributions of the study variables at baseline by employment status for each cohort. It is not possible to compare the 1970s cohort OWIH category with the others, as only one participant was OWIH at baseline.

Cohorts had similar patterns of employment with respect to sex, education, and marital status groups. In all three cohorts, the proportion with qualifications was higher for those who were employed than for any of the workless groups. Despite the similar trend, the actual proportions were quite different—50% of the 1930s cohort, 69% of the 1950s cohort and 92% of the 1970s cohort had qualifications at baseline. The younger the cohort, the more likely its participants were to have qualifications, indicating that level of qualification is unlikely to be a consistent measure of socioeconomic position over time.

For all three cohorts a higher proportion of the employed participants had better health than the workless groups. The only exception to this was in the 1930s cohort, where the employed and the active out of work had similar proportions of poor health on all measures, and there was a higher proportion of employed than active out of work participants with anxiety or depression (46.3% compared to 37.0%). A higher proportion of those active out of work compared to those OWIH exceeded the weekly recommendation of alcohol intake. There was also an apparent cohort effect for alcohol intake: similar proportions of employed and active groups in the 1970s and 1950s cohorts exceeded the recommended intake, but the active group of the 1930s had a considerably higher proportion that exceeded the alcohol intake compared to the employed group (26.6% compared to 15%). As may be expected, the proportion of those OWIH with poor health (on all health measures for all cohorts) was higher than all other employment groups.

Table 3-3: Distribution of variables among 1970s cohort at baseline*, for different employment statuses

	Employment Status at wave 2			
	Out of work because of ill health N (%)	**Out of work – inactive N (%)**	**Out of work – active N (%)**	**Employed N (%)**
Total	1 (0.1)	56 (4.2)	209 (15.6)	1076 (80.2)
Female	1 (100.0)	46 (82.1)	90 (43.1)	567 (52.7)
Has qualifications	1 (100.0)	42 (75.0)	169 (80.9)	1021 (94.9)
House tenure: rent/other	0 (0.0)	42 (75.0)	145 (69.4)	493 (46.6)
Married/cohabiting	0 (0)	22 (39.3)	8 (3.8)	24 (2.2)
Has limiting condition	0 (0.0)	10 (17.9)	25 (12.0)	85 (7.9)
Fair or poor self rated health	1 (100.0)	21 (37.5)	99 (47.4)	330 (30.7)
HADS anxiety or depression	1 (100.0)	32 (59.3)	85 (41.1)	421 (39.4)
12+ GP visits in last year	0 (0.0)	16 (28.6)	16 (7.7)	32 (3.0)
Condition classification:				
No condition	1 (100.0)	46 (82.1)	184 (88.0)	991 (92.1)
Physical health condition	0 (0.0)	5 (8.9)	11 (5.3)	50 (4.6)
Mental health condition	0 (0.0)	3 (5.4)	11 (5.3)	29 (2.7)
Both physical & mental	0 (0.0)	2 (3.6)	2 (1.0)	6 (0.6)
Exceeds recommended alcohol limit	0 (0.0)	7 (12.5)	47 (22.5)	222 (20.6)
	mean (standard deviation)	**mean (standard deviation)**	**mean (standard deviation)**	**mean (standard deviation)**
Self-esteem	-0.77	-0.21 (0.94)	-0.12 (1.08)	0.03 (0.98)
Carstairs score	0.44	4.51 (4.58)	4.07 (4.70)	1.48 (4.29)
Income	16.35	46.11 (53.54)	19.88 (12.73)	38.32 (29.99)

* Baseline for the 1970s cohort, for the purpose of this study, is wave two.

Table 3-4: Distribution of variables among 1950s cohort at baseline, for different employment statuses

	Employment Status at wave 1			
	Out of work because of ill health **N (%)**	**Out of work— inactive** **N (%)**	**Out of work – active** **N (%)**	**Employed** **N (%)**
Total	29 (2.0)	245 (17.0)	145 (10.1)	1019 (70.9)
Female	9 (31.0)	233 (95.1)	46 (31.7)	499 (49.0)
Has qualifications	13 (44.8)	140 (57.2)	77 (54.3)	754 (74.5)
House tenure: rent/other	16 (55.2)	127 (51.8)	94 (65.3)	320 (21.4)
Married/cohabiting	16 (55.2)	201 (82.4)	92 (63.4)	779 (76.5)
Has limiting condition	27 (93.1)	78 (31.8)	40 (27.6)	221 (21.7)
Fair or poor self rated health	21 (80.8)	72 (31.2)	41 (31.3)	205 (21.1)
HADS anxiety or depression*	N/A	N/A	N/A	N/A
12+ GP visits in last year	10 (40.0)	19 (8.4)	6 (4.7)	28 (2.9)
Condition classification:				
No condition	2 (6.9)	167 (69.0)	105 (72.9)	798 (78.9)
Physical health condition	22 (75.9)	64 (26.4)	31 (21.5)	200 (19.8)
Mental health condition	3 (10.3)	11 (4.5)	5 (3.5)	13 (1.3)
Both physical & mental	2 (6.9)	0 (0.0)	3 (2.1)	0 (0.0)
Exceeds recommended alcohol limit	5 (17.2)	12 (4.9)	28 (19.3)	219 (21.5)
	mean (standard deviation)	**mean (standard deviation)**	**mean (standard deviation)**	**mean (standard deviation)**
Self-esteem*	N/A	N/A	N/A	N/A
Carstairs score	2.86 (4.10)	2.36 (4.74)	3.50 (4.73)	1.09 (4.11)
Income	91.67 (49.99)	90.92 (53.63)	81.14 (63.11)	159.69 (81.19)

* No available information on HADS or self-esteem for the 1950s cohort at baseline.

Table 3-5: Distribution of variables among 1930s cohort at baseline, for different employment statuses

	Employment Status at wave 1			
	Out of work because of ill health N (%)	**Out of work – inactive N (%)**	**Out of work – active N (%)**	**Employed N (%)**
Total	224 (14.4)	357 (23.0)	109 (7.0)	861 (55.5)
Female	82 (36.6)	323 (90.5)	20 (18.3)	424 (49.2)
Has qualifications	89 (40.1)	141 (39.7)	42 (38.5)	506 (58.9)
House tenure: rent/other	191 (85.3)	206 (57.7)	89 (81.7)	410 (47.7)
Married/cohabiting	143 (63.8)	272 (76.2)	66 (60.6)	680 (79.0)
Has limiting condition	184 (82.1)	171 (47.9)	29 (26.6)	228 (26.5)
Fair or poor self rated health	173 (84.0)	161 (47.4)	38 (37.3)	278 (34.0)
HADS anxiety or depression	133 (68.9)	177 (53.2)	37 (37.0)	374 (46.3)
12+ GP visits in last year	67 (33.0)	48 (14.1)	7 (6.9)	46 (5.6)
Condition classification:				
No condition	40 (17.9)	186 (52.1)	80 (73.4)	633 (73.8)
Physical health condition	137 (61.4)	137 (38.4)	23 (21.1)	190 (22.1)
Mental health condition	9 (4.0)	11 (3.1)	3 (2.8)	14 (1.6)
Both physical & mental	37 (16.6)	23 (6.4)	3 (2.8)	21 (2.4)
Exceeds recommended alcohol limit	37 (16.5)	34 (9.6)	29 (26.6)	122 (15.0)
	mean (standard deviation)	**mean (standard deviation)**	**mean (standard deviation)**	**mean (standard deviation)**
Self-esteem*	N/A	N/A	N/A	N/A
Carstairs score	4.16 (3.95)	2.47 (4.51)	4.06 (4.28)	1.95 (4.26)
Income	89.98 (44.46)	102.84 (63.74)	69.64 (36.39)	154.48 (86.29)

* No available information on self-esteem for the 1930s cohort at baseline.

3.4.2 Present in analysis and missing data because of attrition

The analyses presented in this chapter include those who were interviewed at two consecutive waves and were workless on the first (t-1). Table 3-6 provides details of the total number of eligible transitions based on those who took part at t-1.

Table 3-6: Present in analyses

	N person waves workless at t-1	N person waves out of work because of ill health at t-1
Total eligible sample (working age at t-1 & t)	2,530	593
(Died before contact at t)	(102)	(52)
(Missing at t)	(593)	(133)
Total excluded at t	695	185
Total sample included in analyses (participated & working age at t-1 & t; workless at t-1)	**1,835 (72.5%)**	**408 (68.8%)**

There is no way of knowing who of those who did not participate at t-1 would have been eligible for the analyses in this chapter. This is because eligibility for these analyses was based on employment status at t-1 rather than baseline measures (and if participants were not interviewed at t-1 then their employment status would not be available). It is likely that most of those missing would not have been eligible (as they were more likely to have been employed than not), but there is no way of confirming this. It is therefore not possible to show a full comparison of those who were included in the analyses with those who were eligible but did not take part. However, some comparison can be made between total eligible person waves at t-1 and the total included in the analysis.

Table 3-7 shows t-1 characteristics of the total eligible sample at t-1, those eligible but who were not in the analysis because of death or being missing at t, and the analysis sample. There were differences between samples; the analysis sample was likely to be slightly less deprived and feeling slightly healthier than the total eligible sample. For example, 13.2% of the analysis sample had high qualifications compared with 11.9% of the total eligible sample, and 51.3% of the analysis sample had excellent or good self-rated health compared with 47.7% of the total eligible sample. These differences arose from death as well as those missed at follow-up. A higher proportion of the sample that had died and the sample that were missing were deprived in terms of qualifications, housing tenure, and area compared to the full eligible sample. Differences in health for the sample in the analyses were largely down to death rather than missing: a higher proportion of the sample that had died had poor health than the full eligible sample; whereas the sample of those missing at follow-up had similar proportions of poor health as the full eligible sample.

In terms of employment status, the proportion OWIH in the eligible sample and the analysis sample was similar. However, there were different reasons for non-follow-up between employment statuses; 8.8% of those OWIH were missing because of death before t, compared to 2% of those active out of work and 2.9% of those inactive out of work. Further information on the characteristics of the OWIH sample is given in Table 3-8. The final sample included in the OWIH analyses was similar to the eligible baseline sample. However, as with the full workless sample, those in poorer health were over-represented in the sample that had died and under-represented in the sample that were missing. For example, 79.7% of those eligible had fair or poor self-rated health at baseline, compared to 86.5% of those who had died by follow-up, and 72.9% of those who were missing at follow-up.

Table 3-7: t-1 characteristics of the total eligible sample at t-1, those missing at t and those followed up at t

Characteristics at t-1		**Full eligible (2,530 person waves)**		**Missing: death (102 person waves)**		**Missing: other (593 person waves)**		**In analysis (1,835 person waves)**	
		N	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**
Sex	Male	1082	(42.8)	73	(71.6)	259	(43.7)	750	(40.9)
	Female	1448	(57.2)	29	(28.0)	334	(56.3)	1085	(59.1)
Cohort	1970s	583	(23.0)	5	(4.9)	191	(32.2)	387	(21.1)
	1950s	1114	(44.0)	23	(22.5)	229	(38.6)	862	(47.0)
	1930s	833	(32.9)	74	(72.5)	173	(29.2)	586	(31.9)
Employment status	OWIH	593	(23.4)	52	(51.0)	133	(22.4)	408	(22.2)
	Active	707	(27.9)	14	(13.7)	208	(35.1)	485	(26.4)
	Inactive	1230	(48.6)	36	(35.3)	252	(42.5)	942	(51.3)
Housing tenure	Rent/other	1547	(61.1)	72	(70.6)	416	(70.2)	1059	(57.7)
	Own/mortgage	978	(38.7)	30	(29.4)	175	(29.5)	773	(42.1)
	Missing	5	(0.2)	0	(0.0)	2	(0.3)	3	(0.2)
Qualifications	High	302	(11.9)	11	(10.8)	49	(8.3)	242	(13.2)
	Low	1189	(47.0)	44	(43.1)	262	(44.2)	883	(48.1)
	None	1028	(40.6)	47	(46.1)	278	(46.9)	703	(38.3)
	Missing	11	(0.4)	0	(0.0)	4	(0.7)	7	(0.4)
Self-rated health	Excellent/good	1207	(47.7)	23	(22.5)	244	(41.1)	940	(51.3)
	Fair or poor	1252	(49.5)	77	(75.5)	298	(50.3)	877	(47.8)
	Missing	70	(2.8)	2	(2.0)	51	(8.6)	17	(0.9)
Limiting longstanding illness	No	1363	(53.9)	27	(26.5)	352	(59.4)	984	(53.6)
	Yes	1165	(46.0)	75	(73.5)	241	(40.6)	849	(46.3)
	Missing	2	(0.1)	0	(0.0)	0	(0.0)	2	(0.1)
Area of deprivation (Carstairs score)		**Mean**	**(standard deviation)**	**Mean**	**(standard deviation)**	**Mean**	**(standard deviation)**	**Mean**	**(standard deviation)**
		2.96	(4.50)	4.38	(4.47)	3.65	(4.53)	2.65	(4.45)

Table 3-8: t-1 characteristics of the total eligible out of work because of ill health sample at t-1, those missing at t and those followed up at t

Characteristics at t-1		Full eligible (593 person waves)		Missing: death (52 person waves)		Missing: other (185 person waves)		In analysis (408 person waves)	
		N	(%)	N	(%)	N	(%)	N	(%)
Sex	Male	394	(66.4)	45	(86.5)	90	(67.7)	259	(63.5)
	Female	199	(33.6)	7	(13.5)	43	(32.3)	149	(36.5)
Cohort	1970s	46	(7.8)	2	(3.8)	11	(8.3)	33	(8.1)
	1950s	224	(37.8)	9	(17.3)	52	(39.1)	163	(40.0)
	1930s	323	(54.5)	41	(78.8)	70	(52.6)	212	(52.0)
Housing tenure	Rent/other	440	(74.2)	36	(69.2)	102	(76.7)	302	(74.0)
	Own/mortgage	150	(25.3)	16	(30.8)	29	(21.8)	105	(25.7)
	Missing	3	(0.5)	0	(0.0)	2	(1.5)	1	(0.2)
Qualifications	High	22	(3.7)	4	(7.7)	2	(1.5)	16	(3.9)
	Low	266	(44.9)	24	(46.2)	54	(40.6)	188	(46.1)
	None	302	(50.9)	24	(46.2)	77	(57.9)	201	(49.3)
	Missing	3	(0.5)	0	(0.0)	0	(0.0)	3	(0.7)
Self-rated health	Excellent/good	102	(17.2)	7	(13.5)	22	(16.5)	73	(17.9)
	Fair or poor	472	(79.7)	45	(86.5)	97	(72.9)	330	(81.1)
	Missing	18	(3.0)	0	(0.0)	14	(10.5)	5	(1.2)
Limiting longstanding illness	No	72	(12.1)	5	(9.6)	32	(24.1)	35	(8.6)
	Yes	520	(87.7)	47	(90.4)	101	(75.9)	372	(91.2)
	Missing	1	(0.2)	0	(0.0)	0	(0.0)	1	(0.2)
Area of deprivation (Carstairs score)		**Mean**	**(standard deviation)**	**Mean**	**(standard deviation)**	**Mean**	**(standard deviation)**	**Mean**	**(standard deviation)**
		2.96	(4.50)	4.38	(4.47)	3.65	(4.53)	2.65	(4.45)

It is clear from this analysis that the final sample was not completely representative of the full eligible sample at t-1. Those who are included in the analyses in this chapter appear to be slightly more advantaged in terms of health and socioeconomic position, therefore estimates on return to work may be higher than would be expected had there been less attrition. However, the analyses in this chapter are interested in associations between variables rather than their prevalence. Associations are unlikely to be affected by biases caused by attrition in the same way that prevalence would be (Powers and Loxton, 2010; Wolke *et al.*, 2009).

3.4.3 Return-to-work analyses: results

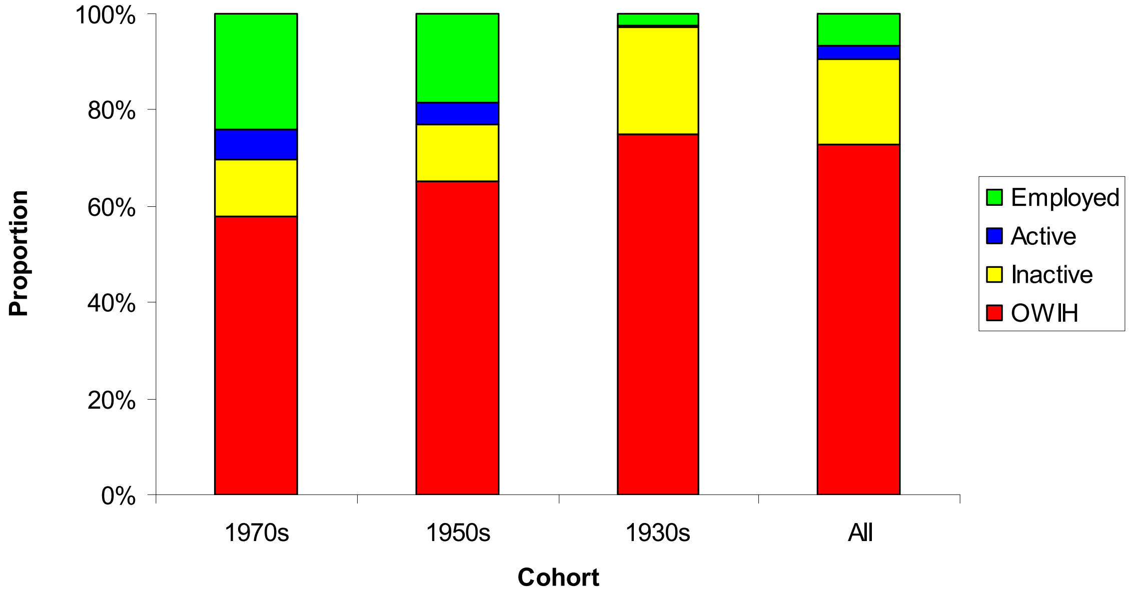
This section provides the results of the analyses looking at factors associated with return to work generally, and then factors associated with return to high- and low-quality work.

3.4.3.1 Return to work for those out of work because of ill health

To show which factors were significant predictors of return to work among those who were OWIH, the following sections describe the results of the relevant descriptive and multivariate regression analyses. Unadjusted models are shown in Appendix A.

A total of 408 transitions, involving 302 participants, were included in the analyses. Figure 3-4 shows employment status at t for those who were OWIH at t-1. The most common employment status was remaining OWIH (70.2%). Of those who were OWIH and participated in the study at the following wave only 27 participants (6.6%) moved into employment. Proportionately more of the 1970s cohort who were OWIH returned to work (24.2%) than the 1950s (8.6%) or 1930s (2.4%) cohorts. There are cohort differences between the destinations at t of those OWIH at t-1: other than remaining OWIH, the most common employment status at t for the 1930s cohort was ‘out of work inactive’. This is accounted for by working-age participants in the 1930s cohort self-classifying as ‘retired’ rather than any other workless status, despite that they technically remained working age.

Figure 3-4: Employment status at t for those out of work because of ill health (OWIH) at t-1, by cohort



Multivariate regression analysis with the independent variables that were statistically significant in the univariate models are shown in Table 3-9. Limiting illness was a significant predictor of return to work from a period OWIH adjusting for sociodemographic characteristics. Those with no limiting illness were over 12 times more likely to return to work when compared with those who had a limiting illness. However, as indicated by the wide confidence interval this was based on a small number (only 35 transitions involved participants with no limiting health condition).

Table 3-9: :Odds Ratios (ORs) for employment status at t, for those out of work because of ill health at t-1, by different measures of health (separate models) all adjusted for sample, sex, age, qualifications, tenure, and year

Health at t-1 (n participants/transitions):	Employment at t OR	95% CI	Significance p-value
Limiting illness (403/298)			
Has a limiting illness	1		
No limiting illness	12.81	(3.03, 54.1)	<0.001
Physical disability (201/163)	1		
Increment of one unit of OPCS disability score	0.87	(0.72, 1.04)	0.116

To provide more information on predictors of return to work, analyses with a larger sample was conducted—those who were out of work for any reason at t-1.

3.4.3.2 Return to work for those workless at t-1

The analyses in this section look at employment outcomes for those out of work for any reason at t-1. Results from unadjusted regression models are shown in Appendix A. The only health-related variable that was not significantly associated with return to work was alcohol intake; therefore this was not used in the multivariate models.

The maximum sample size for each statistical model was 1835 transitions, involving 1547 participants, but some models have fewer transitions because of missing information on variables used. Table 3-10 shows the proportion of those who had moved into employment at t by the different employment statuses at t-1.

Table 3-10: Employment status at t by workless status at t-1

	Employment status at t N (%)	
Employment status at t-1	**Remain out of work**	**Moved into employment**
Out of work because of ill health	381 (93.4)	27 (6.6)
Out of work active	245 (50.5)	240 (49.5)
Out of work inactive	619 (65.7)	323 (34.3)
Total workless	1245 (67.8)	590 (32.2)

The findings from the multivariate logistic regression models are shown in Table 3-11 and Table 3-12. As can be seen in Table 3-12, better health was associated with one and-a-half times to double the odds of employment at t. However self-esteem was not statistically significant once sociodemographic characteristics were included (Table 3-12). This suggests that self-esteem is associated with factors that are predictors of return to work e.g. age and qualifications, rather than being a predictor of return to work in itself. Including categories to define type of health condition did not show significantly different odds of return to work for those with mental or physical health conditions. However, only 4% of the sample reported a mental health condition without a physical health condition and of those only 18 (22.8%) moved into employment.

The sociodemographic factors shown to be statistically significant in Table 3-11 were consistently significant in the multivariate models with each measure of health, with the exception of marital status. Indicators of low socioeconomic position remained significantly associated with employment at t; those with low or no qualifications and those living in rented accommodation had lower odds of being employed at t in all models. Time of interview was also predictive of employment outcome, with those interviewed in the 1990s having significantly lower odds of return to work than those interviewed in the 2000s. Being OWIH at t-1 was consistently associated with (around four times) lower odds of return to work than those inactive at t-1.

Table 3-11: Odds ratios (OR) for employment at t for those out of work at t-1, by sociodemographic characteristics, adjusted for all variables in table

Sociodemographic characteristics (n = 1822 transitions/1285 participants):	Employment at t OR	95% CI	Significance p-value
Sex			
Female	1		
Male	1.10	(0.81, 1.49)	0.550
Age			
For every one year increase	0.93	(0.92, 0.94)	<0.001
Year			
2007-2008	1		
2000-2004	1.30	(0.85, 1.98)	0.225
1995-1998	0.67	(0.45, 0.99)	0.043
1990-1992	0.58	(0.40, 0.84)	0.004
Employment status at t-1			
Out of work inactive	1		
Out of work active	1.90	(1.37, 2.65)	<0.001
Out of work because of ill health	0.22	(0.14, 0.35)	<0.001
Housing tenure			
Mortgage/own	1		
Rent/other	0.62	(0.48, 0.81)	0.001
Marital status			
Currently married/cohabiting	1		
Not currently married/cohabiting	0.64	(0.48, 0.85)	0.002
Qualifications			
High	1		
Low	0.61	(0.43, 0.86)	0.005
None	0.47	(0.32, 0.69)	<0.001
Sample			
Locality	1		
Region	1.01	(0.76, 1.33)	0.969

Table 3-12: Odds ratios (OR) for employment at t for those out of work at t-1, by different measures of health (separate models), all adjusted for employment at t-1, sex, age, year, tenure, qualifications, and study sample

Health at t-1 (n transitions/n participants):	Employment at t OR	Employment at t 95% CI	Significance p-value
Self-reported health (1804/1276)			
Fair or poor	1		
Excellent/good	1.76	(1.36, 2.27)	<0.001
Limiting illness (1820/1283)			
Has a limiting illness	1		
No limiting illness	1.67	(1.27, 2.21)	<0.001
Type of health condition (1814/1280)			
Both physical and mental condition	1		
Physical condition only	0.98	(0.44, 2.17)	0.950
Mental condition only	1.17	(0.63, 2.18)	0.662
None	1.92	(1.04, 3.56)	0.038
N GP visits (1793/1273)			
12+	1		
0-11	1.67	(1.11, 2.51)	0.014
HADS anxiety or depression (1388/1088)			
HADS anxiety or depression case	1		
Not HADS anxiety or depression case	1.54	(1.15, 2.07)	0.004
Physical disability (754/592)			
Increment of one unit of OPCS score	0.88	(0.82, 0.95)	0.001
Self-esteem (945/728)			
Increase of one standard deviation	0.96	(0.82, 1.13)	0.637

3.4.3.3 Predictors of return to high- and low-quality work

It has been shown that few people OWIH at t-1 moved into employment at t and that health and sociodemographic factors at t-1 were strong predictors of employment status at t. Results of analyses presented in this section aimed to find out what factors were associated with the quality of job obtained following a period out of work.

Regression analyses explored which factors were associated with control over work among those who had moved from worklessness at t-1 to employment at t (Table 3-13). Those who were OWIH or active out of work at t-1 had lower odds of moving into a high-control job than those who were inactive at t-1, as well as those who rated their health fair or poor. Higher qualifications, but not housing tenure, were associated with high-control jobs, suggesting that qualifications are directly related to job control rather than qualifications being a marker of deprivation. Gender was associated with the type of job obtained; males had over double the odds of returning to a high-control job than females.

Workless status at t-1 did not predict job demand at t (data not shown); in the unadjusted model those who were OWIH at t-1 did not have significantly different odds of being in a low- rather than high-demand job at t than those who were inactive at t-1 (OR 1.33; 95% CI 0.46, 3.86; p=0.605). Also, health at t-1 did not predict job-demand status at t, meaning there was no evidence of health selection to high- or low-demand jobs.

Table 3-13: Odds ratios (OR) for high-control job at t among those employed at t, by workless status at t-1, adjusted for sex, age, marital status, tenure, qualifications, study sample, self-rated health at t-1, self-rated health at t

	High-control job at t*		**Significance**
(n=341 transitions/333 participants)	**OR**	**95% CI**	**p-value**
Employment status at t-1			
Out of work inactive	1		
Out of work active	0.43	(0.24, 0.78)	0.005
Out of work because of ill health	0.30	(0.09, 1.02)	0.054
Sex			
Female	1		
Male	2.76	(1.53, 4.97)	0.001
Qualifications			
None	1		
Low	1.58	(0.81, 3.10)	0.181
High	4.31	(1.98, 9.39)	<0.001
Self-rated health at t			
Fair or poor	1		
Excellent/good	2.32	(1.30, 4.15)	0.005
Age			
For every one year	0.97	(0.95, 0.99)	0.046

* Only the variables that were significant (p<0.05) in the model are shown in the table.

3.4.3.4 Return-to-work analyses: summary of results

There was a very low return-to-work rate for those OWIH. Although it was not possible to determine much about factors associated with return to work for this group, owing to few employment transitions, the analyses with the total workless group have shown that those who were OWIH at t-1 had lower odds of return to work even after adjusting for sociodemographic factors. Additionally, those with poorer health, older age, and lower socioeconomic position had lower odds of returning to work compared to those in good health, those who were younger and held a higher socioeconomic position. Wider factors also play a role in return to work—odds of return to work were higher in some interview years than others. Although there were no gender differences in odds of moving from worklessness to employment there were differences for the type of job that participants obtained; males had significantly higher odds of moving into a high-control job than females. The group OWIH were disadvantaged both in terms of whether they would return to work and in the type of job they would return to; they had lower odds of return to any type of work, and those who did return to work had lower odds of returning to a high-control job compared to those who were inactive out of work. There was no evidence of health (or other) selection to low-demand jobs.

3.4.4 Health-outcomes analyses: results

This section presents the analyses that explored the health outcomes of transitions into employment. It presents (1) health outcomes of transitions from worklessness to employment and (2) the role of job quality in the relationship between employment transitions and health.

3.4.4.1 Health outcomes of transitions from worklessness to employment

Table 3-14 and Table 3-15 show predictors of poor health at t for those out of work at t-1. The strongest predictor of poor or fair health and anxiety or depression at t was prior health, but other factors were significant as well. Table 3-14 shows that participants who remained workless had more than doubled odds of rating their health as fair or poor at t than those who moved into employment (after initial health, workless status, and sociodemographic characteristics were adjusted for). Table 3-15 shows that those who remained out of work also had higher odds of anxiety and/or depression than those who became employed. Even after adjusting for health at t-1 and employment status at t, being OWIH at t-1 was a significant predictor of both fair or poor self-rated health and having anxiety or depression at t. Although the previous section showed that there was some health selection to employment, these analyses suggest that such selection did not account for the full relationship between employment and health because the employment transition variable remained significant even after adding prior health to the models.

Table 3-14: Odds ratios (OR) for rating health fair or poor by potential predictors at t-1 and t, unadjusted and adjusted models for those out of work at t-1

(n transitions/ participants for unadjusted models—max if not shown)	Unadjusted odds of fair or poor self-rated health (max n=1833 transitions/ 1295 participants)			Adjusted* odds of fair or poor self-rated health (n=1626 transitions/ 1186 participants)		
	OR	(95% CI)	p-value	OR	(95% CI)	p-value
Employment status at t						
Employed	1			1		
Workless	3.43	(2.76, 4.25)	<0.001	2.52	(1.92, 3.32)	<0.001
Self-rated health at t-1 (1816/1286)						
Excellent/good	1			1		
Fair or poor	5.81	(4.66, 7.24)	<0.001	4.01	(3.14, 5.12)	<0.001
Workless status at t-1						
Other inactive	1			1		
Out of work because of ill health	4.86	(3.67, 6.43)	<0.001	2.52	(1.76, 3.59)	<0.001
Out of work – active	1.09	(0.86, 1.37)	0.491	1.15	(0.82, 1.61)	0.418
Sex						
Female	1			1		
Male	1.22	(0.99, 1.51)	0.064	0.87	(0.65, 1.16)	0.354
Age						
Each increase of one year	1.02	(1.01, 1.03)	<0.001	0.99	(0.98, 1.00)	0.099
Marital status at t-1 (1830/1294)						
Not currently married/cohabiting	1			1		
Currently married/cohabiting	0.84	(0.68, 1.04)	0.109	1.08	(0.85, 1.39)	0.517
Income (1647/1197)						
Increment of £1 per week	0.997	(0.995, 0.998)	<0.001	0.998	(0.997, 1.00)	0.060
Housing tenure (1830/1293)						
Own/mortgage	1			1		
Rent/other	2.54	(2.06, 3.13)	<0.001	1.64	(1.29, 2.09)	<0.001

* Adjusted for all other variables in table and study sample (region/locality)

Table 3-15: Odds ratios (OR) for HADS anxiety or depression caseness by potential predictors at t-1 and t, unadjusted and adjusted models for those out of work at t-1

(n transitions/participants for unadjusted models—max if not shown)	Unadjusted odds of anxiety or depression caseness (max. n=1685 transitions/ 1227 participants)			Adjusted* odds of anxiety or depression caseness (n=1105 transitions/ 895 participants)		
	OR	**(95% CI)**	**p-value**	**OR**	**(95% CI)**	**p-value**
Employment status at t						
Employed	1			1		
Workless	1.91	(1.54, 2.38)	<0.001	1.50	(1.05, 2.16)	0.027
HADS anxiety or depression case at t-1						
Not a HADS case	1			1		
HADS case	6.90	(5.31, 8.97)	<0.001	5.99	(4.53, 7.91)	<0.001
Workless status at t-1						
Other inactive	1			1		
Out of work because of ill health	2.11	(1.60, 2.77)	<0.001	1.59	(1.07, 2.38)	0.023
Out of work – active	0.82	(0.64, 1.06)	0.137	0.97	(0.65, 1.46)	0.887
Sex						
Female	1			1		
Male	0.81	(0.64, 1.02)	0.071	0.72	(0.51, 1.00)	0.049
Age						
Each increase of one year	1.01	(1.00, 1.02)	0.095	0.99	(0.98, 1.01)	0.329
Marital status at t-1 (1682/1226)						
Not currently married/cohabiting	1			1		
Currently married/cohabiting	0.88	(0.70, 1.11)	0.284	0.94	(0.69, 1.29)	0.706
Income (1507/1127)						
Increment of £1 per week	0.998	(0.997, 1.000)	0.025	0.99	(0.997, 1.001)	0.573
Housing tenure (1683/1225)						
Own/mortgage	1			1		
Rent/other	1.87	(1.50, 2.33)	<0.001	1.36	(1.02, 1.83)	0.038

* Adjusted for all other variables in table and study sample (region/locality)

3.4.4.2 The role of job quality in the relationship between a move to employment and self-rated health

To explore whether the positive health outcome following return to work held regardless of the quality of the job obtained, further analysis was conducted looking at the association between health and transition to low- or high-quality jobs.

Table 3-16 presents the final model showing the association between job control at t and self-rated health at t for those who were workless at t-1. Those who remained workless had higher odds of fair or poor self-rated health than those who moved into a low-control job. However, the model suggests that some of the association between transitions from worklessness to employment and self-rated health was attributable to job control; those who moved into a high-control job had significantly lower odds of poor or fair self-rated health than those who moved into a low-control job.

There were no significant differences in self-rated health at t between those who had moved into high-demand jobs and those who had moved into low-demand jobs (Table 3-17). This was also true in the univariate model that looked only at the relationship between job demand and self-rated health before adjusting for any other factors. Those who remained out of work had significantly higher odds of rating their health as fair or poor than those who moved into high-demand jobs, even after adjusting for prior health.

To summarise, those who remained workless had higher odds of poor self-rated health than those who moved into employment, regardless of the quality of the job. However, that is not to say that job quality is unimportant; those in high-control jobs had significantly lower odds of fair or poor self-rated health compared to those in low-control jobs. This association was not fully explained by selection by prior health or sociodemographic variables to high-control jobs, as these variables were controlled for in the model. Job demand was not associated with self-rated health; there was no statistically significant difference in self-rated health between those who moved into low- and high-demand jobs.

Regardless of employment transition and taking account of prior health, those OWIH at t-1 had higher odds of poor self-rated health than those who were inactive at t-1 (in Table 3-16 and Table 3-17). It was not possible to explore employment transitions with the OWIH group further; there were only 16 transitions from OWIH at t-1 to employment at t that had information on job quality and other covariates. Of these, only three moved into a high-control job and four into a high-demand job. Running the models with this small sample (or including interactions between workless category and job quality in the previous models) did not tell us anything more about the role of job quality for those OWIH at t-1.

Table 3-16: Odds ratios (OR) for rating health fair or poor by job control status at t, for those out of work (any reason) at t-1: adjusted for age, sex, marital status, study sample, self-rated health at t-1, tenure, income, workless status at t-1

	Fair or poor self-rated health*		Significance
(n=859 transitions/664 participants)	**OR**	**(95% CI)**	**p-value**
Employment status at t			
Low-control job	1		
High-control job	0.52	(0.29, 0.92)	0.026
Remain workless	2.40	(1.60, 3.60)	<0.001
Self-rated health at t-1			
Excellent/good	1		
Fair or poor	3.21	(2.31, 4.45)	<0.001
Workless status t-1			
Out of work inactive	1		
Out of work active	1.22	(0.77, 1.92)	0.392
Out of work because of ill health	2.96	(1.82, 4.80)	<0.001
Housing tenure at t-1			
Mortgage/own	1		
Rent/other	1.42	(1.02, 1.98)	0.037
Income at t-1			
Per £1 increase per week	0.998	(0.995, 1.000)	0.042

*Only variables that were significant (p<0.05) in the model are detailed in the rows.

Table 3-17: Odds ratios (OR) for rating health fair or poor by job demand status at t, for those out of work (any reason) at t-1: adjusted for age, sex, marital status, study sample, self-rated health at t-1, workless status at t-1, tenure, and income

	Fair or poor self-rated health*		Significance
(n=860 transitions/665 participants)	**OR**	**(95% CI)**	**p-value**
Employment status at t			
High-demand job	1		
Low-demand job	0.88	(0.50, 1.54)	0.648
Remain workless	2.82	(1.67, 4.76)	<0.001
Self-rated health at t-1			
Excellent/good	1		
Fair or poor	3.14	(2.27, 4.35)	<0.001
Workless status t-1			
Out of work inactive	1		
Out of work active	1.29	(0.82, 2.03)	0.276
Out of work because of ill health	3.10	(1.91, 5.04)	<0.001
Housing tenure			
Mortgage/own	1		
Rent/other	1.45	(1.04, 2.01)	0.027
Income			
Per £1 increase per week	0.998	(0.996, 1.000)	0.041

*Only variables that were significant (p<0.05) in the model are detailed in the rows.

Table 3-18 shows similar models to the previous sets, but with the sample that were out of work at t-1 and employed at t. This allowed both job demand and job control to be considered in the same model. In models 1, 2, and 3, odds of rating health as fair or poor were significantly higher for those who had been OWIH than out of work inactive at t-1. However, the addition of job quality variables to the model (model 4) attenuated these odds, making workless status at t-1 no longer statistically significant in the model (p=0.083). This suggests that part of the reason that those OWIH at t-1 had higher odds of rating health as fair or poor at t was to do with the types of jobs they moved into, although other factors must also be at play. Again, job control was significant in predicting self-rated health, whereas job demand was not.

Table 3-18: Odds ratios (OR) for rating health fair or poor by job demand and control at t, for those out of work (any reason) at t-1 and employed at t: adjusted for age, sex, marital status, study sample, self-rated health at t-1, tenure, income, job demand, and job control

	OR for fair or poor self-rated health (95% CI) p-value*			
(n=304 transitions/298 participants)	**1. Age, sex, marital status & study sample**	**2. Model 1 + self-rated health at t-1**	**3. Model 2 + tenure and income**	**4. Model 3 + job demand + job control**
Employment status at t-1				
Out of work inactive	1	1	1	1
Out of work active	1.52 (0.82, 2.81) p=0.183	1.48 (0.80, 2.75) p=0.214	1.43 (0.75, 2.75) p=0.281	1.26 (0.67, 2.37) p=0.470
Out of work because of health	5.93 (1.81, 19.42) p=0.003	3.89 (1.10, 13.74) p=0.035	3.75 (1.06, 13.29) p=0.041	3.03 (0.87, 10.60) p=0.083
Self-rated health at t-1				
Excellent/good		1	1	1
Fair or poor		2.26 (1.31, 3.88) p=0.003	2.24 (1.29, 3.87) p=0.004	2.34 (1.34, 4.07) p=0.003
Job control				
Low				1
High				0.45 (0.25, 0.81) p=0.008
Job demand				
Low				1
High				1.25 (0.71, 2.19) p=0.438

*Only variables that were significant ($p<0.05$) in one of the models are detailed in the rows.

3.4.4.3 The role of job quality in the relationship between a move to employment and anxiety or depression

To assess whether dimensions of psychosocial job quality had a similar impact on a different measure of health, the analyses from the previous section were repeated with HADS anxiety or depression as the health outcome rather than self-rated health.

Table 3-19 shows HADS anxiety or depression caseness for transitions from worklessness into low- and high-demand jobs, as well as for those who remained out of work. Job demand was a significant predictor of anxiety and/or depression caseness. Moving into a high-demand job was associated with double the odds of having anxiety or depression as moving into a low-demand job. There were no significant differences in odds of anxiety or depression for those moving into high-demand jobs and those who remained workless (this was also true before adjusting for other factors).

Those who remained workless had significantly higher odds of anxiety or depression than those who moved into a low-control job (Table 3-20 model 1). However, this association did not remain after sociodemographic factors and prior health were controlled for (model 2 and model 3). This suggests that moving from worklessness to a low-control job is not significantly different in terms of anxiety or depression outcomes than remaining workless. Moving into a high-control job was associated with lower odds of anxiety or depression than moving into a low-control job, although this association was attenuated by the addition of sociodemographic factors (model 2) and anxiety or depression at t-1 (model 3).

Table 3-19: Odds ratios (OR) for HADS anxiety or depression caseness by job-demand status at t, for those out of work (any reason) at t-1: adjusted for age, sex, marital status, study sample, HADS at t-1, tenure, income, job demand, and job control

(n=726 transitions/589 participants)	Anxiety or depression caseness* OR	(95% CI)	Significance p-value
Employment status at t			
High-demand job	1		
Low-demand job	0.53	(0.30, 0.93)	0.027
Remain workless	1.01	(0.58, 1.74)	0.978
HADS at t-1			
Not HADS anxiety or depression case	1		
HADS anxiety or depression case	7.05	(4.97, 10.00)	<0.001
Workless status t-1			
Out of work inactive	1		
Out of work active	0.99	(0.60, 1.64)	0.969
Out of work because of ill health	1.85	(1.09, 3.14)	0.022
Housing tenure			
Mortgage/own	1		
Rent/other	1.61	(1.13, 2.31)	0.009

*Only variables that were significant ($p<0.05$) in the model are detailed in the rows.

Table 3-20: Odds ratios (OR) for HADS anxiety or depression caseness by job control status at t, for those out of work (any reason) at t-1: adjusted for age, sex, marital status, study sample, HADS at t-1, tenure, income, job demand, and job control

	OR for HADS anxiety or depression caseness (95% CI) p-value*		
(n=725 transitions/ 588 participants)	**1. Job control**	**2. Model 1 + age, sex, marital status, sample, tenure & employment status at t-1**	**3. Model 2 + HADS anxiety or depression at t-1**
Employment status t			
Low-control job	1	1	1
High-control job	0.55 (0.34, 0.91) p=0.014	0.60 (0.36, 0.99) p=0.046	0.58 (0.32, 1.04) 0.068
Remain workless	1.57 (1.10, 2.26) p=0.019	1.39 (0.93, 2.06) p=0.105	1.26 (0.81, 1.97) p=0.311
Sex			
Male		1	1
Female		1.55 (1.05, 2.29) p=0.029	1.30 (0.85, 2.00) p=0.225
Workless status t-1			
Out of work inactive		1	1
Out of work active		0.84 (0.53, 1.33) p=0.467	0.94 (0.56, 1.57) p=0.815
Out of work because of ill health		2.37 (1.45, 3.88) p=0.001	1.79 (1.06, 3.03) p=0.031
Housing tenure			
Own/mortgage		1	1
Rent/other		1.66 (1.17, 2.36) p=0.004	1.60 (1.11, 2.29) p=0.011
HADS at t-1			
Not case			1
Anxiety or depression case			7.08 (4.98, 10.05) p=<0.001

*Only variables that were significant (p<0.05) in the model are detailed in the rows.

Looking only at those who moved into employment (Table 3-21), a similar result was obtained; job demand was a better predictor of anxiety or depression (those who moved into a high-demand job had almost double the odds of anxiety or depression than those who moved into a low-demand job) than job control (not significant in the model).

Table 3-21: Odds ratios (OR) for HADS anxiety or depression caseness by job demand and control at t, for those out of work (any reason) at t-1 and employed at t: adjusted for age, sex, marital status, study sample, HADS at t-1, tenure, income, job demand, and job control

	Anxiety or depression caseness*		Significance
(n=275 transitions/ 269 participants)	**OR**	**(95% CI)**	**p-value**
Employment status at t-1			
Out of work inactive	1		
Out of work active	1.42	(0.65, 3.09)	0.380
Out of work because of ill health	3.06	(0.76, 12.28)	0.115
Sex			
Female	1		
Male	0.46	(0.22, 0.95)	0.036
HADS anxiety or depression case at t-1			
Not a case	1		
Case	5.54	(3.10, 9.92)	<0.001
Housing tenure			
Mortgage/own	1		
Rent/other	2.24	(1.21, 4.13)	0.010
Job control			
Low	1		
High	0.60	(0.32, 1.11)	0.103
Job demand			
Low	1		
High	1.90	(1.06, 3.41)	0.031

*Only variables that were significant (p<0.05) in the models are detailed in the rows.

In summary, there did not appear to be any significant benefit in terms of anxiety or depression of moving from worklessness to a low-quality job. However, those who did return to a high-demand job had significantly higher odds of having anxiety or depression compared to those who moved into low-demand jobs. Job control was not significantly associated with anxiety or depression.

Mainly because of availability of HADS anxiety or depression in the study (it was not asked at wave three) there were different numbers of transitions in the analyses with anxiety or depression as an outcome and with self-rated health as an outcome. However, differences in the results were not related to the different samples in the two analyses—complete case analysis showed no meaningful difference in results (results not shown).

3.4.4.4 Health-outcomes analysis: summary of results

Moving from worklessness to employment was associated with better health outcomes (self-rated health and anxiety or depression) than remaining workless. However, this was not true for both measures of health once job quality was taken into account. There was not a statistically significant health benefit for anxiety or depression of moving into a low-quality job (high-demand or low-control job) compared to remaining workless. On the other hand, there was a health benefit in terms of self-rated health of moving into a high-demand or low-control job compared to remaining workless.

Comparing job quality for those who moved into employment showed that the different indicators of job quality had different associations with health. There was a statistically significant difference in self-rated health for those who moved into a high-control job compared to those who moved into a low-control job. There was a statistically significant difference in anxiety or depression for those who moved into a low-demand job compared to those who moved into a high-demand job. However there were no differences in self-rated health between those in low- and high-demand jobs and no differences in anxiety or depression between those in low- and high-control jobs.

Those who were OWIH at t-1 had lower odds of positive health outcomes than other workless groups. However, looking at the employed-only sample showed that part of the reason those OWIH at t-1 had poorer health at t than those inactive at t-1 was the quality of the jobs they moved into.

3.5 Discussion

This section discusses the results and considers how they compare to other relevant studies. The strengths and limitations of the analyses are then considered before conclusions are drawn.

3.5.1 Proportion out of work because of ill health

There were distinct cohort differences for proportions OWIH. As age increased, the proportion OWIH also increased. Although such differences were in large part down to age, period was also shown to be important. The data allowed a comparison of the same age groups at different periods in time e.g. age 35 in 1987 and age 35 in 2007. This analysis showed that as well as age and attrition effects, period also had an effect on the rate of participants OWIH. In 2007 participants were more likely to be OWIH than participants of the same age in 1987. This is in line with rates of IB claims in Scotland for these periods. However, as previously mentioned, it is difficult to fully unpick age, period, and cohort effects using these data. For example, the employment context for those aged 35 in 2007 and those aged 35 in 1987 was very different in that the late 80s were a time of industry closure and rising unemployment in the west of Scotland where as 2007 was characterised by relatively high employment.

3.5.2 Return to work for those out of work because of ill health

The analysis showed that a low proportion of those OWIH moved into employment in a five year follow-up period, and based on the information available, this is also true of longer follow-up periods. Seventy percent of those who were OWIH were OWIH five years later. As discussed, this may reflect some bias owing to selective drop out. However, the direction of bias is most likely to mean that the proportion is an overestimate of return to work. This is because the analysis sample was slightly more healthy and less deprived than the total eligible sample and therefore more likely to return to work (based on the predictors of return to work determined in the analyses). Such a low rate of return to work highlights how much has to be done if people are to be supported into employment.

One of the findings was that those who transitioned out of a period OWIH did not necessarily move into employment; a higher proportion went to being inactive out of work. The focus in the UK is to move people off of OWIH-related benefits, both by stricter reassessment of health for all IB recipients and by providing support to individuals to move into employment. However, little good quality research has been done to assess whether such measures are having an impact on employment outcomes. Recent (2012) figures show that although the number of people receiving IB and ESA has fallen, less than half of those who stop receiving ESA move into employment (Adams, 2012). It is important for the Department for Work and Pensions (DWP) to continue to monitor employment outcomes after IB and ESA receipt, rather than simply looking at rates of benefit receipt, particularly if the benefit was stopped because the recipient was judged that they were no longer eligible.

3.5.3 What factors are associated with return to work for those out of work without an employment contract?

Every measure of self-rated, physical, and mental health that was tested was important for a return-to-work outcome. This is evidence that health is important for a transition into employment and that poor health is likely to be a barrier to return to work. There are different possible reasons for this: those with poor health or disability are not able to work (therefore do not look for jobs); or do not think they can find a job because of issues related to their health condition e.g. employer discrimination or an unsuitable or inaccessible workplace (so do not look); or they cannot find a job (despite job search). Different reasons have different implications for the type of intervention required e.g. from support with management of health conditions to improvement of labour-market opportunities for those with a health condition or disability.

Other than poorer health, those who have lower socioeconomic position may have fewer employment opportunities because of lower qualifications, lack of employment opportunities in the area, and/or employer discrimination. Likewise, older age may be associated with lower odds of return to work because of employer discrimination or because of making the decision to retire. Similar to poor health it is not clear whether these characteristics make people less likely to look for a job or less likely to be offered. However, the findings that poor health, older age, and lower qualifications are all significantly associated with low-control jobs for those who do return to work suggest that these characteristics lead to disadvantage in employment outcomes.

Alcoholism was the reason for claiming IB in over 6% cases in Scotland and in Glasgow in 2000 (Brown *et al.*, 2008), yet alcohol intake was not associated with a transition from worklessness to employment, even before adjusting for other covariates. One possible explanation is that those in the poorest health do not drink alcohol at all or move into employment, both because of their health, eliminating the association between alcohol and employment for the group as a whole. This is one problem with using alcohol units as a variable: there may be a difference between those who have never consumed over the recommended alcohol limit and those who no longer exceed the limit because of a decline in health. Typically there is a 'J-shaped curve' relationship between alcohol intake and health, whereby non-drinkers and heavy drinkers have higher mortality than light or moderate drinkers (Di Castelnuovo *et al.*, 2006).

It is difficult to disentangle the effect of psychological factors from their context i.e. those who have low confidence or motivation may do so because their chances for return to work are low. The finding in this chapter—that self-esteem was significantly associated with return to work in the univariate analysis but not once other factors were adjusted for—suggests that it correlated with other sociodemographic or health or macro-level factors that are also predictors of return to work. In effect, therefore, psychosocial factors may play a role in return to work for some of those OWIH—there is likely to be a relationship between psychological and social factors rather than psychological factors acting alone (Martikainen *et al.*, 2002). This challenges the assumption that measures need to be put in place to improve the confidence of those who are receiving IB or ESA in order for them to find employment—if the reasons for low self-confidence were removed then perhaps it would not be an important factor. Focus in welfare-policy documents locates confidence and motivation for return to work with the individual and therefore recommends individual-focused interventions to support return to work (Gregg, 2008; HM Government, 2009). However, this focus is on the psychological rather than the psychosocial therefore may not address the full problem.

Similar to other studies that looked at individual return-to-work outcomes, sex and marital status were not predictive of return to work. Beatty *et al.* (2009) have conducted various strands of qualitative and quantitative research looking at whether there is a need for different approaches to support men and women into work. Although the explanation for the rise in number of female IB claimants is slightly different to the rise in male IB claimants, the research largely finds that males and females now benefit from similar return-to-work support, especially since "distinction between 'male' and 'female' jobs is becoming more blurred" (Beatty *et al.*, 2009, p.34). The analysis in this chapter supports that gender is not a predictor of return to work. However, despite 'male' and 'female' jobs being similar, it appeared from the analysis that females became employed in poorer-quality employment following a move from OWIH. This could be related to available employment with suitable hours for those with family responsibilities or could be related to more deep-rooted issues with employment positions for men and women. Either way, there appears to be a need to improve working conditions for women in particular. Smith (2010) argues that gender inequalities are likely to be exacerbated if gender identities continue to be invisible in welfare-to-work policy, leading to further embedding of gender inequalities (Lewis, 2007; MacLeavy, 2007).

Macro-level context was accounted for by including the variable 'year' in return-to-work analyses. There were marked differences in the labour market over the study period. The employment rate in Glasgow was still low in the 1990s largely owing to the effects of deindustrialisation and large scale loss of manual jobs over the previous decades (Webster *et al.*, 2010). However, the labour market did strengthen in the 1990s and rates of IB receipt began to fall: 18.8% of the working-age population were receiving IB in Glasgow in 2000, but this levelled off and steadily dropped to 13.6% by 2008 (Brown *et al.*, 2010). The results from the current analysis are in line with such changes in the labour market. 'Year' was significantly associated with return-to-work outcomes in much of the analyses, with odds of employment being higher in the 2000s than in the 1990s. Although this does not provide information on specific factors that caused the period effect, the findings add to the evidence that macro-level context plays a role in the return-to-work pathway of those who are OWIH.

3.5.4 Return to work: good for health?

There was evidence that a transition from worklessness, and more specifically OWIH, to employment was associated with good or excellent self-rated health.

As discussed in the previous section the effect of health selection to employment was evident. However, selection of the healthiest to employment does not account for all of the association between return to work and better health. The worklessness-employment transition itself was significantly associated with better health even after accounting for prior health, thus suggesting there were beneficial health effects from making the transition. These findings support the argument that the government has used to promote work rather than benefit receipt—that work is good for health (Black, 2008; Waddell and Burton, 2006). However, when employment was broken down there was evidence that the quality of the job obtained was associated with the positive health outcome.

Findings on job demands and anxiety and depression are consistent with other studies that have analysed the association between job demands and mental health (Bonde, 2008; Netterstrøm *et al.*, 2008; Nieuwenhuijsen *et al.*, 2006; Stansfeld and Candy, 2006). There are less consistent findings with mental health and job control in previous research, whereby some studies have found associations and others have not (Netterstrøm *et al.*, 2008). The analyses with Twenty-07 data did not find an association between job control and presence of anxiety or depression. The opposite results were found when looking at self-rated health outcomes; job control was significantly associated with self-rated health whereas job demand was not.

There were also some differences in health between those who remained out of work and those who moved into low-quality jobs. Those who moved from worklessness to a low-quality (high-demand/low-control) job did not have any better anxiety or depression outcomes than those who remained workless. This finding is similar to other longitudinal research that has found that remaining unemployed is associated with similar or worse health than moving into a poor-quality job (Butterworth *et al.*, 2011; Leach *et al.*, 2010). However, remaining workless was associated with poorer self-rated health than moving into a low-quality job (either low-control or high-demand).

Like Leach *et al.* (2010) slightly different outcomes were found for different measures of health. However, neither of the previous longitudinal studies looking at transitions from unemployment to low or high-quality jobs considered self-rated health as an outcome.

3.5.5 Strengths and limitations

Strengths and limitations of the analyses are considered before outlining further research.

Although an important finding in itself, the fact that a small proportion of those OWIH moved into employment meant that the number of transitions in the analyses for this group was low. It was not possible to determine with confidence the return-to-work predictors specifically for this group. However, inclusion of separate workless categories within the analyses with the larger workless group showed that those OWIH had poorer employment outcomes when compared with other workless groups. Given that very little quantitative analysis with longitudinal data has been done on return to work for this group, this is a step towards better understanding.

As is true of all longitudinal studies there was some attrition throughout. Those who took part differed from those who were lost to follow-up in that they were socioeconomically more advantaged and in better health. Previous research has been done to analyse whether non-response in longitudinal studies has an effect on exposure-outcome associations, finding that although results related to prevalence could be problematic, effects of non-participation on odds ratios between exposure and outcome are small (Nohr *et al.*, 2006; Wolke *et al.*, 2009). The rate of return to work for those OWIH should therefore be taken with caution, in that it is likely to be overestimated.

Non-overlapping cohorts (with the exception of two brief age points) meant that it was difficult to compare the prevalence of OWIH at different time periods because age and cohort effects could not be separated. A larger study, with data on employment status for people of the same age at different time periods would facilitate more in-depth investigation and comparison of the effects of age, period, and cohort on employment outcomes.

Some of the factors in the conceptual model could not be controlled for in the analyses because they were not available in the data e.g. length of time out of work, participation in return-to-work interventions, attitudes and expectations for return to work. The measure of job quality available for analysis in the Twenty-07 Study was Karasek's job demand and job control. However, there are other aspects of job quality that may play a part in the association between work and health e.g. social support, job insecurity, effort-reward imbalance (Butterworth *et al.*, 2011; Leach *et al.*, 2010), which could not be included in these analyses.

It is possible that personality factors play a role in people's assessment of their jobs (Spector, 1994). The Twenty-07 data did not include any explicit measures of personality; therefore this could not be controlled for in the analysis.

Despite these limitations, this research has added longitudinal analysis to the limited existing literature, exploring factors that are important for transitions from OWIH to employment and the health outcomes of the transitions. It has the benefit of having a wide range of relevant covariates that previous studies did not have. Even for the workless group more generally there is little available evidence on the health impact of transitions into employment that take account of the quality of the job obtained. The longitudinal design of the Twenty-07 Study made it possible to take account of health and other covariates prior to the employment transition to test the independent effect of the transition on health. Additionally, analyses of data that was able to explore cohort and period effects allowed valuable information that studies with specific age groups and/or at specific points in time do not permit.

3.5.6 Further research

The longitudinal data analysis presented in this chapter has provided evidence on predictors of return to work for those out of work. However, there are different possibilities for why each is important in the relationship e.g. health may be a barrier to work because it stops people looking for work or because there is a lack of suitable and available employment. Owing to low rates of return to work for those OWIH, little longitudinal research has been able to provide statistical analysis on this group. Qualitative research is one method of finding out more about the group where quantitative research is limited. Furthermore, even when quantitative research is possible qualitative research is important. The quantitative research in the last two chapters has shown which factors are important in the return-to-work pathway, but—other than showing which variables are significant—has not provided information about why these factors play a part. In order to better understand the situation of those OWIH, more in-depth research with people who are OWIH is required.   Chapter four expands on this by reviewing qualitative studies of barriers to work for people out of work because of health.

Chapter four: Systematic review and qualitative synthesis

This chapter presents a systematic review and synthesis of qualitative studies that aims to explore perspectives on barriers and facilitators to work for people out of work because of ill health (OWIH).

4.1 Rationale for study and chapter layout

The previous chapter provided information on predictive factors for return to work. However, it did not provide much insight into how and why these factors affect the possibility of return to work. Qualitative research can help us to understand how these factors act as mechanisms in return to work for those OWIH. Qualitative research also gives greater opportunity—than quantitative research with pre-determined topics—for participants to set the agenda about what issues are important to them.

4.2 Aim and research questions

Research questions:

What factors do people OWIH say are barriers or facilitators to employment, and why/how?

Are there differences in emphases placed on barriers or facilitators to work by those OWIH, and are there patterns in these differences e.g. by health condition or personal characteristics?

Qualitative studies that explored perspectives of those OWIH on their facilitators and barriers to work were identified and synthesised to address these research questions. The over-arching aim was to provide an explanation of the barriers to return to work for those OWIH by producing a synthesis of the findings from the identified qualitative studies. It was intended that the synthesis would provide new findings amounting to more than the sum of each of the individual studies (Thorne *et al.*, 2004).

4.3 Methods

This section has four main parts: inclusion criteria, search strategy, critical appraisal, and data synthesis. There are debates and methodological considerations surrounding different aspects of qualitative syntheses, and these are discussed in the relevant sections before describing the methods used.

As is standard procedure in systematic review methods, to ensure rigor, a colleague was involved as a second reviewer (ME). ME was involved in screening a sample of identified studies, critical appraisal, and checking the identification of themes. His input to the review is indicated throughout.

4.3.1 Inclusion criteria

The review included papers whose primary focus was participants' experiences of being OWIH and their views on return to employment. Studies had to use qualitative methods of data collection and analysis, and participants had to be reflecting on their experience of gaining employment, with reference to having a health condition or disability. Initial inclusion and exclusion criteria are shown in Table 4-1; however, these were refined iteratively as the review progressed (details of refinement given in later sections). Inclusion criteria were defined with assistance of the SPIDER tool: Sample, Phenomenon of Interest, Design, Evaluation, Research type. SPIDER is a variation of the commonly used PICO (Population, Intervention, Comparison, Outcome) tool for quantitative research (Cooke *et al.*, 2012). Studies were included regardless of whether or not participants had already returned to work, as long as they had experience of being OWIH. This was important as it meant that issues for people who remained workless could be compared to those identified by people who had returned to work.

It was expected that the search may identify studies related to particular conditions and potentially in diverse settings. However, the inclusion criteria were initially kept broad with the intent that they would be revised after full-text screening and critical appraisal, particularly if there were an unmanageable number of, or very diverse, studies. It was not known whether differences by health condition and country would be appropriate for synthesis until going through each of the studies. Such an approach is consistent with other published qualitative syntheses. For example, Campbell *et al.*'s (2003) synthesis of experiences of diabetes combined studies looking at type I and type II diabetes, and although the two types were thought to be clinically different, the review authors in the end decided that the "syntheses should not be driven by medical considerations but should rather concern itself with the way in which patients' experience disease and illness" (p.674). Initially it was not clear whether a similar conclusion about different health conditions and experiences of employment would be reached here. Further inclusion criteria are discussed alongside the section on critical appraisal and relevance grading, which is the stage at which inclusion criteria were finalised.

Table 4-1: Inclusion and exclusion criteria for studies

SPIDER	Inclusion criteria	Exclusion criteria
Sample	Working age participants who have experience of being out of work because of ill health.	Studies focusing on participants with learning disabilities. Studies that included populations that were outwith working age.
Phenomenon of Interest	Return to work from worklessness.	Experiences of being on short-term sick leave and returning to work i.e. returning to the same job, having kept an employment contract.* Only look at experiences of maintaining employment.
Design	Interviews & focus groups (& other methods that elicited participants' experiences from their point of view).	Questionnaires, surveys, single case studies.
Evaluation	Views, attitudes, beliefs about the phenomenon of interest.	
Research type	Qualitative methods.	Studies that only used quantitative methods, literature reviews, editorials, single case studies.
Locations	All countries.	
Language	English.	All other languages.
Year of publication	1995-2011.	Outwith 1995-2011.

* Different countries have different rules regarding employment contract & sick leave, for example in The Netherlands employers are responsible for vocational rehabilitation of employees for the first 2 years of sick leave and employees cannot apply for disability benefits until 1.5 years sick leave (Dekkers-Sanchez *et al*., 2010). Therefore, studies were included if they involved participants who retained an employment contract but who had been out of work for ≥12 months.

4.3.2 Search terms and sources

After initial scoping in two database platforms (CSA Illumina and Ebsco), a list of possible search terms were identified. Certain terms were removed because of the number of irrelevant hits they produced e.g. the keyword 'work'. The terms were then modified for use in each of the databases. Different terms were used between databases where appropriate to reflect specific subject headings or index terms. A full list of search terms for each database is given in Appendix B.

Although the SPIDER tool was used when defining inclusion criteria, it was not practical to limit the search to each of its components e.g. searches were not confined to one methodology as qualitative research is not commonly indexed in bibliographic databases to the same extent as quantitative research (Cooke *et al.*, 2012). Two sets of search terms were written, one relating to the sample (those who have experienced being OWIH) and one to the phenomenon of interest (return to work). Terms related to 'return to work' included broad terms for employment e.g. 'job', and 'labour market', and sample terms included those related to disability and welfare benefits. Keywords and index headings/Medical Subject Heading terms were used. All searches were limited to English language papers published from 1995. Searches were conducted in March and April 2011.

Eleven electronic databases were searched: Applied Social Sciences Index and Abstracts (ASSIA), Sociological Abstracts, Social Services Abstracts, Worldwide Political Sciences Abstracts, International Bibliography of the Social Sciences (IBSS), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Psychology and Behavioural Sciences, Psych INFO, SOCINDEX, MEDLINE, and Social Care Online.

A request was sent to the IDOX information service for articles relevant to 're-entering employment for people with health problems and disabled people'. Organisation websites were also searched: The Campbell Library, Mind, Scottish Centre for Healthy Working Lives, Joseph Rowntree Foundation, and the Department for Work and Pensions (DWP) research reports by subject. Reference lists from included research were examined for other potential studies.

Search terms were produced, electronic databases searched, and full screening conducted by one reviewer (KS). An independent screening of the title and abstract was done on 10% of the retrieved papers, and on 14% of the full texts by the second reviewer (ME). Disagreements were discussed and consensus reached. Data extraction was carried out by one reviewer (KS) and checked by another (ME).

4.3.3 Critical appraisal and relevance grading

Qualitative methodologies vary in terms of data collection method and approach, meaning that developing a critical appraisal tool is problematic

(Dixon-Woods *et al.*, 2004). Some argue that because of these issues, quality in qualitative research cannot be scored by fixed criteria e.g. (Garratt and Hodkinson, 1998). Others reason that there is a practical need for quality appraisal using standard assessment tools, but such tools should not ignore that qualitative research involves different methods and approaches (Dixon-Woods *et al.*, 2004).

A number of quality appraisal tools for qualitative studies have been defined, but there is no agreed standard framework for use in systematic reviews (Petticrew and Roberts, 2006). Seale and Silverman (1997) advocate the use of counts (to show how common and representative events and instances are), computer programmes in analysis (to ensure it is systematic), and the use of detailed transcripts (to allow a more accurate and objective analysis) as tools, to be able to assess the 'rigour' in qualitative research. A more popular approach, critical of methods that treat quality assessment of qualitative and quantitative research in the same way, identifies three broad criteria that underpin the assessment of good quality research: "interpretation of subjective meaning, description of social context, and attention to lay knowledge" (Popay *et al.*, 1998, p.345). Different critical appraisal tools have been developed that align with or incorporate these broad criteria (e.g. Attree and Milton, 2006; NHS Critical Appraisal Skills Programme, 2003; Spencer *et al.*, 2003).

Just as there is no standard quality appraisal framework, there is no standard agreement on how to apply the criteria e.g. to facilitate decisions on inclusion, to use as consideration points during the review, or to weight evidence used in the review. Noting that different aspects of quality appraisal carry different weights and that there are no standard methods of deciding which aspects are more important to determine inclusion and exclusion, some feel that studies should not be excluded from synthesis on this basis e.g. Sandelowski (1997). Saini and Shlonsky (2012) suggest that studies should not be excluded based on quality, but quality assessment should be part of the analysis as it can add to the interpretation and synthesis; whereas Atree and Milton (2006) argue that poor quality studies cannot be reliably used as evidence for confidently formulating policy and practice and therefore should be excluded.

Critical appraisal was deemed necessary for this review; it was felt that distinction should be made between the qualities of the identified research, which should be taken into account in the synthesis. It was decided that a critical appraisal tool would allow the quality to be assessed in a structured format and would mean that appraisals between reviewers could be compared with use of the explicitly recorded reasons for each judgement. The quality appraisal tool developed by Attree and Milton (2006) was used, which allowed grading of papers with a quality score. Details of the quality appraisal are given in Table 4-2. The final grade was not achieved from totalling the scores from each domain—a subjective score was decided upon independently by both reviewers with differences of opinion resolved through discussion.

Table 4-2: Checklist for the quality appraisal

Quality score: A (no or few flaws); B (some flaws); C (considerable flaws, study still of some value); D (significant flaws that threaten the validity of the whole study).

Methodological area	Key criteria	Yes/No & details	Score
Background of research	Source of funding (relationship to findings?) Name of study Is the connection of the research to an existing body of knowledge or theory clear?		
Aims and objectives	Is there a clear statement of the aims of the research? Are the research questions clear?		
Context	Is the context or setting adequately described?		
Appropriateness of design	Are qualitative methods appropriate? Is the research design appropriate to address the aims?		
Sampling strategy & sample size	Is the sampling strategy appropriate to address the research aims? Criteria used to select the sample: Does the sample include an adequate range of possible cases or settings? Is the sample size justified? (Data saturation.) Did any participants choose not to take part? If so, why?		
Data collection	How data were collected, and by whom? Is the form of data clear (e.g. tape recordings, fieldnotes etc.)? Were any methods modified during the research process? If so, why? Does data collection involve triangulation (of multiple methods or data sources)? Is there evidence that data collection was systematic (e.g. an ‘audit trail’)?		
Data analysis and findings	How was the analysis carried out? Are sufficient data presented to support the findings? How were data selected for inclusion in the report? Are data annotated with demographic details of contributors? Do the findings directly address the research question? Does the research privilege subjective meaning? What steps were taken to demonstrate the trustworthiness of the findings (e.g. negative cases, respondent validation)? Have the limitations of the study and their impact on the findings been taken into account?		
Reflexivity	Has the relationship between researchers and participants been adequately considered? Do the researchers reflect on their personal viewpoints and experience that they bring to the research setting?		
How valuable or useful is the research?	Does the research add to knowledge, or increase the confidence with which existing knowledge is regarded? Is there discussion of how findings relate to wider theory; consideration of rival explanations? What are the implications for policy and practice – how is it ‘fit for purpose’?		
Ethics	How have ethical issues been taken into consideration (e.g. consent, confidentiality, anonymity, distress to participants)?		
		OVERALL STUDY SCORE	

As well as critical appraisal for quality, a further appraisal for relevance was required. As previously mentioned, this was done after the critical appraisal stage as it was unknown how many studies would be identified and how diverse they would be in terms of setting and health conditions. The best quality studies were appraised for relevance first. Having judged the relevance of those studies with critical appraisal grades A/B/C it was decided to exclude those graded D, these studies were therefore not appraised for relevance.

Table 4-3 gives details on each dimension of the relevance appraisal. Studies scoring C on any of the dimensions were excluded. Although there were differences in terms of the health conditions and disabilities reported in the retrieved studies, there were similarities in the participants' experiences of barriers and facilitators for return to work. It was therefore decided not to limit included studies to one particular health focus or employment status. Studies that did appear to have slightly different findings were those that looked at barriers and facilitators to work specifically for people OWIH owing to HIV/AIDS status. None of these studies were included in the final sample (mainly because they were from USA so were excluded on country basis—if any had been judged relevant and of good quality a further decision on whether to include them would have to have been made).

Table 4-3: Scoring relevance of qualitative papers

Dimensions & explanations	Score (A-C)
Focus of the study	
To explore barriers/facilitators to employment for people with poor health/disability.	A: If this was the main focus of the study. B: if a substantial part of the paper focused on this. C: If this was only a small section of the study, or if the results were purely descriptive (e.g. description of the barriers that people faced rather than an exploration of how they acted as barriers).*
Country/setting	
It became clear that studies undertaken in the USA frequently brought up factors that were not relevant to the study of return to work in the UK e.g. to do with medical insurance and healthcare.	A: UK. B: countries with developed welfare systems similar to the UK. C: for other (including USA because of differences in health insurance that were picked up on in retrieved papers).
Employment status	
Studies were included if they involved (i) participants with a disability who had experience of being on the open job market for any length of time, and/or (ii) participants who had been off work with a disability for over 12 months who may or may not be able to negotiate returning to their previous employer.	A: Studies where the full sample was made up of one or both of these groups. Studies that included one or both of these groups as part of a wider population: B: Those studies that allowed us to distinguish the findings from the included groups from other members of the sample. C: When no distinction was possible or where studies that did not contain either of these groups.

* This was a subjective assessment based on joint agreement between the two reviewers.

Critical appraisal was carried out by both reviewers and scores for each dimension were compared. Relevance appraisal was done by KS and checked by ME.

4.3.4 Data synthesis

There has been debate about the appropriateness of integrating qualitative research from different studies, particularly because by doing so there is the possibility of losing any sense of context from the data. However, interpretive synthesis is possible and has benefits in that it builds knowledge from different sources (Pope *et al.*, 2007). The over-arching aim of an interpretive method for synthesising qualitative studies is to bring together the findings from each study, going further than the findings from each included study (Pope *et al.*, 2007). Where meta-analysis of quantitative studies seeks to pool and aggregate findings from individual studies, interpretative qualitative synthesis seeks to bring together the concepts from each study and translate them into one another in order to develop higher-order theory (Dixon-Woods *et al.*, 2005; Pope *et al.*, 2007).

Several publications have suggested possible ways to synthesise research findings from qualitative studies (e.g. Barnett-Page and Thomsa, 2009; Dixon-Woods *et al.*, 2005; Ring *et al.*, 2011). Barnett-Page *et al.* (2009) identified nine main approaches plus three others that have not been as widely used. Meta-ethnography was chosen as the synthesis method for this review. It is perhaps the most developed and widely used method of qualitative data synthesis. Meta-ethnography developed out of the interpretivist paradigm, in keeping with most qualitative research studies that it seeks to synthesise (Noblit and Hare, 1988). Synthesis using meta-ethnography has led to valuable insight, particularly in healthcare, which has resulted in recommendations for policy and practice e.g. related to medicine taking (Pound *et al.*, 2005) and asthma action plans (Ring *et al.*, 2009 referenced in Ring *et al.*, 2011).

Although Noblit and Hare (1988) originally developed meta-ethnography from the initial stage of the review (step 1: identify the area of interest that qualitative research can inform), they did not devise the method to include an exhaustive search for literature and did not provide guidance on critical appraisal. However, it was felt that for the current study it was important to be transparent in selection of primary studies for review; lack of transparency at this stage has been identified as a problem for meta-ethnography (Dixon-Woods *et al.*, 2005). The meta-ethnography method was adopted for the synthesis because it offered a systematic approach. It also allowed interpretations of the primary data (the authors' interpretations of their data) to be retained alongside 'third-order' interpretation—unlike many other synthesis methods, which provide more descriptive concepts (see Table 4-4 for description of first-, second- and third-order constructs) (Britten *et al.*, 2002).

Table 4-4: Explanation of different key constructs involved in qualitative syntheses

Constructs	Explanation
First-order	Understandings of participants in the studies.
Second-order	Author interpretations of their participants' understandings.
Third-order	Interpretations from synthesising second-order constructs.

Noblit and Hare's (1988) steps to meta-ethnography were followed:

1. Determine how the studies are related: create a key list of concepts, phrases, ideas, and begin to work out how the studies are related with respect to their main concepts.

2. Translate the studies into one another: compare the main concepts from each study and identify the similarities and differences.

3. Synthesise translations: take similar concepts from the previous steps and construct third-order interpretations (Britten *et al.*, 2002). There are three main strategies when synthesising studies: 'reciprocal translations' where the concepts in the studies are comparable; 'refutational translations' where concepts are in opposition; and taken together a 'line of argument synthesis' involves creating a general interpretation from the key concepts to answer the research questions (Noblit and Hare, 1988).

It was not pre-determined whether the synthesis would follow a reciprocal or refutational strategy, or to follow a particular line of argument; the process was data-driven. Britten *et al.*'s (2002) worked example of their qualitative synthesis was referred to for further guidance on the steps of conducting the meta-ethnography, in particular in adopting methods to ensure transparency throughout.

Key themes from each study were identified and added to a matrix (similar to that used in qualitative Framework Analysis: Ritchie and Lewis, 2003). KS and ME began identifying themes independently, using different studies as starting points with the purpose of reducing the possibility that the first group of studies reviewed would be most influential in determining the themes for review. Differences were discussed before a final matrix of key concepts was devised (by

KS). Nvivo software was used to organise the data from each study by key concept (by KS). Synthesis of second- and third-order concepts was developed by KS with feedback from ME through discussion.

4.4 Results

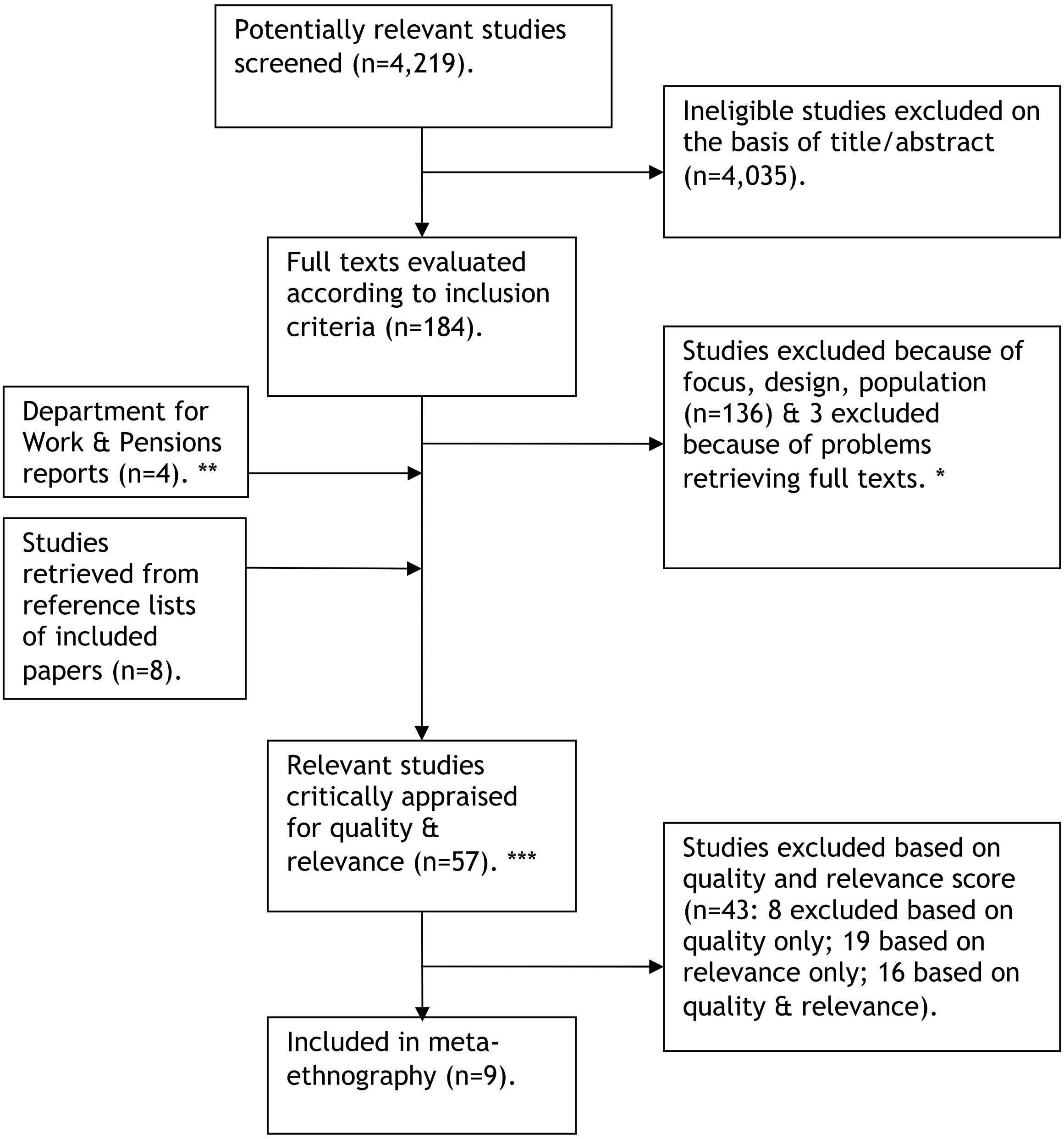
After removing duplicates, 4,219 studies were retrieved from bibliographic databases and twelve from organisational searches and reference lists. Figure 4-1 shows a flow chart of the retrieved studies through to inclusion in the synthesis.

Twenty-five of the full texts were screened by both reviewers (ME screened 25 of the total 184, and KS screened all 184) there was agreement on all but one and a decision was made through discussion (agreement was with KS who did the full sample of screening).

An example of a completed critical appraisal form is given in Appendix B. Agreement between the two reviewers for the overall quality grades from critical appraisal was 80%; disagreements were discussed and consensus reached. Of the 57 studies critically appraised, five were graded ‘D’ (lowest score) and were therefore not taken forward for relevance scoring; therefore 52 studies were appraised for relevance. Appendix B details the final grades for the individual dimensions and overall score of the critical appraisal, as well as indicating where there was initial disagreement on overall grades. The table in Appendix B also includes the relevance score details for each of the 52 studies. Details of the nine studies that were included in the synthesis are provided in Table 4-5. The final summary line gives an overview of the group of included studies.

The following section is split into two main parts (4.4.1 and 4.4.2). The first is descriptive and draws from participant voice (first-order constructs) rather than author interpretation. The second explores authors’ interpretations (second-order constructs) and moves on to the synthesis, which includes my interpretation of the data (the formation of third-order concepts). The reason for separating participant and author voice was that, on the whole, there were many similarities between studies on what participants actually said about barriers and facilitators to work; however, the interpretation of these findings sometimes differed between authors. Also, the descriptive summary was undertaken as a preliminary stage leading to the synthesis, in order to develop ideas and be transparent about how the synthesis progressed.

Figure 4-1: Flow chart of inclusion of identified studies



* One was a short report and the author was emailed for the full report but the email address was out of date. Two were dissertation abstracts and full texts could not be retrieved.

** Some DWP reports were identified in the database search, but the most relevant ones from the full list on website were included (7 in total).

*** Five studies were given a quality grade D & were therefore not appraised for relevance.

Table 4-5: Study characteristics

First author, year, country (critical appraisal grade)	Relevance appraisal: focus/ country/ employment status	Aim	Sample, recruitment & data collection	Employment status	Health
Allen, 2003, Australia (A)	A/B/A	To provide experiences of people who have re-entered employment having lost capacity for previous job.	13 participants. 8 female, 5 male; age 26-54 years. Recruited via local media and data generated through individual interviews.	Out of work for 6 months to 14 years and successfully re-employed. 6 had used vocational rehab & 7 had not.	Not recruited for specific health problem/condition; only that they had lost the capacity for their work because of health (achieved sample: range of conditions, including musculoskeletal conditions, mental health conditions, cancer, HIV/AIDS, head injury).
Boyce, 2008, UK (B)	B/A/B	To explore experiences of people with mental health conditions who moved back into the labour market.	20 participants. 13 male, 7 female; age 27-64. Recruited via a larger study that recruited participants from employment agencies. Data collection with interviews.	Current: all in work (5/20 had been in work >7 years). History: had spent time out of work but not stated how long for.	Participants were recruited because they had mental health conditions.
Beatty, 2009, UK (B)	B/A/A	To explore the rise in the rates of UK women claiming Incapacity Benefit (IB).	73 participants. All female; 39 aged <50; 31 aged 50+. Purposively recruited from a larger survey, originally recruited from the Department for Work & Pensions (DWP) register of IB recipients. Data collection with interviews.	Current: IB recipients, so all out of work because of ill health (OWIH)—no information on length of time out of work. History: not stated (although some participants talked about being in work in the past).	Not recruited for a specific health problem/condition; all were receiving out of work health-related benefits (does not go into detail about health conditions of achieved sample).

First author, year, country (critical appraisal grade)	**Relevance appraisal: focus/ country/ employment status**	**Aim**	**Sample, recruitment & data collection**	**Employment status**	**Health**
Dekkers-Sanchez, 2010, Netherlands (B)	A/B/A	To provide information on factors related to chronic sick leave & return to work.	27 participants. 14 male, 13 female; age 25-63. Purposive sampling from register of Dutch sick-listed patients. Data collection with focus groups (5).	Current: not worked for 18-24 months because of health. History: had worked up until health meant that they could no longer continue. Most had contact with their employer (employers are partly responsible for employees until they have been absent for 2 years in the Netherlands).	Not recruited for a particular health problem/condition (achieved sample: various physical conditions/diseases & mental health conditions).
Gilworth, 2009, UK (B)	A/A/B	To explore expectations & experiences of return to work for people at different stages of recovery from stroke.	13 participants. 6 female, 7 male; age 18-65. Recruited from a clinic after post-stroke surgery & from another study (a postal survey of stroke patients). Data collection with interviews.	Current: 6 in work; 7 not returned to work.* History: not stated (but topic guide asks them about previous experience of work).	Participants were recruited because they had suffered a stroke (3 months - 8 years post-stroke).
Hedges, 2001, UK (B)	B/A/B	To explore moves between Jobseeker's Allowance (JSA) & IB or Income Support.	40 participants. 16 female, 24 male; age 16-55+. Recruited from a DWP database of people who had made one or more claims for both JSA & IB between Feb 1999 & May 2000. Data collection with interviews.	At the time of interview 15 were receiving IB, 8 JSA & 17 neither IB or JSA, but all had made at least one claim to both JSA & IB in the past year. 31 not in work & 9 employed at interview.	Not recruited for a particular health problem/condition (achieved sample: 31 had physical health problems, 8 had mental health problems & 1 had alcohol/drug abuse).

First author, year, country (critical appraisal grade)	Relevance appraisal: focus/ country/ employment status	Aim	Sample, recruitment & data collection	Employment status	Health
Hudson, 2009, UK (B)	B/A/A	To explore how Pathways to Work may better meet the needs of the mental health client group.	44 participants. 18 male, 26 female; age 20+ years. 27 were mandatory clients of Pathways to Work & 13 were voluntary. Data collection with interviews.	Were all receiving IB & had been for <6 months (3 participants) to over 10 years. 16 participants had been receiving IB for 1-2 years.	Participants recruited because they had mental health conditions. 29 had depression. Most participants had a multiple conditions e.g. depression as well as a physical condition.
Magnussen, 2007, Norway (B)	A/B/A	To explore perceived barriers of return to work for Disability Pensioners (DPs).	17 participants. 12 female, 5 male; age 38-56 years. Recruited through a larger study evaluating the effect of an intervention to get DPs with low-back pain into work. Data collection with focus groups (3).	Not in work—DPs at the time of the study (but not clear how long for). Were involved in a vocational-related intervention (at least were involved in a study evaluating it).	Participants were recruited because they had chronic low-back pain.
Mettavainio, 2004, Sweden (B)	A/B/A	To explore important factors in successful return to work for disabled people.	10 participants. 6 female, 4 male; age 31-58. Jobseekers with a work disablement were sampled from the national employment service register. Data collection with interviews.	People with a work disablement, who had been out of work 2 months—15 years, who had subsequently got a permanent job (that had started less than 2 years before the study).	Not recruited for a specific health problem/condition (achieved sample: all had physical conditions, one had a psychiatric as well as physical condition).

First author, year, country (critical appraisal grade)	Relevance appraisal: focus/ country/ employment status	Aim	Sample, recruitment & data collection	Employment status	Health
Summary			Studies included 10 to 44 participants (total of 257 in the 9 studies) & a mix of male/female participants (1 study included only females) & age ranges. Participants were recruited via a range of sources: databases of benefit recipients (5 studies); media releases (1); larger evaluation studies of vocational rehab interventions (2); & specific clinical (stroke) services (1). 7 studies used interviews & 2 used focus groups for data collection.	4 studies included only participants who were not in work; 3 studies included only participants who had been OWIH but had become employed; 2 studies included a mix of participants (some in work after a period OWIH & some still out of work).	2 studies recruited participants with mental health conditions; 1 recruited participants who had survived a stroke; 1 recruited participants with low-back pain; & 5 studies did not recruit participants based on a specific health problem/condition.

4.4.1 Identified themes

The themes identified from the studies were: health as a direct barrier/facilitator to work; workplace and employment factors; change of career or job type; financial barriers and facilitators; life stage and social circumstances; support; and self-construct. This section discusses the identified barriers and facilitators to work from the nine studies, organised by these themes. This section draws upon participant voice rather than authors' interpretations. Participant voice has been taken from verbatim quotes, paraphrases, or reports from the authors about what participants have said.

4.4.1.1 Health as a direct barrier or facilitator to work

Health was seen as a direct barrier and/or facilitator to work for four main reasons: pain, disability, and other symptoms; uncertainty about capability; unpredictability and reliability; and work being bad for health. Table 4-6 illustrates which studies identified the individual sub-themes.

Pain, disability, and other symptoms such as restricted movement or activity, memory problems, trouble sleeping, and stress were discussed by participants largely as having a negative impact on their capability to perform at work and therefore as direct barriers to employment. Participants who were not in work often felt that their health was incompatible with employment because of these symptoms (Beatty *et al.*, 2009; Dekkers-Sanchez *et al.*, 2010; Gilworth *et al.*, 2009; Hedges and Sykes, 2001; Hudson *et al.*, 2009; Magnussen *et al.*, 2007). Following a change in health, others were uncertain about whether they were capable of work or not, making them question whether they should attempt return to work. Participants who had transitioned into work reflected that they had been concerned their health was not compatible with employment, but that these concerns were overcome with support and workplace adjustments (Allen and Carlson, 2003; Mettavainio and Ahlgren, 2004).

Table 4-6: Health as direct barrier or facilitator to work: sub-themes and presence in each study

	Sub-themes reported as a barrier to work (B) &/or a facilitator to work (F)			
First author (year)	**1. Pain, disability & other symptoms**	**2. Uncertainty about capability**	**3. Unpredictability & reliability**	**4. Work bad for health**
Allen (2003)	B/F*			
Beatty (2009)	B		B	B
Boyce (2008)				
Dekkers-Sanchez (2010)	B			
Gilworth (2009)	B	B		
Hedges (2001)	B		B	B
Hudson (2009)	B	B	B	B
Magnussen (2007)	B		B	B
Mettavainio (2004)	B	B		

* The term 'facilitator' in this context is problematic in the sense that participants would not have been out of work in the first place if it was not for their health, hence ill health is almost always referred to as a barrier to work. However, the experience of pain was discussed in a positive way by some participants in Allen & Carlson's (2003) study.

Health and related symptoms were only discussed in a positive way in one study, where pain was considered by one participant to make him more determined and by another to be a source of psychological growth (Allen and Carlson, 2003). This study included participants who were 'successfully' returned to work. The same study talked about participants constructing 'positive role models' i.e. people who were seen to have overcome a lot of barriers to return to work, and 'negative role models' i.e. people who were out of work but thought of as not having to cope with much, to stimulate determination to return to work (Allen and Carlson, 2003). Other studies did discuss determination as a facilitator for a return to work, but they and/or their participants did not directly associate this determination as stemming from the experience of poor health or disability.

Several studies reported that participants believed that the unpredictable nature of their illness posed a particular problem to achieving or sustaining employment (Beatty *et al.*, 2009; Hedges and Sykes, 2001; Hudson *et al.*, 2009; Magnussen *et al.*, 2007). Having a fluctuating condition meant having to "consider work ability from day to day" (Magnussen *et al.*, 2007, p. 193). The necessity to attend medical appointments or treatment—the timings of which could also be unpredictable—was another reason participants questioned their reliability as employees (Hedges and Sykes, 2001; Hudson *et al.*, 2009).

Some studies identified participants' concern that employment would contribute to worse pain as a barrier to return to work, sometimes borne out of the fact they felt that their previous job had contributed to the health problem or disability in the first place (Beatty *et al.*, 2009; Hedges and Sykes, 2001; Magnussen *et al.*, 2007).

Boyce *et al.* (2008) did not include examples of participants talking about health as a direct barrier to work. The participants in Boyce *et al.*'s (2008) study were all engaged with vocational rehabilitation programmes and had become re-employed before the study interview. Although health was not attributed as a direct barrier to gaining employment, it was directly identified as one of the reasons that some participants had problems at work: "four participants attributed dissatisfaction or difficulties with aspects of their job to their own mental health problems" (Boyce *et al.*, 2008, p.18).

Health was also an indirect barrier to work, operating through various pathways that are discussed in the following sections.

4.4.1.2 Workplace and employment factors

It was possible to categorise work factors seen as important to return to work in three separate but inter-related ways: (i) attitudes of employers and colleagues; (ii) job demands and ergonomic environment; and (iii) macro-level context of labour market issues. Further sub-divisions of these themes and their identification in each paper are shown in Table 4-7. Sometimes the distinction between barrier and facilitator is not entirely clear as participants may be talking about a need they have identified but have not yet had satisfied e.g. participants who were not in work in Dekkers-Sanchez *et al.*'s (2010) study identified numerous factors that would facilitate their return to work (e.g. "modified work in a quiet environment"), but since these factors were not achieved, their absence was a barrier to work (p. 549).

Table 4-7: Workplace factors as direct barriers or facilitators to work: sub-themes and presence in each study

	Sub-themes reported as a barrier to work (B) &/or a facilitator to work (F)						
	Attitudes				**Job demands & ergonomic environment**		
First author (year)	**Related to health/disability at the job application process**	**Related to non-health factors at the job application process**	**Of colleagues & supervisors when in work**	**Safety regulations & health clearance**	**Work place adjustment****	**Job content & hours****	**Macro-level context**
Allen (2003)	B/F	B	B/F		F		
Beatty (2009)	B				B	B	B
Boyce (2008)	B/F		B/F	B	F/B	B/F	
Dekkers-Sanchez (2010)	B		B/F		F/B	B/F	
Gilworth (2009)	B	B	F*	B		F	
Hedges (2001)	B	B	B		B	B/F	
Hudson (2009)	B/F	B	B/F		B	B/F	B
Magnussen (2007)			B		B	B/F	
Mettavainio (2004)			B		F	F	

* Although the example given was of a participant who returned to his previous employer after sickness absence, so not clear whether others who had started a new job also experienced this in this study.

** Described as barriers because participants identified lack of suitable workplace adjustment, job content and hours.

Workplace attitudes were discussed in terms of barriers and facilitators to sustaining, as well as securing, employment. If participants did not think it was likely that they would be able to sustain a job then this was a barrier to their seeking a return to work in the first place. Participants had expectations—sometimes from experience—that employers would not seriously consider their application for employment because of their health. Some studies also discussed participants' expectation that they would be discriminated against because of other factors e.g. age (discussed further in section 4.4.1.5). Owing to concerns about employer attitudes, participants often expressed their predicament of whether to disclose health conditions or disabilities to employers when going for work and when in employment (Allen and Carlson, 2003; Beatty *et al.*, 2009; Boyce *et al.*, 2008; Hedges and Sykes, 2001; Hudson *et al.*, 2009). Trepidation about disclosure leading to a poorer chance of employment had to be weighed up against not wanting to be dishonest, needing workplace modifications, and explaining time out of work. Some participants noted that they had positive experiences of disclosing their health condition or disability, as it prompted understanding and workplace modification e.g. (Allen and Carlson, 2003; Boyce *et al.*, 2008; Hudson *et al.*, 2009).

Aside from getting a job, participants were concerned or had experienced that once in work, the attitudes of colleagues may prevent them from being able to sustain their employment. They felt that they may be stigmatised by colleagues for their health conditions and may also be resented because of their workplace modifications (Allen and Carlson, 2003; Boyce *et al.*, 2008; Hedges and Sykes, 2001; Hudson *et al.*, 2009; Magnussen *et al.*, 2007; Mettavainio and Ahlgren). Such expectation deterred them from applying for jobs and was therefore a barrier to work. Some participants noted that they had positive experiences after returning to work, where colleagues and supervisors were supportive and helpful, thus enabling a more successful return to work (Allen and Carlson, 2003; Boyce *et al.*, 2008; Dekkers-Sanchez *et al.*, 2010; Hedges and Sykes, 2001; Hudson *et al.*, 2009; Mettavainio and Ahlgren, 2004).

One of the studies identified issues with occupational health clearance to start work (Boyce *et al.*, 2008). Participants felt that occupational health professionals could prevent or delay entry into employment, and that they placed too much emphasis on health problems and too little on capabilities.

Another study mentioned that safety regulations could be a barrier to work; for example, a participant could not work because his HGV licence had been invalidated because of his health (Gilworth *et al.*, 2009).

Job demands and ergonomic environment were seen as barriers if participants expected or had experienced work environments that, in combination with their health or disability, they could not work in. For example, physical demands of jobs (Beatty *et al.*, 2009; Dekkers-Sanchez *et al.;* Hedges and Sykes, 2001; Magnussen *et al.*, 2007), unsuitable hours (Beatty *et al.*, 2009; Dekkers-Sanchez *et al.*, 2010; Hudson *et al.*, 2009; Magnussen *et al.*), and the stressful nature of jobs (Hudson *et al.*, 2009; Magnussen *et al.*, 2007), with a lack of available modified work meant that participants felt that they could not realistically take on a job. Unsuitable hours, stressful working conditions, and isolated work-spaces were also identified by participants in work as problems (Boyce *et al.*, 2008). Characteristics were portrayed as facilitating where modifications to ensure a suitable work environment had been arranged or were expected. Such modifications included changes to the ergonomic environment e.g. appropriate workspace furniture, modifications of work tasks such as lighter duties, and allowing some flexibility in working hours (Allen and Carlson, 2003; Boyce *et al.*, 2008; Dekkers-Sanchez *et al.*, 2010; Gilworth *et al.*, 2009; Hedges and Sykes, 2001; Hudson *et al.*, 2009; Magnussen *et al.*, 2007; Mettavainio and Ahlgren).

Issues concerned with the wider macro-context were also identified as barriers to work. The fact that participants felt there were a lack of suitable jobs for disabled people can be seen as a macro-level factor as well as a factor related to job demands and ergonomic environment. One participant highlighted this: "The politicians have to do something about the job situations, it is far too demanding. It seems like the management wants to make greatest possible profit with no concern for employers. We (the disabled) are not welcomed as employees anymore" (Magnussen *et al.*, 2007, p. 193). Two studies specifically talked about the lack of jobs more generally. Those who thought that the job market was poor (in the "present climate") were concerned about there being lots of applicants for each job. They therefore felt that they would have competition from healthier and/or younger applicants, and so did not expect that they had a realistic chance of being successful (Beatty *et al.*, 2009; Hudson *et al.*, 2009). There was also some concentration on the types of available jobs e.g. temporary or seasonal, which were thought inappropriate because of the difficulties of securing income from benefits after the end of the contract (Beatty *et al.*, 2009; Hudson *et al.*, 2009).

4.4.1.3 Change of career or job type

All nine studies made some reference to participants having to consider a change of career or job type if their return to work was to be successful. Changing to a new type of job has its own difficulties, relating to the kinds of resources needed to successfully adopt a different working role. Table 4-8 summarises this theme and its inclusion in the nine studies. There were two main reasons that change of job type was discussed as a barrier or facilitator to work: finding a job (issues specific to finding a new type of job, such as experience, skills, and qualifications); and whether a new type of job would satisfy participants' interests and preferences.

Table 4-8: Change of job type as a barrier or facilitator to work: sub-themes and presence in each study

	Sub-themes reported as a barrier to work (B) &/or a facilitator to work (F)	
First author (year)	**Finding a new job**	**New job type & satisfaction of interests or preferences**
Allen (2003)	B	B
Beatty (2009)	B	
Boyce (2008)		B
Dekkers-Sanchez (2010)	B	
Gilworth (2009)	B	F
Hedges (2001)	B	
Hudson (2009)	B	F
Magnussen (2007)		B
Mettavainio (2004)	B	B

Most of the studies explained the need for change in job type as a result of a change in capability for previous employment; however, Beatty *et al.* (2009) noted that some participants felt that a shift in the job market linked to more marco-level trends (e.g. de-industrialisation) had provoked this need for change in job type e.g. one participant said “there’s no clothing industry at all see and that’s all I’ve ever known, so it’s hard” (p.84). Participants saw a change in job type largely as a barrier to work because it meant looking for work that they did not have any experience, qualifications, or skills for, and therefore felt they would be at a further disadvantage to other candidates.

As well as questioning their employability because of the need to change job type, some participants discussed that new jobs may not or did not suit individual interests and preferences. There was an anticipated lack of employment opportunities, particularly employment that would satisfy personal needs and interests (Mettavainio and Ahlgren, 2004). Some participants considered themselves unsuited to the kinds of jobs suggested to them by employment advisors (e.g. at Jobcentre Plus) (Magnussen *et al.*, 2007), or to the kinds of work they had moved into (Allen and Carlson, 2003; Boyce *et al.*, 2008; Hudson *et al.*, 2009).

Conversely, some participants saw their need to change job type as an opportunity to start afresh, to do something that they actually wanted to do, or to find a job that would not contribute to poor health in the way that they felt their previous occupation did (Gilworth *et al.*, 2009; Hudson *et al.*, 2009).

4.4.1.4 Financial barriers and facilitators to work

Financial issues were talked about both as barriers and as push factors for return to work (Table 4-9).

Table 4-9: Finance as a barrier or facilitator to work: sub-themes and presence in each study

	Sub-themes reported as a barrier to work (B) &/or a facilitator to work (F)		
First author (year)	**Fear that employment removes benefit safety net**	**Income in work**	**Financial implications of not working**
Allen (2003)		F	F/B
Beatty (2009)	B	B	
Boyce (2008)*			
Dekkers-Sanchez (2010)		F	F/B
Gilworth (2009)			
Hedges (2001)	B	B	
Hudson (2009)	B	B	
Magnussen (2007)	B	B	
Mettavainio (2004)			

* Commented that the risk of losing benefits was not discussed by participants as a barrier to work, and that finance did not seem to play a big part in return-to-work decisions, although was identified as a positive outcome of return to work.

The financial implication of not working was identified as a factor that compelled people to return to work; people needed to earn a wage to support themselves and their families and therefore had increased determination to move into work (Allen and Carlson, 2003; Dekkers-Sanchez *et al.*, 2010). However, finance was more often discussed as a barrier to work than as a push factor to return to work. Concerns about losing welfare-benefit entitlements were repeatedly identified as a source of anxiety (Beatty *et al.*, 2009; Hedges and Sykes, 2001; Hudson *et al.*, 2009; Magnussen *et al.*, 2007). Participants talked about their concern that if return to work was unsuccessful (i.e. only sustained for a short period of time) they might no longer find themselves eligible for the full level of benefits they received prior to working. Hence, work was seen as a financial risk in this respect (Beatty *et al.*, 2009; Hedges and Sykes, 2001; Hudson *et al.*, 2009; Magnussen *et al.*, 2007). The same studies that identified this view of work as risky also found that participants often doubted that they would be financially better off in work. Some even believed that they would be financially worse off by working. Beatty *et al.* (2009) noted that perceiving return to work as risky was particularly obvious among participants who received multiple benefits e.g. housing and council tax. Such participants feared that they would not be able to cover these costs if in work or that they might lose entitlement to some of these benefits if return to work was not successful.

The final reason that finance was considered a barrier to return to work was more indirect: stress as a result of lack of money was linked to perpetuated sick leave (Allen and Carlson, 2003; Dekkers-Sanchez *et al.*, 2010).

4.4.1.5 Life stage and social circumstances

Demographics, human capital, multiple demands and responsibilities, and concurrent life events, have the potential to impact on return to work (Table 4-10).

Negative events that occurred during the period out of work were commonly talked about in the studies. Most of the examples could apply to general populations, rather than being specific to people who were OWIH. Examples were, amongst others, divorce, bereavement, and relocation (Allen and Carlson, 2003; Dekkers-Sanchez *et al.*, 2010; Hudson *et al.*, 2009). These sometimes arose from or were exacerbated by health and employment problems, or may have co-occurred alongside the period of ill health or disability. Participants who experienced these negative life events had extra barriers to overcome to return to work and it was felt by some that these events needed to be adapted to or resolved for sustained return to work to be a success.

Table 4-10: Life stage and social circumstance as barriers and facilitators to work: sub-themes and presence in each study

	Sub-themes reported as a barrier to work (B) &/or a facilitator to work (F)				
First author (year)	**Negative life events that can complicate or perpetuate the period out of work**	**Other demands & responsibilities e.g. caring for others, household responsibility**	**Gender roles**	**Age**	**Lack of qualifications or poor/disjointed employment history**
Allen (2003)	B		*	B	
Beatty (2009)		B	B		B
Boyce (2008)					B
Dekkers-Sanchez (2010)	B	B		B	B
Gilworth (2009)				B	
Hedges (2001)				B	B
Hudson (2009)	B	B		B	B
Magnussen (2007)				B	
Mettavainio (2004)		B	B		

* Not specifically discussed as a barrier or facilitator to work but some male participants talked about the extra distress they felt because of the effect their health & situation was having on their partners, as well as one man stating that he felt upset “that he could not fulfil his role as a male” by earning a living for his family (p. 191).

An overload of responsibility that could conflict with work was also discussed as a barrier to employment e.g. caring for children and other relatives, household responsibilities, and work-life balance (Beatty *et al.*, 2009; Dekkers-Sanchez *et al.*, 2010; Hudson *et al.*, 2009; Mettavainio and Ahlgren, 2004). Beatty *et al.*’s (2009) study of women on IB reported that some of the participants were discouraged by their partners from going into work. Discouragement from partners was linked to partners’ apprehension about caring responsibilities and apprehension for their wives’ health. There was indication from one of the participants in Allen and Carlson’s (2003) study that men may feel additional pressure to return to work in order to assume the masculine role of supporting their family.

Lack of education and experience were also thought of as barriers to getting a job (Beatty *et al.*, 2009; Boyce *et al.*, 2008; Dekkers-Sanchez *et al.*, 2010; Hudson *et al.*, 2009). In some cases, participants did not have much work experience at all and found it difficult to get any (Beatty *et al.*, 2009). Spending long periods of time out of work because of health or disability could also mean that participants felt they were out of touch or had forgotten or lost the skills required for work.

Older age was seen as a barrier to work by participants in six of the studies (Allen and Carlson, 2003; Dekkers-Sanchez *et al.*, 2010; Gilworth *et al.*, 2009; Hedges and Sykes, 2001; Hudson *et al.*, 2009; Magnussen *et al.*, 2007). These studies gave examples of participants who felt this way who were in their 50s and 60s, but one reported that this was a barrier to people over 40 (Hedges and Sykes, 2001). Mostly, age was talked about as affecting participants' perception of their employability; they were unconvinced that employers would consider their application given their age, especially when up against younger applicants. However, it is possible that some participants also saw age—in combination with health problems—as a barrier to capacity; one participant stated that because of age (54) and health he thought he would "be a hindrance in employment more than a help!" (Hudson *et al.*, 2009, p. 37).

4.4.1.6 Support

A number of sources of support were identified by participants as helping to facilitate return to work e.g. family and friends, health professionals, government rehabilitation, and other forms of vocational rehabilitation. It is difficult to provide a synthesis of the types of support because the studies focused on quite diverse issues. For example, two of the UK studies focused on certain DWP welfare-to-work interventions (Hedges and Sykes, 2001; Hudson *et al.*, 2009). Synthesising evaluations of return-to-work interventions was not the aim of this review. Sections of the DWP reports that concentrated on barriers and facilitators to return to work were used for this review rather than sections that asked participants' views on specific interventions. A number of similar issues were identified from the studies, and these are summarised in Table 4-11. Sub-themes in the table refer to general issues with both vocational rehabilitation and medical treatment from health professionals, as participants' issues with each were similar.

Given that much effort has been put into creating systems which facilitate a move into work, many of the issues raised in the qualitative studies show that services are perhaps flawed for facilitating return to work. There were some examples where intended support could even be seen as a barrier to work. For example, engagement with services that were perceived as unhelpful could have the result of discouraging people from taking any further steps to return to work (Hudson *et al.*, 2009).

Support was necessary at different stages of the return-to-work process. It was felt that support to actually move into employment needed to be realistic and timed correctly. Six of the studies discussed timing of return-to-work support; however, they differed slightly in their messages (Beatty *et al.*, 2009; Dekkers-Sanchez *et al.*, 2010; Gilworth *et al.*, 2009; Hedges and Sykes, 2001; Hudson *et al.*, 2009; Mettavainio and Ahlgren, 2004). These studies mainly found that participants needed to feel ready to start work, an issue that often revolved around whether or not they had achieved a sufficient level of recovery from their illness for them to see work as a realistic option (Beatty *et al.*, 2009; Hedges and Sykes, 2001; Hudson *et al.*, 2009). Hudson *et al.* (2009) found that their participants who were voluntary clients of Pathways to Work had noted an improvement in their health prior to attempting to return to work. However, in their study with survivors of stroke, some of Gilworth *et al.*'s (2009) participants felt that they had missed an opportunity to return to work as they were advised not to attempt to return when, in retrospect, they felt that they should have.

Table 4-11: Issues identified with return-to-work support and medical treatment: sub-themes and presence in each study

	Sub-themes reported as a barrier to work (B) &/or a facilitator to work (F)					
First author (year)	**Unrealistic advice***	**Timing of support****	**Too general/ perspectives undervalued/ misunderstood***	**Intimidating***	**Dissatisfaction—do not lead to (suitable) jobs***	**Lack of follow-up/ discontinued***
Allen (2003)	B		F/B	B	B	
Beatty (2009)	B	B	F		B	B
Boyce (2008)						B
Dekkers-Sanchez (2010)		B	B		B	
Gilworth (2009)	B	B	B			B
Hedges (2001)	B	B	B	B	B	
Hudson (2009)	B	B/F	B	B		B
Magnussen (2007)	B		B		B	
Mettavainio (2004)	F	B/F	F			

* Facilitators if the opposite was discussed as helping return to work. ** Participants discussed that the timing of the support or advice was not appropriate for their return to work (B) or that the timing was important and was appropriate (F).

Support was at times said to be inflexible, failing to tailor advice to individual needs in terms of work and health (Allen and Carlson, 2003; Dekkers-Sanchez *et al.*, 2010; Hedges and Sykes, 2001; Hudson *et al.*, 2009; Magnussen *et al.*, 2007; Mettavainio and Ahlgren, 2004). Participants perceived that their opinions were ignored or undervalued, or that support and advice was very general and therefore not of particular use to them. Some participants also reported that staff on welfare-to-work programmes were discouraging and had a lack of knowledge about the diverse and changing ways in which health could affect capacity and about how to deal with pain. This meant that staff sometimes gave inappropriate advice or support (Allen and Carlson, 2003; Dekkers-Sanchez *et al.*, 2010). Related to the issues discussed on work-related barriers, participants discussed being dissatisfied with the types of jobs that welfare-to-work programmes tried to encourage them into e.g. with no consideration of preference, previous experience, or ability (Magnussen *et al.*, 2007).

On other occasions support was described as more positive in terms of quality, but still criticised for duration and accessibility. Participants reported that support services were sometimes only provided short-term and could be suddenly withdrawn. Access to continued support was an important issue for people who moved into work to facilitate sustainable employment (Boyce *et al.*, 2008). Participants could be discouraged from engaging with further support services if they had experienced other services being discontinued (Hudson *et al.*, 2009).

4.4.1.7 Self-construct

Self-esteem (feelings of worth) and/or self-confidence (belief in self) were discussed by participants in all of the included studies. Related themes were determination to return to work and adaptation to situation. Table 4-12 shows these themes by inclusion in each study. In line with the previous sub-sections, this section discusses the findings from participants related to self-construct, endeavouring to keep distinct from the authors' interpretation.

Table 4-12: Self-construct

First author (year)	Sub-themes reported as a barrier to work (B) &/or a facilitator to work (F) Self-confidence	Self-esteem	Determination	Acceptance/ adaptation
Allen (2003)	B/F	B	F	**
Beatty (2009)	B	B	B*	**
Boyce (2008)	B	B	F	
Dekkers-Sanchez (2010)	B		F	F
Gilworth (2009)			F **	**
Hedges (2001)	B	B	**	
Hudson (2009)	B	B		
Magnussen (2007)	B	B		**
Mettavainio (2004)	B/F	B	F	F

* Lack of determination was identified as a barrier to return to work. ** These issues were discussed by participants, but not in terms of barriers/facilitators to return to work (included here because authors interpreted them as barriers/facilitators, discussed in the following section).

'Failure', 'defeat' (Allen and Carlson, 2003; Magnussen *et al.*, 2007; Mettavainio and Ahlgren, 2004), 'rejection' (Beatty *et al.*, 2009), and 'disappointment' (Dekkers-Sanchez *et al.*, 2010) were particular fears acknowledged by participants. Such fears were not only apparent in those who remained out of work but also discussed by participants who had returned to work (Allen and Carlson, 2003; Boyce *et al.*, 2008; Mettavainio and Ahlgren, 2004). Participants attributed their low confidence to a variety of sources—a combination of the barriers mentioned in the previous sections e.g. they were not confident about return to work because they did not think their health would enable them to work; they did not think that they would be able to secure employment because of employer attitudes etc. Most of the studies also reported that participants had negative feelings about being out of work, for example that they felt 'useless', 'worthless', 'isolated', 'like a fool', unwanted, or uncomfortable (Allen and Carlson, 2003; Beatty *et al.*, 2009; Boyce *et al.*, 2008; Gilworth *et al.*, 2009; Mettavainio and Ahlgren, 2004). Although their poor self-confidence or low self-esteem originated from the other barriers, participants occasionally talked about issues of self-construct as barriers to work in their own right e.g. "the biggest difficulty is that horrible feeling of feeling useless" (Beatty *et al.*, 2009, p. 88).

Determination was a related theme that was felt by some to facilitate return to work. Those who had returned to work described their ‘strength’, ‘strong will’, and ‘desire’ as driving their motivation (Allen and Carlson, 2003; Boyce *et al.*, 2008; Gilworth *et al.*, 2009; Mettavainio and Ahlgren, 2004). However, this was not restricted to those who had returned to work. There were participants who remained workless despite their determination (Dekkers-Sanchez *et al.*, 2010), or who had been determined to return to work but had to stop working because they could not cope with it (Hedges and Sykes, 2001). Participants also linked their determination with the role that work played in their lives and the feelings of being under-valued when not working (Boyce *et al.*, 2008; Hedges and Sykes, 2001). Even where work was central to someone’s life it was not always enough to facilitate a successful return to work. Gilworth *et al.* (2009) highlighted the difficulty with which some participants realised that they would not return to work on account of their health, despite work being a major part of their life prior to having a stroke. Generally, determination and ‘work ethic’ were talked about as characteristics that could facilitate return to work, rather than their absence as a barrier to work. However, Beatty *et al.* (2009) noted that some of their participants felt that they were not particularly motivated to return to work because of the lack of financial benefit from doing so.

Participants in six of the studies discussed the issue of accepting or adapting to their situation (Allen and Carlson, 2003; Beatty *et al.*, 2009; Dekkers-Sanchez *et al.*, 2010; Gilworth *et al.*, 2009; Magnussen *et al.*, 2007; Mettavainio and Ahlgren, 2004). For some this meant accepting that they would not return to work (Beatty *et al.*, 2009; Gilworth *et al.*, 2009; Magnussen *et al.*, 2007); because of health, work “was not a realistic goal” (Magnussen *et al.*, 2007, p.193). For others it meant accepting that they could not return to the same type of work and having to adjust to new capabilities (Allen and Carlson, 2003; Dekkers-Sanchez *et al.*, 2010; Mettavainio and Ahlgren, 2004). Acceptance and adaptation were mentioned by participants as facilitators to their return to work in two of the studies—once they had adapted to their capacity they could think about returning to a different type of job (Dekkers-Sanchez *et al.*, 2010; Mettavainio and Ahlgren, 2004). Even those who had moved back into work talked about adaptation being a difficult process. For example, participants in

Allen and Carlson's (2003) study talked about feeling out of control, with multiple barriers stacked up against them. Successful return to work for these participants brought positive feelings e.g. ‘happiness’, ‘well-being’, ‘joy’, ‘achievement’ (Allen and Carlson, 2003; Boyce *et al.*, 2008; Mettavainio and Ahlgren, 2004). However, even where participants were happy about their return to work, they were not necessarily happy in their specific jobs (Allen and Carlson, 2003; Boyce *et al.*, 2008).

4.4.2 Synthesis: second- and third-order constructs

Author interpretations of the identified themes, and links between the themes, are considered in this section. As described in section 4.3.4, the synthesis was not pre-determined as refutational or reciprocal; these decisions were made throughout the process of forming third-order constructs. With respect to the barriers and facilitators to return to work, the synthesis was reciprocal. However, when considering authors’ interpretations of some of the findings (second-order constructs) and developing third-order constructs, it was clear that there were different and sometimes opposing explanations of the key concepts. Different explanations in turn led to different focus on the recommendations for supporting people into employment. Rather than explore multiple realities, the aim of refutational synthesis is to explore and explain differences, which, after pursuing the initial line of argument, this section goes on to do (Thorne *et al.*, 2004).

Key concepts, second-order, and third-order interpretations are presented in Table 4-13. The following sub-sections discuss each of the third-order interpretations in turn, drawing on second-order constructs to show how the synthesis was arrived at.

Table 4-13: From concepts to third-order interpretation: progression of the qualitative synthesis

Concepts: **Participant identified barriers/facilitators**	**Second-order interpretation (& the concepts it relates to):** **Authors' interpretation of the concepts identified in the included studies.**	**Refutation?:** **Highlights where authors of different studies had opposing interpretations of the concepts.**	**Third-order interpretation:** **The synthesis: my interpretation of the second-order interpretations (with reference to participant themes).**
1. Health as a direct barrier to work	There are multiple & interacting barriers to work making return to work a complex process (1-7).	No.	**Complex pathway to return to work** There are different levels at which barriers & facilitators to work present themselves, therefore different levels for interventions to be targeted.
2. Workplace factors			
3. Change of job type	The majority of the barriers to work that people face stem from a health condition but health as a direct barrier to work was often seen as related to self-construct (1-7).	Some authors viewed health/limitations as barriers to work & others viewed health/limitations as a self-confidence issue.	**Competing narratives & difficulty of interpretation** Competing narratives among participants revealed that there is a difficulty of interpretation of individual-based barriers to work, perhaps compounded by the fact that the return-to-work process is so complex.
4. Financial issues			
5. Life stage & social circumstance	Some barriers to work are based on experience & others based on expectation, some are perceived & others are real (1-7).	No.	**Expected/experienced barriers to work** If barriers are expected rather than experienced then individual-focused support is necessary, but if barriers are experienced then wider intervention is required. However, even if barriers are expected rather than experienced, they are likely to be grounded in reality & the reason for that expectation should also be given some attention.
6. Support			
7. Self-construct			
			Differences in barriers/facilitators by participant characteristics Not widely discussed by authors but there were some points can be made about differences by gender, type of health condition & country.

Concepts: **Participant identified barriers/facilitators**	**Second-order interpretation (& the concepts it relates to):** **Authors' interpretation of the concepts identified in the included studies.**	**Refutation?:** **Highlights where authors of different studies had opposing interpretations of the concepts.**	**Third-order interpretation:** **The synthesis: my interpretation of the second-order interpretations (with reference to participant themes).**
1. Health as a direct barrier to work **2. Workplace factors**	Capacity for work is related to the demands of the work. Work can also contribute to poor health in first place (1&2).	Not with interpretation, however, recommendations had different focuses.	**Job quality** Health led to being unable to fulfil demands in work & being out of work has, for some people, left them with little opportunity for control over work (trade-off).
3. Change of job type	Labour market changes have led to increased job demands (2).	No.	
4. Financial issues	Expectation of high job demands & low control over work impacts on perception of capacity to return to work & often requires a change of job (1-3).	No.	
5. Life stage & social circumstance			
6. Support	Work as risk (to health & to financial situation) (1, 2 & 4).	Differing interpretations of finance as a barrier/facilitator to work, just as there were different participant findings.	**Work-role centrality, adaptation & financial risk** Determination & desire to return to work may arise out of worker identity, & may help to facilitate return to work, however are not sufficient for securing return to work.
7. Self-construct	Some degree of 'adaptation' to new roles take place. This could be to new 'worker identity' taking account of limitations because of health, or could be to a 'sick-role' (1-3).	There were differences in the ways that adaptation was discussed: sometimes as a barrier to work & sometimes as necessary to return to work.	Strong work-role centrality could hinder adaptation to a change in health if that change precluded future employment. In many cases people need to adapt to their situation to be able to make a successful return to work, which involves finding a new worker identity. However, adaptation to 'sick-role' rather than new worker identity may make it more difficult to return to work.

4.4.2.1 Complex pathway to return to work

There are links between all of the barriers and facilitators to work that participants described. There is a complex pathway between being OWIH and making a return to work, involving different aspects of participants' lives as well as different actors e.g. employers, potential colleagues, employment advisors, health professionals etc. Several of the authors pointed out this "range of factors, often multiple and interacting" (Hudson *et al.*, 2009, p.91). Mettavainio and Ahlgren (2004) talked about return to work as a process. Barriers and facilitators to work can be thought of as being located at different levels throughout this process, relating to the individual, the local work environment, the macro-level context etc. This aligns with the conceptual model of return to work that was illustrated in Chapter two, where it was highlighted that individual, health, psychosocial, and macro-level factors are likely to be important for return to work for those OWIH. These different levels also draw parallels with Dahlgren and Whitehead's (1991) model of determinants of health, highlighting that there are different "layers of influence". For example, the macro context includes influences such as government policy decisions, public perceptions of health and disability, the unemployment rate, and the National Health Service. Then there is the local context including area-based employment opportunities and attitudes, and initiatives related to the bigger structures e.g. employability initiatives targeted at individuals and employers, such as Pathways to Work. Lastly, there are the individual-level resources e.g. education, skills, motivation, self-esteem, confidence, and attitude, which are all modifiable resources; and individual demographics e.g. age and sex, which are not modifiable. Thinking about barriers to return to work in this way highlights that there are different layers that need to be targeted by interventions to improve return to work for this group.

4.4.2.2 Competing narratives and difficulty of interpretation

All but one of the included studies found that participants perceived their physical or mental impairments as barriers to employment (section 4.4.1.1). However, the authors differed with regards to how they explained these perceptions. Some interpreted participants' views about their health-related limitations as direct-health barriers to return to work (e.g. Allen and Carlson, 2003; Hedges and Sykes, 2001). However, others suggested the possibility that such perceptions reflected a lack of self-confidence on the part of participants (perhaps linked to experiences or expectations of discrimination, financial concern etc.) rather than an actual limitation caused by the disability (Dekkers-Sanchez *et al.* 2010; Magnussen *et al.*, 2007). Studies taking the latter approach did identify and acknowledge that barriers to work arose from health conditions but explained them, for example, as issues of “attitude toward return to work, self-efficacy expectations and illness representations” (Dekkers-Sanchez *et al.*, 2010, p. 547), or “poor self-judgement of work ability and low self-esteem” (Magnussen *et al.*, 2007, p. 193) rather than as capability issues (therefore as indirect- rather than direct-health barriers). In such cases the authors appeared to form their own opinions about participants’ capabilities and prioritise these over and above the participants’ own opinions on their capabilities. This leads to difficulties in establishing what the actual barriers to work are and therefore what should be targeted in return-to-work support. Tensions between explanations of health-related barriers to work are reflected in the recommendations offered in each of the studies. Some highlighted the need to provide medical support to people OWIH, e.g. stating that the evidence “strongly supports the inclusion of pain management in work rehabilitation programmes” (Allen and Carlson, 2003, p. 190) and given that few IB recipients think they are capable of work, “physical and mental rehabilitation is essential” (Beatty *et al.*, 2009, p. 103). Although others did not actively discount direct-health barriers to work, they also failed to make recommendations or suggest interventions that focus on improving health itself.

Interpretation of health as an indirect rather than direct barrier to work may reflect academic theories of disability that emphasise issues related to empowerment and discrimination rather than medical limitations. The social model of disability implies that people are disabled by society and have a right to work and engage in other mainstream social activities, irrespective of the impairment (Oliver, 1996). Shakespeare and Watson (2001) proposed that the social model of disability was an ‘outdated ideology’. Empowering disabled people by shifting focus from the need to change the individual to the need to change society, the social model presented the issue as black and white. Such a dichotomy, even if originally unintended, excludes the individual’s experience of pain and limitation, which is an integral part of the experience of disability (Crow, 1996; Twigg, 2002). Even if this is a misconception of the original use of the social model, or a simplistic interpretation of it, it can neglect important health-related barriers that need to be addressed for return to work to be successful. Adherence to this model may discourage some authors from readily accepting the view of participants who believe their health to be a limitation in itself. From a rights-based perspective, the utility of a social-model interpretation is clear but, nonetheless, it can create a tension between the reported views of participants and researchers, and potentially underestimates the need for further healthcare for this group.

The social model of disability does not, however, explain the over reliance on recommendations directed at the individual. Despite the studies highlighting such complex return-to-work pathways, the emphasis the authors placed on each level varied. A disproportionate (to the range of barriers to work identified) number of the recommendations or policy implications identified by authors seemed to focus on individual-level interventions or support. These recommendations were aimed at improving participants' confidence and self-esteem rather than tackling the barriers that were beyond the individuals' control e.g. employer discrimination, lack of suitable employment opportunities, financial barriers. To be clear, each study made recommendations to challenge these wider barriers, but in many there appeared to be a stronger focus on issues related to individual self-construct. In part, this could relate to who was receiving the recommendations e.g. Gilworth *et al.* (2009) were investigating how to rehabilitate a particular group (patients who had suffered a stroke); therefore recommendations were directed at those who work in rehabilitation. Other studies were published in journals also focusing on rehabilitation for disabled people (Dekkers-Sanchez *et al.*, 2010; Magnussen *et al.*, 2007), or occupational therapy (Mettavainio and Ahlgren, 2004), or recommendations were directed at rehabilitation professionals who, presumably, work directly with people OWIH (Allen and Carlson, 2003). Therefore, the audience for this research was perhaps professionals who work in rehabilitation, who may have the ability to make a difference to individual-level support but not to wider barriers and facilitators to return to work.

Some participants also made judgements about other people's capacity to work;

participants “had negative comments to make about people with the same or similar conditions and whom they perceived as not putting in an effort to return to work” (Allen and Carlson, 2003, p. 192). It is possible that these participants were concerned with proving their legitimacy (to those in charge of welfare, to the public, to their family and friends), given that achieving acceptance of disability status is not easy (Magnussen *et al.*, 2007) and being OWIH has increasingly been represented negatively in the media (Briant *et al.*, 2011).

It is difficult to distinguish whether participants would still face barriers of low confidence if other barriers were removed, or whether initiatives to improve self-construct could be successful without removing the other barriers to return to work. However, one study with participants in work highlighted that some felt their self-confidence and self-esteem only improved once they had started work (Allen and Carlson, 2003). Most of the studies highlighted the complex nature of the return-to-work process and Beatty *et al.* (2009) noted that given the issues faced, few “could realistically expect to secure and retain employment after a short programme of confidence building and job search skills” (p. 93). Therefore, despite such strong focus on individual-level barriers, it appears unlikely that measures to improve issues related to self-construct would be successful on their own; a wider programme of return-to-work support and interventions is required.

4.4.2.3 Expected or experienced barriers to work

On several occasions participants identified barriers to work that they had expected rather than experienced. Two studies picked up on this difference (Boyce *et al.*, 2008; Hedges and Sykes, 2001). Although they made the broad distinction between ‘perceived’ and ‘actual’ barriers to work, Boyce *et al.* (2008) did not discuss it further. Hedges and Sykes (2001) distinguished between ‘real’ and ‘perceived’ barriers to work. They noted that real barriers were those that would actually prevent someone OWIH from doing a job whereas perceived barriers were things that people expected would prevent someone OWIH from doing a job, which in reality would not. They explained that perceived barriers were not limited to the perceptions of those OWIH, but that such beliefs and attitudes were also true of some employers and employment advisors. However, such expectation may represent a vicious cycle of expected and experienced barriers to work e.g. if employers expect that those OWIH are not suitable for employment then this is a real barrier for those OWIH trying to return to work.

Negative expectation appeared to be the default for participants. For example, when talking about the positive attitudes of employers as facilitators to work they were always experienced rather than expected, whereas some participants seemed to expect negative attitudes to be barriers to work without having experienced them. Perhaps this led some authors to reason that personal perceptions needed to be changed first and foremost. Research with OWIH participants after they returned to work showed that there were negative expectations regarding employer and colleague attitudes that were not experienced in reality (Boyce *et al.*, 2008). However, because these studies only sampled participants who had returned to work, they did not include the perspective of people who had experienced discrimination that resulted in them not returning to work. The actual barriers to work were similar regardless of whether they were expected or experienced; therefore, it seems that although barriers are not always based on personal experience they are grounded in wider experiences of return to work. Given that so many participants talked about their negative experiences, it is risky to recommend that the focus for change should be on the participants' expectation—something needs to be done to ensure their trust. Otherwise participants could take part in confidence building schemes (e.g. to make them feel confident about their capability of return to work) only to find that, as one example, employers do discriminate.

4.4.2.4 Job quality

It is possible that there is a trade-off between interests and skills and available jobs, whereby practical considerations e.g. proximity to home (Boyce *et al.*, 2008) and only approaching employers with a good reputation for employing disabled people (Hudson *et al.*, 2009), outweigh job satisfaction. Loss of capacity for the demands of former employment may mean that people OWIH face a situation where they have little control over the jobs that are available for them, and over the work itself. Even where authors highlighted the benefits of moves into work there were also some problems. Although Hudson *et al.* (2009) say that "the transition into work was unanimously a positive one", they later note that the unpredictability of some participants' health conditions caused problems in work, and for some, meant that return to work could not be sustained because of job demands and unsuitable hours (p. 68).

Expectancy of high-demand work was partly explained by authors by a change in the labour market (Beatty *et al.*, 2009; Hedges and Sykes, 2001; Magnussen *et al.*, 2007). It was felt that industry had changed so that there are more temporary contracts and the nature of work itself has actually become more demanding. However, related recommendations on how to improve return to work prospects were thought to be problematic—summed up by Magnussen *et al.* (2007): "post-modern, profit driven economies seem oblivious of this perspective [where society morals mean that working life should be inclusive], and it might be difficult to turn around this development" (p. 195). Recommendations related to the macro-context highlight the extent of the changes required e.g. Beatty *et al.* (2009) state that the main policy implication of their research is to make sure that there are a sufficient number of jobs, particularly in areas where there is high unemployment, requiring "national economic growth, and sustained regional and local economic regeneration" (p. 103). Perhaps because of the difficulty of seeing uptake on such a policy, many recommendations on how to tackle issues relating to expectancy of job demand fell back to the individual. For example, it was advised that rehabilitation should focus on improving people's perception of themselves and of their capacity to work so that they felt more confident about applying for jobs and returning to work.

4.4.2.5 Work-role centrality, adaptation, and work as financial risk

Work-role centrality is the general importance that work holds in one's life (Paullay *et al.*, 1994). Although the authors did not necessarily use the term 'work-role centrality', much of the discussion around motivation or determination to return to work was associated with this concept. Many participants across the studies reflected that work was important and desirable in terms of self-identity. This was true of participants who had returned to work, but also those who had tried unsuccessfully and those who had accepted that they could not work.

The studies showed that determination to return to work was linked with high work-role centrality. Despite some authors concluding that determination and related concepts were facilitators for return to work, it was clear from the synthesis that having the desire and determination was not always sufficient to secure a successful return to work. In some examples, determination had helped to secure employment, but not to sustain it (Hedges and Sykes, 2001; Hudson *et al.*, 2009). Gilworth *et al.*'s (2009) study included 'determined' participants who had successfully returned to work as well as those who had not. They did not draw attention to any differences in determination between the two groups; rather they showed lack of support and information for the people who had not returned to work.

For those who did not return to work, Gilworth *et al.* (2009) highlighted that when work brought "personal identity and worth" it was difficult for participants to be able to adjust to facing a life without employment (p. 101). Work-role centrality could therefore hinder adaptation to life changes linked to disability, if those changes preclude work.

On the other hand, adaptation was discussed by authors as both a barrier and facilitator to work, depending on circumstances such as individuals' determination to regain employment and the degree to which disability or related issues made employment unlikely. Willingness to adapt could be a facilitator to employment because return to work often involves the need to change work role or even career, to which individuals are obliged to adapt (Dekkers-Sanchez *et al.*, 2010; Mettavainio and Ahlgren, 2004). 'Reorientation' is therefore needed to be able to develop a 'new worker identity' (Mettavainio and Ahlgren, 2004). Allen and Carlson (2003) concluded that there was a need to adapt to stressful concurrent life events before being able to make a successful return to work. On the other hand, Beatty *et al.* (2009) considered that adaptation to a 'sick-role', with acceptance that work is not possible, was a barrier to return to work. Adaptation itself was discussed as the barrier because it leads to the development of self-identities and routines that no longer involve work. Magnussen *et al.* (2007) discussed the difficult process of obtaining a disability pension, and the personal need to gain acceptance of one's 'disability status' and identity as a disability pensioner. Beatty *et al.* (2009) even concluded that adaptation to a life with benefit receipt rather than work may encourage individuals to believe that they are sicker than they actually are.

It is possible that financial concerns played a part in adaptation and return to work. Fear that employment removes the benefit safety net was identified as a barrier to work in the two studies that also identified adaptation as a barrier to work (Beatty *et al.*, 2009; Magnussen *et al.*, 2007). Financial implications of not working were seen to be a push factor for return to work in two of the studies that saw adaptation as a facilitator to work (Allen and Carlson, 2003; Dekkers-Sanchez *et al.*, 2010) (finance was not mentioned in the third). It is possible that the participants in the latter studies had not adapted to their new financial situation but needed to adapt to their disability or condition in order to make a successful return to work. However, it is not clear why some studies' participants adapted to their financial situation and others did not.

Financial barriers to work are intrinsically linked with the welfare-benefit system but were not limited to one country. Participants from both the UK and Norway identified similar issues over concerns about finance in work, but explanation differed. Authors of the UK studies partly attributed financial concern to a lack of knowledge about the financial support available to encourage return to work. In the UK there are different benefit schemes to encourage people into work (e.g. Return to Work Tax Credit) and the opportunity to return to benefit receipt if the job does not work out. However, there was a lack of knowledge about such schemes, participants did not always trust them and/or found them to be confusing (Beatty *et al.*, 2009; Hedges and Sykes, 2001; Hudson *et al.*, 2009). There are similar, although perhaps more generous, benefit rules in Norway (return to benefit receipt is possible if the job does not work out). However, the authors of the Norwegian study did not align the financial barrier to work with a lack of knowledge about benefit options. Instead they presented paradoxical possibilities: that benefit rules were "insufficient to support a return to working life", or that it was possible that benefits in Norway are "too generous to encourage a return to work" (Magnussen *et al.*, 2007, p. 195).

Where studies reported that lack of income out of work was an incentive to try to return to work they also showed that it was a stressor to the participants, therefore for obvious reasons did not make the recommendation that people OWIH should be subject to lower income to facilitate return to work (Allen and Carlson, 2003; Dekkers-Sanchez *et al.*, 2010). Financial advice as part of rehabilitation and better information on in-work benefits may be more practical recommendations (Allen and Carlson, 2003; Hedges and Sykes, 2001).

4.4.2.6 Different barriers and facilitators by personal characteristics and health conditions

One aim of this review was to look at differences in barriers and facilitators to work by different groups of people. This sub-section considers how country, gender, socioeconomic background, and health condition (specific conditions, mental/physical) may influence potential for return to work.

It is possible that country differences exist, particularly because of different available benefits and benefit-receipt rules. As previously mentioned, there appeared to be some difference between barriers to work identified by studies conducted in the USA and those conducted in other developed countries. The participants in the studies included in this review identified similar issues (to each other) and it is difficult to tell whether (or how) the benefit rules in each country played a part in any of the differences that were apparent. Of the studies that identified finance as playing a role in the return-to-work process (six out of the nine) there were two that came to different conclusions from the rest, in that the participants did not identify the financial risk of moving into work as a barrier to making that transition. It could be that they were more aware of financial support in work, or ability to return to benefits if work was not successful, or that they were not receiving benefits in the first place. These two studies were from the Netherlands and Australia, while the ones identifying work as financially risky were from the UK and Norway. However, the studies from the Netherlands and Australia did not give any information on participants' benefit receipt and studies from the UK and Norway did not give information on how long participants were out of work. It is therefore difficult to come to a conclusion regarding the role that the benefit receipt played, if any, in the different findings.

Beatty *et al.*'s (2009) wider research aim (than drawn upon so far in this synthesis) was to determine whether women required a different approach to support them into work than men, and, by and large, their conclusion was that they did not. This is in line with the findings of the other studies, which did not report major differences between return-to-work paths for male and female participants. The one difference that was brought up was related to gendered roles: it is possible that some females adapt to fulfil roles other than working, to the extent that work is not a priority or is difficult alongside competing responsibilities, and the opposite for males—some feel an extra incentive to return to work to fulfil their ‘masculine role’ as main breadwinner (Allen and Carlson, 2003; Beatty *et al.*, 2009; Mettavainio and Ahlgren, 2004). However, this hypothesis on return-to-work differences by gendered roles was only based on a few participants in each of the studies that discussed it, and not a major finding in any. Mettavainio and Ahlgren’s (2004) conclusion, relating to gender and return to work, seems apt: that “in order to achieve successful vocational rehabilitation the individual’s whole life situation should be in focus”, therefore including gender issues where appropriate (p.23).

Other than being able to say that some of the factors identified as barriers are more common among people in lower socioeconomic positions e.g. lack of qualifications, poorer health, and lack of jobs in local areas, it is not possible—using the included studies—to distinguish between barriers or facilitators to work by socioeconomic group because few of the studies discussed this specifically.

Most of the studies with samples including some participants with mental health and others with physical health conditions did not mention any differences in barriers or facilitators to return to work by type of health condition (Allen and Carlson, 2003; Beatty *et al.*, 2009; Dekkers-Sanchez *et al.*, 2010). Dekkers-Sanchez *et al.* (2010) noted that barriers and facilitators were “independent of the clinical diagnosis” (p.550). However, the same authors made striking claims about generalisability as well, and it seems more appropriate on the basis of these studies to take a similar view to Allen and Carlson (2003) who suggest further research is needed, with single or mixed diagnosis groups, to determine how applicable the findings are. Hedges and Sykes (2001), whose study had a mixed sample in terms of physical and mental health conditions, highlighted issues that they felt were particularly pertinent barriers for those with mental health conditions: self-confidence, worries about fluctuating nature of condition, and being able to cope in work. However, by comparing with the results of the other included studies these issues do not appear to be specific to people with mental health conditions. Looking across studies, there were no obvious differences in participants' perceptions of barriers and facilitators to work by physical or mental health conditions. The only difference by health condition was between the participants in Gilworth *et al.*'s (2009) study who had a stroke and participants in other studies who had experienced a more gradual, and perhaps less immediately life-changing, deterioration in their health. Differences in barriers and facilitators to work in Gilworth *et al.*'s (2009) study focused on adapting to a completely new circumstance, and participants in this study tended to receive a medical-based rehabilitation programme (perhaps explaining why the recommendations were aimed at working with the individual).

The question remains whether differences in return-to-work outcomes for people with mental and physical health conditions are down to differences in the individuals themselves, in the support they receive, or the discrimination they encounter. Hudson *et al.* (2009) list a range of reasons or life events that participants identified as leading to their depression e.g. bereavement, relationship breakdown etc. It is possible that those who experience more negative life events in the first place are more likely to develop mental health conditions as a reaction to these experiences, and in turn have even poorer return-to-work outcomes (double disadvantage).

4.5 Discussion

This chapter has presented a systematic review and synthesis of nine qualitative studies that explored those OWIHs' perspectives on barriers and facilitators to their return to work. After reflecting upon the critical appraisal and synthesis methods—and identifying particular strengths and limitations of the research—this final section identifies areas where further research could be directed.

4.5.1 Limitations and strengths

One limitation common to systematic reviews is that the data found are dependent on three different levels of reporting: participants, authors of included studies, and systematic reviewers. Synthesising existing studies involves relying on other authors' reports of the data they have collected, and relying on the accuracy of these reports. At the next level, it should be acknowledged that although care was taken to check interpretation of the data i.e. by independent interpretation by two reviewers, it is possible that our own judgement may be different to other interpretations of the same data. The review has made every effort to be transparent about the process of arriving at the conclusions, for example by providing summaries of original data and referring to participant voice and authors' interpretations in the text.

The search for studies was comprehensive in that it searched a breadth of databases and included manual search, identifying over 4,000 studies to start with. Specific health condition terms were not used in the search (general terms for disability were used), potentially missing studies that looked at specific barriers to work for people who had experienced certain conditions. If the research aims were to provide individually-focused rehabilitation to a particular group of people (based on health condition) then it would be worthwhile doing a more intensive search for studies with that particular condition (as mentioned, there were slight differences for those who had stroke and the studies with HIV/AIDS participants). Additionally, forward as well as backward citation searching may have generated further relevant studies.

As discussed in section 4.3.3, there are differing views on whether critical appraisal should be part of qualitative synthesis. The experience of critically appraising the qualitative studies found that agreement on individual items of quality e.g. on specific aspects of sampling, data collection etc. differed, but that our overall assessments of the quality and relevance of each study tended to agree. The original pioneers of meta-ethnography suggested that "the worth of studies … is determined in the process of achieving a synthesis" (Noblit and Hare in Campbell, 2003, p.682). However, the use of a quality assessment tool and excluding studies based on quality was a worthwhile step in this review. Out of all the identified studies, many more of them could have been synthesised, but that does not automatically mean that they were methodologically sound. A strength of the study is therefore that it synthesised the highest quality studies.

The main strengths of qualitative research are that it gives participants the space to give detailed accounts of their experiences and, in some cases, allows more scope to bring out attitudes that are important to the participants rather than to the researchers. This is the first comprehensive search and synthesis of qualitative studies on this topic. Use of a second reviewer throughout, including on comparison of interpretation, was a strength of the review.

4.6 Conclusion and areas for further research

Comparing the reports of participants who did return to work and those who did not, it is striking that both groups tend to identify a similarly broad range of barriers to employment. This similarity of narratives makes it difficult to establish why some overcame such barriers and others did not, although it does suggest that even those who successfully gained employment still contextualised their achievements as occurring within an environment largely characterised by barriers rather than facilitators.

Two main gaps have emerged from this review as opportunity for further research: comparison between those OWIH with physical and mental health; and further exploration of the concept of motivation for return to work.

None of the studies made any in-depth attempt to compare participants by health condition. This is important because, as discussed in Chapter two, there is some evidence that those OWIH with mental health conditions have poorer outcomes than those OWIH with physical conditions. Other researchers have suggested that a better evidence base of how best to support those OWIH with mental health conditions into employment is required (Anyadike-Danes, 2010). Differences between the experience of those OWIH with physical and mental health conditions therefore warrants further research.

An aim of the thesis was to explore whether the focus on activating IB and ESA recipients is appropriate. One aspect of return-to-work support has concentrated on claimants' motivation to work. Motivation to work was discussed in the included studies in terms of determination and desire, often drawing parallels with the concept of work-role centrality. Determination and associated concepts were talked about as being facilitators to return to work. However, the studies rarely gave examples of participants who were not motivated or determined to return to work or of those who had low work-role centrality. Beatty *et al.* (2009) did discuss that some participants had a lack of aspiration or flailing motivation after adapting to benefit receipt. They explained that people who had low motivation to work were discouraged from return-to-work attempts because of the barriers that they perceived would stop them from finding a job. In combination with their quantitative research, Beatty *et al.* (2009) estimated that around a quarter of IB recipients were discouraged workers fitting this description. Although they explained that people's motivation was worn down because of the obstacles faced, they did not explain why some people remained motivated to work when others did not, nor did they consider barriers to work relative to others. There was no exploration in the studies of what leads to work-role centrality, therefore it is not clear how low work-role centrality can be addressed. An area for further research is to explore what it is that motivates people to return to work and why or if some people are more motivated to return to work than others, and whether this is linked to the concept of work-role centrality. This also relates to the finding in this synthesis about the difficulty of interpretation of people's barriers to return to work. It is important to understand participants' motivation (or lack thereof) to return to work, rather than impose researcher views on the situation.

The issues brought up in this section are further explored in the results of a primary qualitative study. The following chapter introduces the primary qualitative study and Chapters six and seven discuss its findings.

Chapter five: A qualitative study of Incapacity Benefit recipients, General Practitioners, and Employment Advisors

While previous qualitative studies have identified various barriers and facilitators for return to work, there are important gaps in the research. For example, there is limited evidence on what determines people's motivation to return to work, whether their work-role centrality plays a part, and whether there are differences in barriers to work for those out of work because of ill health (OWIH) with mental or physical health conditions. The following presents a qualitative study to address these gaps. This chapter provides rationale for the study and the methods used, a description of the methods, and finally initial results to introduce the participants. Chapters six and seven present the main study findings and discussion.

5.1 Research questions and objectives

Specific research questions and objectives were:

Are the barriers to work identified by people who have been OWIH long-term (>2 years) and receiving health-related benefits in the west of Scotland similar or different to the barriers identified in previous research? A related objective is to explore differences between experiences and perceptions of barriers to work for people out of work because of physical ill health and those out of work because of mental ill health.

Do those OWIH need to be motivated to work, and what causes some to be motivated and others not? A related objective is to explore the concept of motivation in relation to: capacity, opportunity, and preference to return to work and work-role centrality.

What are the barriers and facilitators to work for OWIH recipients from the perspective of General Practitioners (GPs) and Employment Advisors (EAs) and do they differ from the perspectives of those OWIH?

What pressures do EAs and GPs face in terms of supporting their patients or clients who are OWIH?

In-depth interviews were conducted with people OWIH, GPs and EAs to address these research questions.

5.2 Rationale for study and theory

5.2.1 Mental and physical health and barriers to work

The studies used for the systematic review in the previous chapter did not provide explanations as to why people with mental health conditions may have poorer outcomes than those with physical health conditions. This was not necessarily because there were no differences in barriers to work for people OWIH with mental health conditions and people with physical health conditions; none of the studies intended to compare participants in this way. The question remains as to whether people with mental health conditions have different barriers to work when compared to people with physical health conditions.

5.2.2 Motivation to return to work

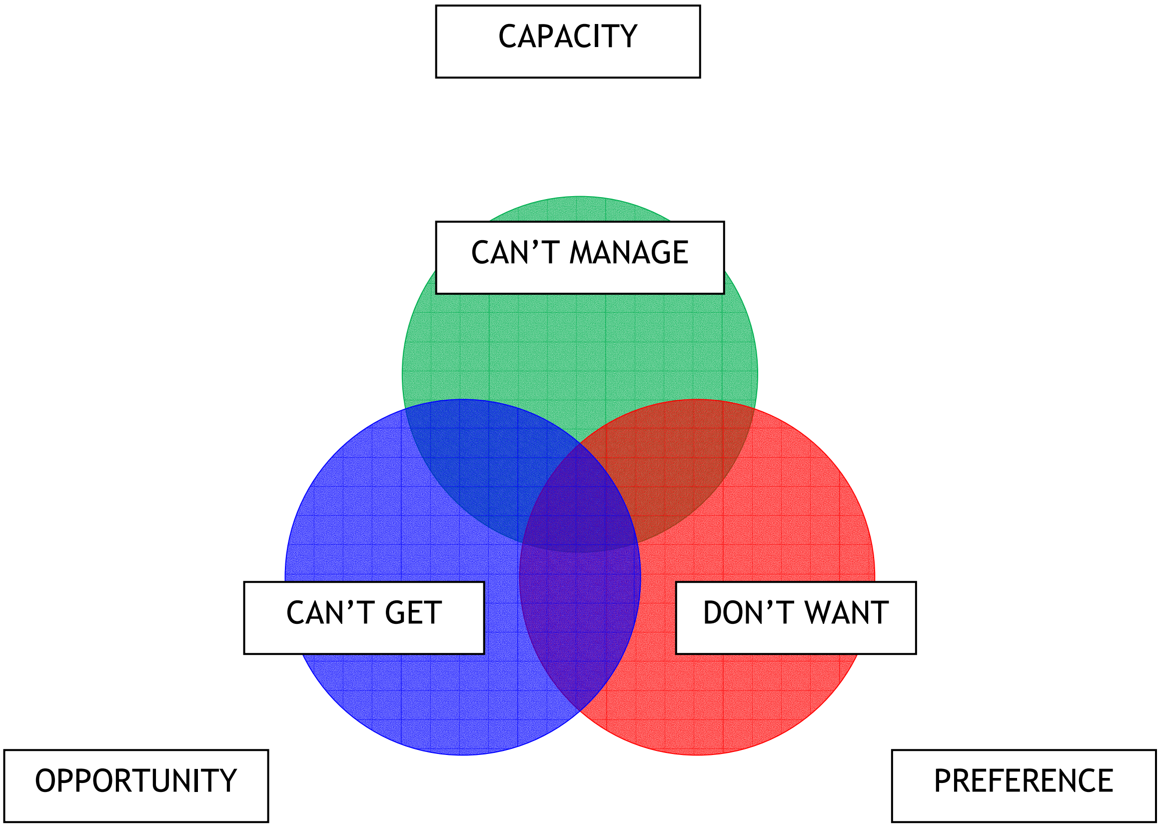
Some of the studies included in the previous chapter's systematic review highlighted motivation as a facilitator to return to work. However, they did not discuss the distinction between participants for whom lack of motivation was a barrier and others for whom motivation was a facilitator to work. Also, in many of the studies, the concept of motivation was undefined. Furthermore, the systematic review showed that tensions exist between authors' interpretations of participants' motivation to work and the participants' own views on what constitutes their motivation to work. This led to a difficulty of interpretation, with implications for recommendations on how best to support people into work. The current study made use of a framework defined by Berglind (1992) as a way of both organising the factors that may alter people's motivation to return to work and of being transparent about how the data were organised.

5.2.2.1 Participatory action theory

One framework that may support an investigation of return to work, looking specifically at the views of those with experience of being OWIH, is participatory action theory (Berglind, 1992). Participatory action theory is theoretically based in philosophical action theory (e.g. Von Wright, 1971), but is used in a practical sense here, similar to Berglind's (2002) application to return to work.

Berglind (1992) created a framework for facilitating the understanding of human action, looking at the choices people make given different alternatives. It is a model of motivation that considers the individual and their context. It is centred on the individual perception of the context rather than any objective measures, for example, of labour market trends etc. Rather than think of motivation as related solely to will, impulse, or preference, Berglind conceptualised motivation as involving preference, perceived capacity, and perceived opportunity and suggested that these three underlying dimensions are interconnected. Participatory action theory was later applied to help understand motivation in relation to return to work among people on sick leave using a questionnaire study in Sweden (Berglind and Gerner, 2002). Participants were out of work because of musculoskeletal problems for at least two months, and still had an employer. Participants were mailed a questionnaire at three time points—each six months apart—and their employment status was collected from the social insurance office approximately two years after they filled in the first questionnaire. The results showed the model, which was derived from preference, capacity, and opportunity, was predictive of return to work at follow-up. Importantly, it showed that preference to work was related to perceptions of capacity and opportunity to work, and should not be thought of in isolation from these other dimensions (see Figure 5-1), challenging the traditional view of motivation for return to work. Thus, those who wanted to return to work were likely to think that they would be able to cope with it. The model has only been tested with participants who had an employment contract, therefore looked at capacity for a specific job, but the general idea and separate dimensions of motivation could be explored among people who do not necessarily have recent employment history or a particular type of job to move into.

Figure 5-1: Participatory action theory



5.2.3 Work-role centrality

In the studies considered in the systematic review for Chapter four, motivation as a facilitator to work was sometimes linked with work-role centrality, but there was no exploration of (lack of) work-role centrality as a barrier to work. As well as using the concepts of participatory action theory as a framework to think about motivation, this study considers the role of work-role centrality in determining participants' motivation to return to work.

Work-role centrality is not only about the importance of a particular job in one's life, but about the commitment to work in general, about how central work is in a person's life, and how much it makes up their self-identity (McKee-Ryan *et al.*, 2005). For example, in a study with recent school leavers, Stafford *et al.* (1980) found that importance of work in someone's life could be assessed even in people who had little or no work experience, and it was found to be important for mental health in unemployment. Much of the research on the concept of work-role centrality with populations who are out of work has looked at the impact of unemployment on mental health, whereby it has been suggested that the higher an individual's work-role centrality, the higher their distress at being unemployed e.g. (McKee-Ryan *et al.*, 2005; Warr, 1987). However, as suggested in the previous chapter, work-role centrality may be associated with motivation to work and could act as a barrier or facilitator to return to work for those OWIH.

5.2.4 Different perspectives

Views other than of people who do not directly experience being OWIH are also important when thinking about barriers and facilitators to return to work, because others are involved the return-to-work process. Key examples of providers of support are EAs and GPs. EAs advise clients who are OWIH on employability and welfare issues within Jobcentre Plus (JCP) or other private or voluntary-sector providers. Although GPs in the UK are no longer directly involved in assessing patients for Incapacity Benefit or Employment and Support Allowance (IB/ESA), they are intrinsically involved in the return-to-work process in that they are a point of contact for people OWIH and they sign off on patients' appeal applications when they wish to reverse a decision following their medical assessment.

Qualitative studies have explored GPs' role in the welfare system, finding that GPs experience conflicting roles with regard to patients out of work receiving health-related benefits, and often find it difficult to support these patients in relation to work (Beatty *et al.*, 2009; Cohen *et al.*, 2010; Hiscock *et al.*, 2005; Hussey *et al.*, 2004; Mowlam and Lewis, 2005). GPs do not feel confident taking care of their patients' work and return-to-work issues, particularly when their patients have social problems in addition to medical problems (Chang and Irving, 2008). Most of the qualitative studies with GPs have concentrated on the GPs' role in the welfare system or in supporting patients who are on sickness absence rather than receiving IB or ESA.

Numerous qualitative studies have been conducted with EAs in the UK, which mainly focus on views of working with clients on IB and ESA in relation to a welfare-to-work service e.g. Pathways to Work (PTW) or one of its components e.g. Hudson *et al.*, 2009; Nunn *et al.*, 2009; Nice *et al.*, 2009; Hedges and Sykes, 2001. These studies concentrate on the barriers that EAs face to supporting their clients into work rather than specifically on the barriers to work that the clients face. For example, access to referral services, building relationships with clients, building relationships with disability-friendly employers, complicated benefit rules, and dealing with confidence problems are all issues that EAs have brought up when discussing the difficulties they face in supporting their clients into work. These issues do bring up barriers to work that clients may face, but the studies have generally not asked directly about clients' barriers to work or about whether there are different barriers for particular clients. Beatty *et al.* (2009) did not explore differences in perspectives on barriers to work but did interview GPs and JCP officials about their patients' and clients' motivation to work and about the reasons for the rise in worklessness because of health in recent decades. Although the research did not find evidence of a 'sickness culture' among IB recipients, it was clear that GPs and JCP staff felt that this ethos did exist and that lack of motivation to work was a problem. It was recognised that lack of motivation was likely to be related to the type of job held, but there was little exploration of other barriers that their patients or clients may have faced. Differences in opinion between GPs, JCP staff, and those OWIH may make it difficult for those providing support to empathise with their patient or client's situation, therefore further comparison of different perspectives is warranted.

5.2.5 Social situation

From previous qualitative research it was difficult to identify differences between OWIH experiences by socioeconomic status. It was clear that some participants in the studies reviewed in Chapter four had experienced concurrent life events that were additional barriers to work alongside their health conditions. However, the impact of having complex social situations on motivation to work was not discussed in depth. It is possible that those OWIH who have additional issues that they have to deal with in their social lives find it more difficult to be motivated to return to work. Also, as mentioned above, some GPs find it difficult to support patients OWIH who have complex social situations. This is something that is explored in the primary qualitative study outlined in this chapter.

5.3 Rationale for study methods

This section summarises the main methodological considerations before the next section outlines the methods used.

5.3.1 Choice and identification of sample

The core aim of this study was to explore the experiences and perspectives of people who are OWIH and receive out-of-work health benefits; therefore these people made up the main participant group for the study. To provide different perceptions on some of the issues that were raised by the main participant group, and to explore the role and pressures faced by service providers in supporting people OWIH, GPs, and EAs were included as additional study populations.

5.3.1.1 Hard-to-reach groups and research ethics

Potential OWIH participants may have been deterred from taking part in the study for a number of reasons e.g. they did not want to discuss sensitive matters or they believed that there may have been benefit-receipt implications. Taking account of ethical issues and bearing in mind that the recruitment phase was during a time when the UK Government was introducing controversial welfare reform (early 2011), particular consideration was given to ensuring that the information given to potential participants was sufficiently detailed and clearly stated that participation would not impact on healthcare or benefit receipt.

5.3.1.2 Sampling

In qualitative research participants are not selected to be representative of the population, but rather to represent key characteristics of the population under study. The main qualitative sampling strategies are purposeful, and there are several different approaches for purposive sampling (Patton, 1990).

The aim of purposeful sampling is to gather 'information-rich' cases for study (Patton, 1990). To address the research questions this study required a sample of people OWIH that included both those OWIH with mental health conditions and those out of work with physical health conditions. Purposeful sampling was therefore used to recruit participants who were OWIH and two main strata were sought: OWIH because of mental health (OWMH) and OWIH because of physical health (OWPH). Since previous research had concentrated less on the views of those with mental health conditions, this study aimed to recruit more people with common mental health conditions, with some participants with physical conditions for comparison.

It was intended to recruit participants with a range of perceived capacity for work, rather than just those who were taking some return-to-work steps. This ruled out recruitment via return-to-work services; the study sought to recruit participants from a wider population of those OWIH. Identification of IB and ESA recipients via national registers was not possible because of privacy restrictions on administrative records (Skivington *et al.*, 2010). To recruit people who did not necessarily have any contact with welfare-to-work services, the best method of identifying participants was via GP practices. GP practices receive information from the Department for Work and Pensions (DWP) when their patients begin receiving health-related benefits and therefore have a record of this benefit receipt.

Given that the main participant group was considered to be a hard-to-reach population, the sampling strategy included opportunistic sampling as a further approach of purposeful sampling. Opportunistic sampling allows advantage to be taken of opportunities throughout the course of the research i.e. approaching potential participants about the study if the research leads to an encounter with them (Patton, 1990).

5.3.1.3 Sample size

Qualitative data are in-depth. Each participant provides rich detail requiring thorough analysis that would be unmanageable if sample sizes were determined in the same way that they are for quantitative studies (Ritchie *et al.*, 2003). At the same time, qualitative samples need to be large enough to ensure that there is some diversity, that key characteristics are not missed, and that meaningful comparisons can be made. Sample size decisions can be determined in advance but there should be some flexibility; it is possible to carry on sampling until the researcher has a picture of what is going on in relation to the phenomenon of interest and is able to develop explanations for it (Mason, 2002).

Based on attempts to fulfil participant characteristics and on previous qualitative research, this study aimed to carry out 30 interviews; 20 with participants who received out-of-work health benefits, five with GPs, and five with EAs. The research plan was open to recruiting more participants if it was felt that this would add new concepts to the data, and if practical.

5.3.1.4 Triangulation

'Triangulation' can refer to different methods to explore the same phenomenon e.g. using more than one qualitative method such as interviews and observations, or combining qualitative and quantitative methods, or can refer to exploring different perspectives on the same phenomenon. In this study, triangulation of three participant groups was used: participants who were OWIH, GPs, and EAs. This was undertaken to provide depth and explore similarities and differences in the data.

5.3.2 Data generation

The research questions in this study required data that would give insights into personal motivations and experiences, and which would also highlight participants' own perspective and interpretation of these things. This required generating data rather than studying naturally occurring data. In-depth individual interviews were therefore chosen as the method of generating data.

Although the subject of the interview may not have been viewed as sensitive to some participants, it was possible that the topics being discussed could be sensitive to others. Advice on dealing with sensitive issues was taken from colleagues who have been involved in sensitive research, and heeded from handbooks e.g. identifying non-verbal cues from participants; taking breaks where necessary; providing empathy but also recognising the limits in doing so

(Legard *et al.*, 2003; Mason, 2002).

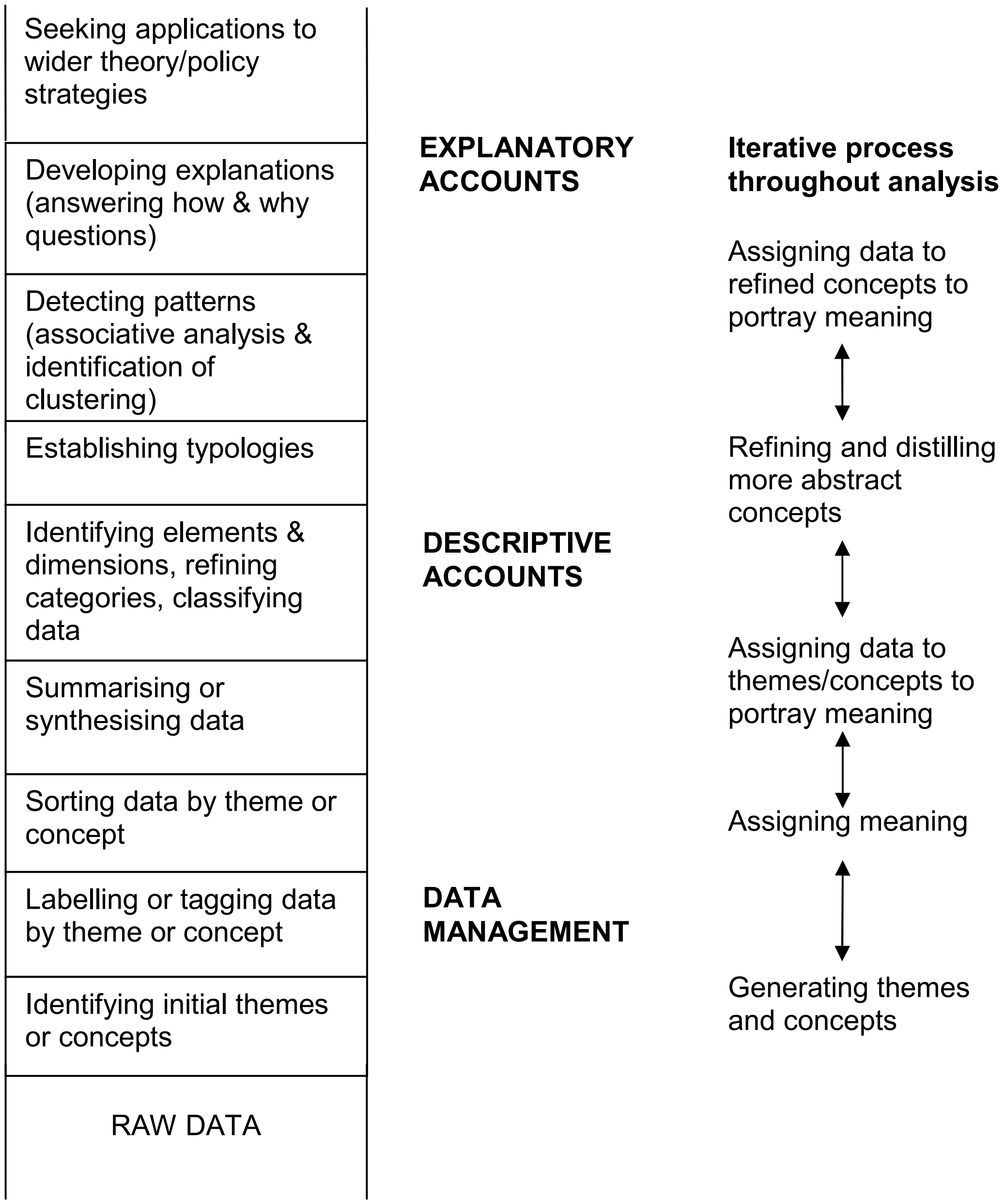
5.3.3 Qualitative data analysis

There are a number of approaches to qualitative data analysis (Coffey and Atkinson, 1996; Mason, 2002; Tesch, 1990). Thematic analysis was used for this research because answering the research questions required exploring what was said, themes that emerged, and patterns across data, rather than looking at, for example, the language used or the sequences evident in the data.

Framework analysis was chosen as an analytical tool for thematic analysis because of certain key features: it aids data management and organisation, concepts remain grounded in the data, it allows flexibility (in that the process can be amended throughout), it provides a tool for retaining the original context of each part of data after they have been synthesised, and is systematic and transparent (Spencer *et al.*, 2003b).

Spencer *et al.* (2003) depicted an 'analytic hierarchy' for framework analysis (shown in Figure 5-2), the steps of which provide structure to the analytic processes. Devising themes and assigning the data to categories is the initial level of analysis, with higher-level analysis to investigate how data are connected to each other and to develop explanatory links (Coffey and Atkinson, 1996; Spencer *et al.*, 2003b). Such explanatory links are the essence of qualitative analysis; they are about interpretation and, eventually, drawing conclusions.

Figure 5-2: The analytic hierarchy



Source: Spencer *et al.*, 2003, p. 212

5.4 Methods

This section describes the specific methods used in the study. It details the identification of the sample, recruitment, data generation, data management, and analysis. The methods were slightly different for each participant group, therefore are discussed separately for each where appropriate.

Since the research involved identifying participants through GP practices, National Health Service (NHS) Ethical and Research and Development (R&D) approval was given by the NHS West of Scotland Research Ethics Committee. A Research Passport was also obtained via NHS R&D to allow access to NHS patients and staff.

The research employed a two-stage recruitment method for OWIH participants, so initial results of recruitment (numbers identified and recruited at each stage) are included in the methods section for ease of explanation.

5.4.1 Identification of sample

5.4.1.1 Participants: out of work because of ill health

GP practices in relatively deprived areas with a high proportion of people on IB or ESA were sampled for the study. Also, given that GPs generally have limited time, practices that were known to be open to participating in research were approached. A GP research colleague and advisor helped with compiling a list of practices to approach. Letters were sent out to GPs in 17 different practices in January 2011, and a copy of each GP letter was sent to their practice manager. The GP research colleague aided the recruitment by co-signing the letters to endorse the research. The practice managers were then telephoned one to two weeks after the letters were sent out to find out if the GP practice was willing to help with identification of OWIH participants. Table 5-1 shows the response from the seventeen GP practices that were contacted about the study.

Table 5-1: Recruitment of GP practices to the study

Action	Outcome	Reason	Number
Letters sent out			**17**
Contact not made by phone	Not possible to get through	To reception	1
		To practice manager	4
Contact made by phone	Refusal	Owing to other commitments	4
		Owing to being too busy/ having a lack of capacity	4
	Agreed to identify potential participants		**4**

GP practices that agreed to identify patients for the study were visited and given study packs to distribute to eligible patients. The study pack contained an information sheet about the study and a consent form to pass on contact details to the researcher (Appendix C), with a stamped-addressed envelope for returning to the GP practice. GP practices inserted their own letter to patients into the study pack. The four GP practices that agreed to send out study packs also agreed to put up a poster about the study in their waiting room. It was intended that reminder letters would be sent to patients who had not responded within six weeks.

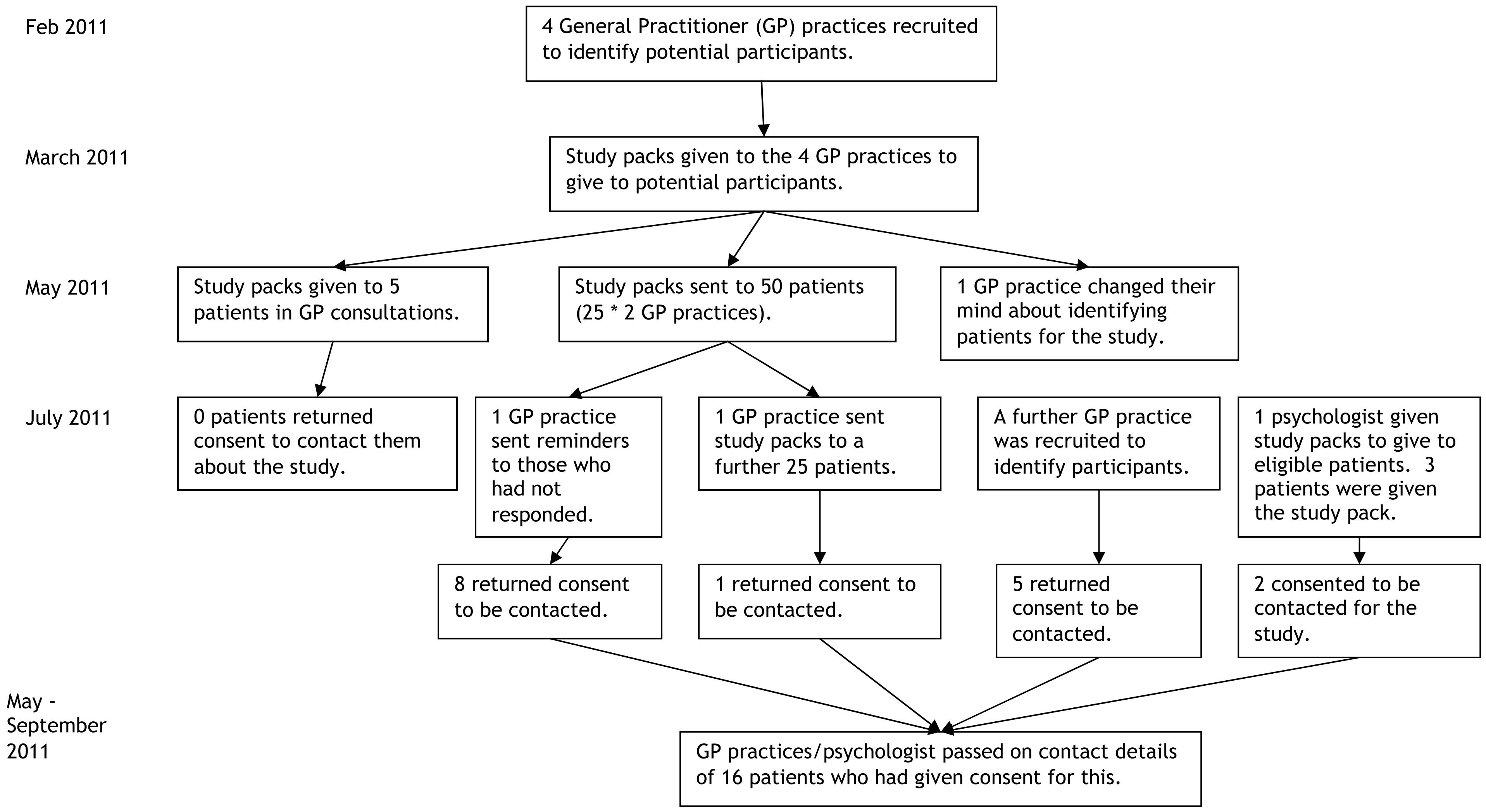
Figure 5-3 shows a flow chart detailing the identification of potential OWIH participants by the four GP practices. Two of the four practices each sent the study pack to 25 of their patients who they knew received health-related benefits and one agreed to give out the study pack during consultations. The fourth GP practice did not end up using the study packs. Although they originally thought that they would be able to identify eligible patients, when it came to sending out the study information, they said they did not know who to send it to.

The two GP practices that sent the study packs out to patients also agreed to send a second batch. The first GP practice sent out reminder letters to the original 25 patients. The second GP practice felt that reminder letters would be futile, but agreed to send out another 25 study packs to a different 25 patients.

From these two GP practices, nine patients (eight from one practice and one from the other) returned their forms giving consent to be contacted. There was no response from the posters, although it was not clear whether GP practices put them in their waiting rooms as intended.

The intention to over-sample patients with common mental health conditions was discussed with practice managers before they or their GPs identified patients to approach. However, in practice this was difficult to achieve as the GP practices controlled who was approached for the study. Further action was taken to recruit more participants with common mental health conditions. A GP practice—with a methadone clinic—and a psychologist at an NHS mental health centre in Glasgow were recruited to identify more participants for the study in July 2011 (see Figure 5-3). They were asked to identify potential participants who had common mental health conditions, and if on a methadone programme, were stable on it rather than using illegal drugs. Five patients from the GP practice (with methadone clinic) and two from the mental health centre then filled in the consent to pass on contact details for the research. This second round of identifying potential participants resulted in seven people passing on contact details, therefore 16 patients in total were identified via three GP practices and the mental health centre. These patients had not consented to take part in the study, just to be contacted about the study.

Figure 5-3: Flow chart of initial identification of potential participants



Opportunistic sampling was used to supplement identification of potential participants from health professionals. Where the opportunity arose to recruit a participant e.g. via another participant, it was taken. There were four opportunities like this, where study information was passed on to potential participants.

5.4.1.2 Participants: General Practitioners

When managers of GP practices were telephoned about the recruitment of OWIH participants, they were also asked if GPs would be willing to be interviewed for the study. GPs were not matched to OWIH participants. Some of the OWIH participants were likely to be patients of the GPs interviewed but the GPs did not know who took part in the interviews and the OWIH participants were not asked who their GP was.

5.4.1.3 Participants: Employment Advisors

It was intended to recruit EA participants from JCP and each of the main welfare-to-work organisations in Scotland. Telephone calls were made and letters sent to each organisation. As mentioned above, opportunistic sampling can be useful in situations where there is not an available sample to recruit from, and this method was used to identify more EAs.

5.4.2 Recruitment: the sample

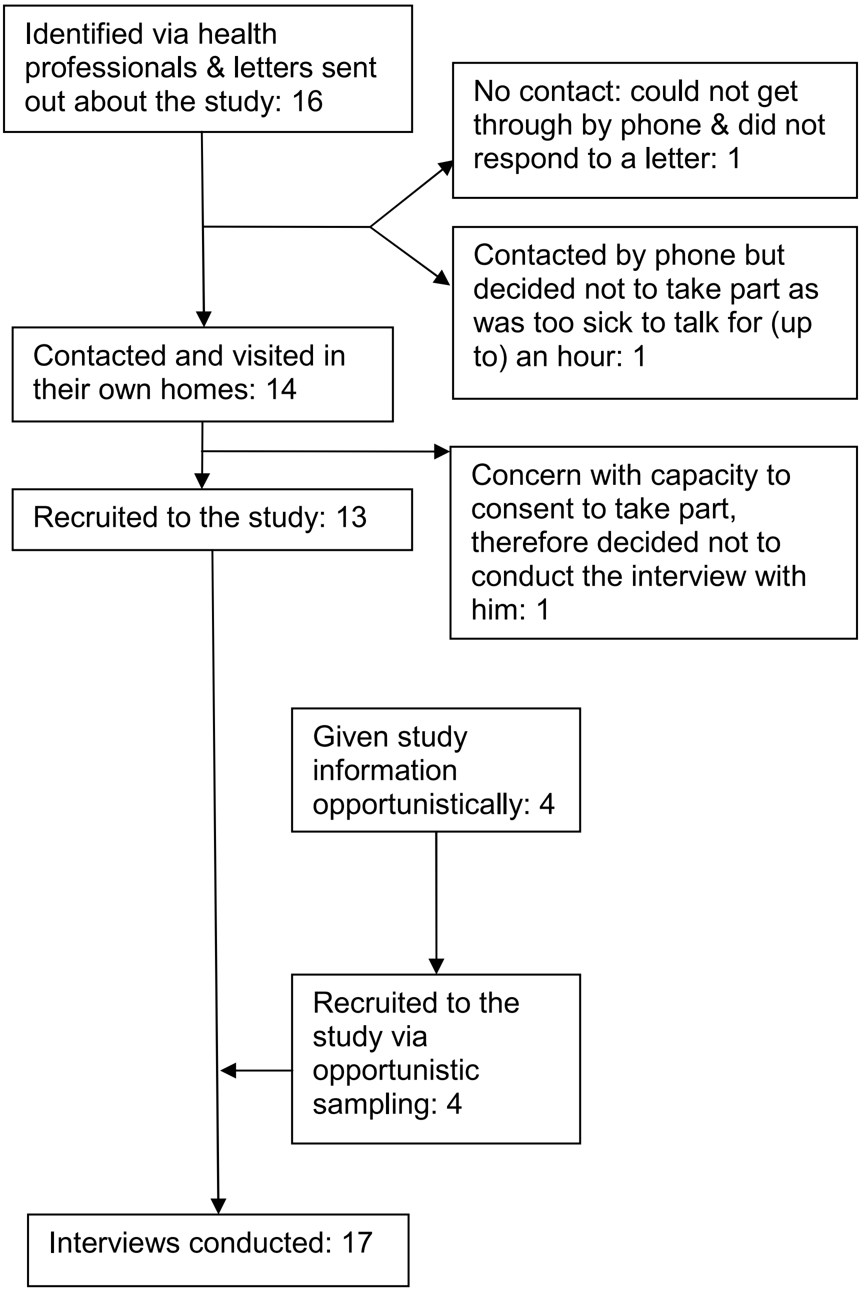
5.4.2.1 Participants: out of work because of ill health

The previous section only discussed identification of participants. Although potential OWIH participants had consented to be contacted about the research they had not yet consented to take part in it. After potential participants had been identified and had given their consent to be contacted further, I sent them a letter with a second Participant Information Sheet (Appendix C), which stated that I would telephone them about the study. If they were willing to take part, an interview time was then arranged. Participants were given the option of being interviewed in their own home, at the research base (SPHSU, Glasgow University), or in a convenient public place.

Figure 5-4 shows the recruitment process of potential participants to the study. Seventeen interviews were conducted with the core participant group. Not everyone who had given their initial consent for their contact details to be passed on ended up participating in the study; some could not be contacted or were too ill. Four participants were recruited via opportunistic sampling (see Figure 5-4). These participants were recruited via participants who had already taken part in an interview—they passed on the information sheet to others they knew who also received health-related benefits.

All core participant interviews took place in the participants' homes. Prior to the start of the interview, the consent form was read aloud to each participant, and they filled it in (Appendix C).

Figure 5-4: Flow chart of recruitment of participants to the study



5.4.2.2 Participants: General Practitioners

Two of the GP practices that agreed to help identify OWIH participants also agreed for GPs to be interviewed. Three GPs were recruited from these two GP practices. These GPs did not know which patients from their practice had taken part in an interview and were not matched to the OWIH patients. A further three GPs were recruited from other practices that were initially contacted about the research but that did not identify OWIH participants. Five of the GP interviews took place in the GPs' surgeries during working hours and the sixth interview was conducted at the research unit. An information sheet was provided and a consent form (Appendix C) signed before each interview took place.

5.4.2.3 Participants: Employment Advisors

Two of the six organisations contacted arranged for EAs to take part in the study; three EAs were recruited from these two organisations. A further three EAs were recruited via opportunistic sampling, two of whom worked for JCP, and one for another main welfare-to-work provider. The three EAs whose organisations had agreed to the research provided time and a place for the interviews to be conducted. The other three EAs participated outside of working hours; two interviews were conducted in the participants' homes and one in the research unit. As with the other participant groups, an information sheet was provided and a consent form (Appendix C) signed before each interview took place.

5.4.3 Data generation

All participant interviews took place between June and October 2011. Each of the interviews began with a discussion about the purpose of the study and focus of the interview. Participants had the chance to ask any questions about the study or the process. All interviews were loosely structured to allow in-depth probing on issues, as well as to explore relevant issues that had not necessarily been anticipated. The ordering of questions was not pre-determined, but was guided by participants' responses.

Fieldnotes were used with the purpose of reflecting generally on the progression of the interview, to note the context of the interview, which was not captured by audio recording, and to initiate ideas that may be relevant in the analysis phase.

5.4.3.1 Participants: out of work because of ill health

To begin the interview, participants were asked to describe how they first began receiving welfare benefits and what had led to this period. Questions stemmed from this first explanation of the participant's situation. Key issues were introduced (when appropriate to the flow of the interview), reflected in the topic guide (Box 5-1). The topic guide was intended to be a list of topics to be explored rather than specific questions.

Asking about participants' feelings towards employment intended to explore the concept of work-role centrality. Since this study was qualitative, with in-depth research of a small sample, a specific scale to measure work-role centrality was not used. However, examples of such existing scales were consulted to determine how previous research has measured work-role centrality as a construct e.g. Kanungo's (1982) Work Involvement Questionnaire. Ideas were taken from here to develop the probing in the interviews.

After the interview participants were given further information and support leaflets where appropriate and all were given a £20 high street voucher to thank them for their time.

Box 5-1: Topic guide for participants out of work because of ill health

The interviews will not follow a rigid structure of questions, as they aim to explore the issues that each participant brings up. Therefore, topics will be introduced as and where appropriate.

After re-iterating the general topic that will be covered in the interview, and making sure the participant feels comfortable, and understands that there are no right or wrong answers; the following topics will be introduced for discussion:

History of health condition and reason for going on to the benefit in the first place, how it felt to move on to claiming IB. Their experience of Incapacity Benefit (IB) receipt, how they feel about claiming this benefit now.

Health now—has it changed since starting on IB? Is the participant restricted by their condition, and if so, how?

Previous work experience and feelings towards work when they were employed.

Exploration of their feelings towards employment currently and throughout their lives, motivation for looking for work now, and motivation to work now. Made attempt to move into work?

Explore the barriers to work and barriers to looking for work and to getting a job.

Support received and the support they feel that they would need in order to make a move towards work.

Welfare reform and reassessment of IB recipients for Employment and Support Allowance (ESA).

5.4.3.2 Participants: General Practitioners and Employment Advisors

As with the OWIH-participant interviews, interviews with GPs and EAs followed a loosely-structured topic guide (shown in Box 5-2). GPs and EAs were not asked to talk about particular patients or clients—rather to give an overview of their perspectives on each of the topics.

Box 5-2: Topic guide for Employment Advisor (EA) and General Practitioner (GP) interviews

Topics to introduce to EAs:

Discussion of their perception of the barriers to work that people who receive Incapacity Benefit (IB) face, explore whether they believe that different groups of people face more or different barriers e.g. male and female, people with physical and mental health condition, young people and older adults.

Perceptions of the reasons for the rise in mental health condition as a reason for claiming IB.

Their capacity to support the group currently on IB into employment—is there always somewhere to refer, something to suggest? Who are the more challenging 'clients'?

Find out about local initiatives, support and referral links. Do they have links with employers in the area? Personal feelings on support available to move people on IB into work.

Views on welfare reform, and re-assessing the group currently on IB.

Topics to introduce to GPs:

Topics introduced in these interviews will be similar to those in the interviews with employment advisors. However, when discussing their capacity to support their patients towards work, they will be asked about the role they have in doing so, and their feelings about this role. They will also be asked about their feelings surrounding the support their patients get to move towards work and whether they feel that it has an impact on their patients' health.

5.4.4 Data management and analysis

Analysis is a continuous and iterative process, which often starts during data generation. This section discusses the issues and processes from data management to interpretation for all three participant groups.

Nvivo software was used in this project as a tool for ease of data management. Audio files from all of the interviews were transcribed verbatim into Nvivo. I transcribed 10 of the interviews, and the remaining 19 were transcribed by an independent contractor. Written transcripts were checked against audio files for accuracy. Potentially identifiable information was excluded from transcripts in order to protect participants' identities; each participant was given a pseudonym and identifying data such as place names, distinctive health conditions or workplaces were removed. The transcripts from the interviews were an average of 7,500 words for OWIH participants, 5,800 words for GPs, and 6,400 words for EAs. Fieldnotes were also typed into Nvivo.

The initial step in data management was moving from raw data to identifying initial themes and concepts. Firstly, this involved becoming familiar with the data. Some degree of familiarisation was obtained through conducting the interviews, transcribing, re-listening to audios, and checking transcripts. Recurring themes were identified and noted. This process involved reference to fieldnotes as well, as these contained ideas that had been noted throughout the fieldwork period. The next step was developing a thematic framework for each participant group, based first on the recurring themes that had been identified in the previous step, and then checked against the issues that were pre-determined by the topic guide. After the thematic frameworks were refined, the data were systematically indexed. The indices were refined throughout application to data, and with each refinement the data that had already been indexed were revisited.

The thematic framework for OWIH participants was created first. It is shown in Box 5-3. A colleague independently read a set of interview transcripts (1/4) and checked that the identified themes matched the original data. GP and EA frameworks were then created. Where appropriate, the themes reflected those that were derived from the interviews with benefit recipients. Figure 5-5 shows the themes that came out of the GP interview data and maps how they relate to each other. Common themes from EA data are in red.

Box 5-3: Descriptive themes for indexing and charting out of work because of ill health participant data

Personal characteristics
Sex, age
Living arrangements
Previous employment
Previous worklessness
Previous benefit receipt

Health
Health conditions
Expectations for health
Limitations & capacity for work

Benefit receipt
Triggers
Experience of/feelings about receiving sickness benefit
Feelings about benefit receipt/worklessness in the area/among other people
Knowledge about benefits
Money

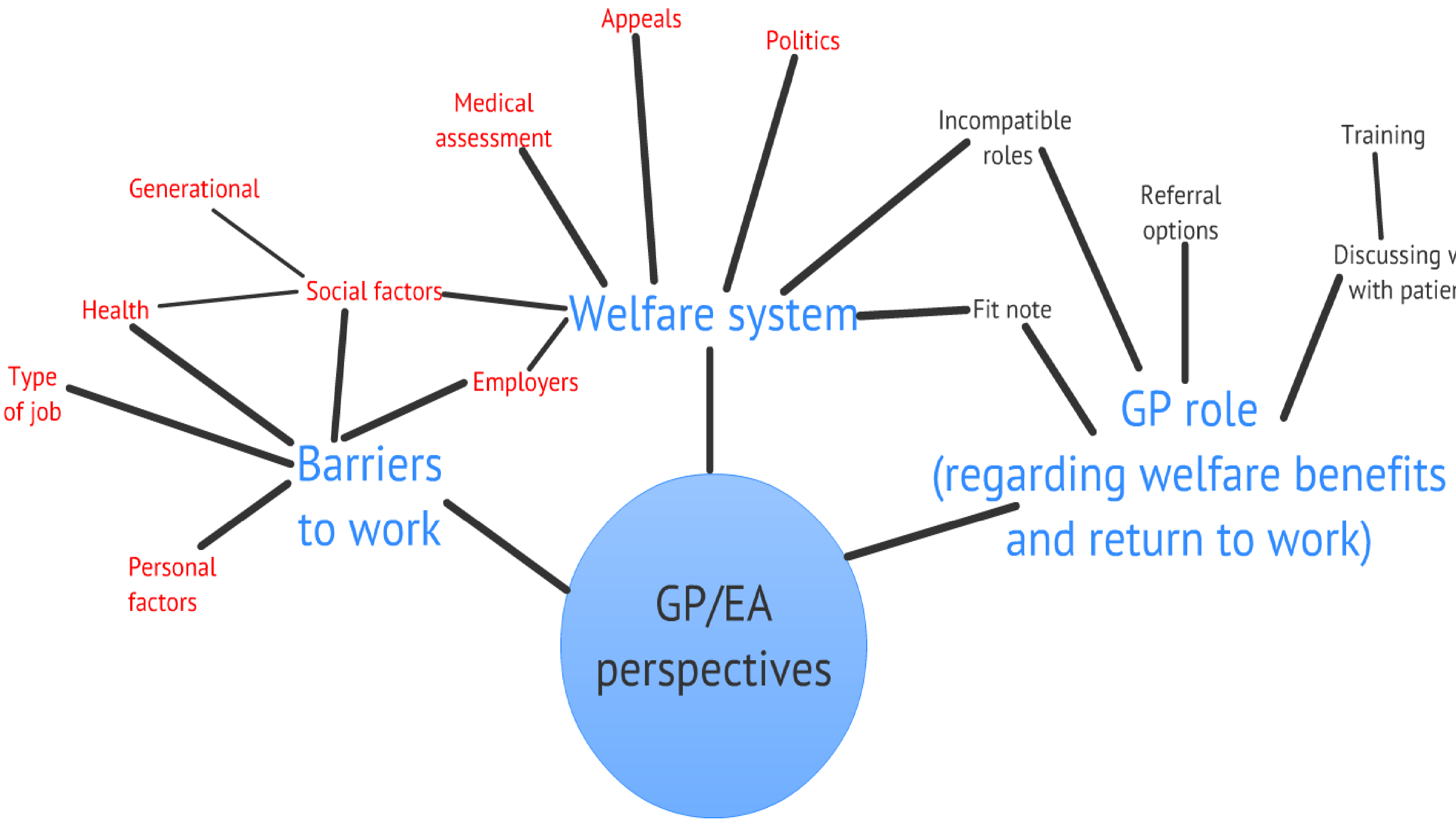
Employment
Feelings about employment: general
Feelings about employment: capacity & motivators
Type of job
Perceived facilitators to work
Perceived barriers to work

Return to work
Steps taken
Experience of return to work
Experience of barriers to work
Contact with employers
Disclosure

Contact with services
Benefits/money: medicals, appeals, permitted work
Employment: experience of, need for
Health

Other
Social contact & isolation
Social support
Relationships (positive & negative)
Substance use

Figure 5-5: Themes arising from General Practitioner (GP) and Employment Advisor (EA) data: used for indexing and charting



Having organised the data into thematic matrices with key concepts and themes, the next step was applying the data to the concepts of participatory action theory. Matrices were developed to organise the data under the headings capacity, opportunity, and preference for each participant. Further matrices were developed to include themes that were not covered by the concepts of participatory action theory. Work-role centrality and social circumstance were explored at this stage.

Explanatory accounts were developed. The process was not as linear as suggested here, in that notes on explanatory accounts were made throughout the study process. The final stage of the data analysis was centred around constructing explanatory themes and considering how they could be used. Creating explanatory accounts is the higher level of data analysis, explaining why patterns within the data occur. Triangulation was part of this, which involved comparing the same themes for each participant group. Patterns for different participant groups were also explored e.g. by type of health condition. Sometimes this involved creating a categorisation to group participants and compare differences e.g. participants with low or high work-role centrality and participants with low or high perceived capacity. These groupings were derived from the data i.e. from participants' responses to the interview topics, rather than from pre-defined or established categories.

5.5 Introducing the participants

This section provides a descriptive overview of participant characteristics using some of the descriptive themes shown in the previous section. It finishes by setting out how the following chapters are organised.

5.5.1 Participants: out of work because of ill health

A participant summary is shown in Table 5-2, and individual participant characteristics are shown in Appendix C. The final sample included 17 OWIH participants. The following sections provide more information about participants' health, benefit receipt, and employment experience.

Table 5-2: Participant characteristics

Characteristics	Primary reason for initial benefit receipt: Mental health	Physical health	Total
Age			
29-39	6	1	7
40-49	3	2	5
50-60	2	3	5
Sex			
Female	4	1	5
Male	7	5	12
Time since last employed			
1-5 years	3	4	7
6-10 years	3	1	4
>10 years	5	1	6
Housing			
Private let (covered by housing benefit)	1	2	3
Local authority rent	10	1	11
Owned with mortgage	0	3	3
Household composition			
Live alone	7	2	9
Live with parents	1	0	1
Live with children (no partner)	3	0	3
Live with partner (& children/no children)	0	4	4
Marital status			
Separated	9	2	11
Married/cohabiting	0	4	4
Single/never married	2	0	2
Total	11	6	17

5.5.1.1 Health

All of the participants had health conditions. A mental health condition was the primary reason for benefit receipt for eleven of the participants, and physical health the primary reason for the remaining six. It was common for participants to have co-morbidity; nine of those with mental health conditions also reported some physical conditions either from medication side effects or injury through an accident or violence. Three of those with primarily physical health conditions also had mental health problems, and all three were taking anti-depressant medication. Two of these participants attributed their depression to their physical diagnosis. Some of the participants had an immediate change in health that meant they had to stop working e.g. accidents resulting in serious injury—both work-related and not—or the diagnosis of a serious illness. Others reported that they had a more gradual change in health, which eventually led to them leaving their last employment. In these cases participants mostly had mental health conditions, whereas those who experienced immediate changes in health all had physical conditions. All of the participants had chronic conditions that they expected to be adapting to or coping with for the rest of their lives.

Three participants were recruited from the methadone clinic, therefore obviously had experienced drug problems, but none of these participants were still regularly taking drugs other than their prescribed methadone. Five other participants mentioned their drug use, one of whom was also on a methadone programme. Four other participants talked about alcohol addiction, or use of alcohol as a coping mechanism or reaction to their situation. Of the twelve participants who talked about substance use only two attributed their out of work status to that drug or alcohol use. The others discussed drugs and alcohol as either coinciding with or following on from health problems, mainly depression.

5.5.1.2 Benefit receipt

All of the participants were out of work because of health, but were receiving slightly different benefits, as shown in Table 5-3. The two participants who were previously receiving IB had recently attended a mandatory medical assessment and were told they were not eligible for ESA; one had decided not to challenge the decision and was receiving Jobseeker’s Allowance (JSA), and the other was about to start an appeal process to overturn the decision.

Participants often did not know offhand which benefit they received, or that there were various benefits available. Also, few had heard about the transfer from IB to ESA, even though they were interviewed almost three years after ESA had been introduced.

Table 5-3: Participants' benefit receipt

	N participants
Incapacity Benefit (not yet notified about re-assessment for Employment & Support Allowance)	11
Incapacity Benefit recently stopped following medical assessment	2
Income Support	1
Employment & Support Allowance (Support Group*)	3
Total	17

* None of these participants knew the distinction between Support Group & Work Related Activity Group, so did not know which Employment & Support Allowance group they were in but did not have any conditions to meet at the time of interview so appeared that they were in the Support Group.

5.5.1.3 Previous employment and return-to-work experience

Participants had varying levels of previous employment experience. Some had been continuously employed until their health condition left them unable to work. Others had fragmented periods of employment up until their current period OWIH, some saying that this was because of fluctuations in their health condition. Participants had worked in a range of occupations: labouring, administration, care work, retail sales, driving, security, art, and professional management. Some participants had very little employment experience, having only worked when they were teenagers for a year or two before leaving because of health. Others left the workforce for other reasons: redundancy or to have children, and spent time unemployed but subsequently moved on to IB, ESA, or Income Support.

Although all participants were in receipt of out-of-work benefits at the time of interview, some had previously moved from benefit receipt to employment and back to benefit receipt. Five of the participants had returned to employment since their first claim for sickness benefits. Four of these participants who had attempted to return to work had subsequently left that employment because their health had deteriorated while in work and had returned to sickness benefits. One participant was in on-going ‘permitted work’, which is work of limited hours and income that is officially allowed while receiving IB.

Other types of employment were considered by the participants. Three of the male participants talked about cash-in-hand jobs when they could not find legal employment, and these tended to be manual labour jobs. As his health condition improved, one of the participants wanted to return to work but said he could only find employment informally (but was holding out to find formal employment). Although a number of participants discussed their openness to doing some voluntary work, only one had started doing voluntary work, and had not kept it up because of a relapse in his health condition.

5.5.2 Characteristics of General Practitioners

All of the GPs were male. All but one had been partners in their surgeries for around 20 years. Details about GP participants and their surgeries are given in Table 5-4. All GP surgeries were in urban settings, mainly with a mix of deprived and affluent catchments, with the exception of one, which was in a very deprived area of Glasgow. All of the experienced GPs said that a lot of their work involved people who were OWIH, and that they had a lot of contact with people who received IB or ESA. The GP trainee did not have as much experience with people who were OWIH. All of the GPs had been involved in signing medical certificates for IB in the past, and all knew and had contact with patients who had appealed on ESA claims when judged ineligible.

Table 5-4: General Practitioner (GP) characteristics

	Sex	GP experience	Practice details*	Special interest
GP1	M	Registrar - final year of GP training.	Mixed area with affluent and deprived catchment.	No—just in his training at the moment.
GP2	M	Partner in practice. Has been a GP for over 30 years.	Deprived area, low life expectancies.	Not mentioned.
GP3	M	Partner in practice. In this practice for over 20 years.	Mixed in terms of demography—at the middle for Glasgow, so in the lower quarter for Scotland.	The practice has an interest in drug use, the GP has an interest in mental health and paediatrics, and has a research job alongside GP work.
GP4	M	Partner in the practice. GP for over 20 years.	Mixed area: from pretty deprived to fairly well off.	The practice has an interest in employment issues.
GP5	M	Partner in the practice for almost 20 years.	Mixed area with spread of employed/unemployed patients.	Family planning, minor surgery and asthma.
GP6	M	Partner in the practice for over 20 years.	Mixed area, with a lot of people out of work.	Welfare benefits.

* Using participants' own language

5.5.3 Characteristics of Employment Advisors

Of the six EAs, four were female and two male. Participants had a varying amount of experience supporting clients into employment, but all had worked in their posts for at least a year. The six EAs came from four welfare-to-work organisations, including JCP and other DWP funded providers of welfare-to-work programmes. The other companies were national welfare-to-work organisations rather than one-off support organisations. Each of the EAs had slightly different roles, because of client base, remit of the organisation, and organisational culture. This meant that they had differing contact with their clients, and therefore some had opportunities to build relationships while others did not. Table 5-5 illustrates the EA participants' roles within their organisations.

Table 5-5: Overview of Employment Advisor (EA) roles in their organisations

	Clients	Target	Work with the clients	Current job status
EA1, private company.	Mix: voluntary/had been assessed as fit for work. Those assessed fit had 6 mandatory appointments. All clients were at different stages—some she thought not ready to work & others who were already looking. If clients do not show up to appointments they are supposed to be referred to Department for Work & Pensions for sanctions.	Return to work (company was paid by results): 6 per month (≥16 hours). A lot of pressure to meet targets. Targets were not related to type of client—blanket for all. Expected to see 8/9 clients (up to 13) per day.	Flexible: could refer for different forms of support within the organisation e.g. exercise, CVs, applications, interviews. Built a relationship with clients during hourly appointments.	Recently left because she was not meeting her targets. Felt like she would have left soon anyway as did not feel comfortable doing the job.
EA2&3, third sector.	Clients made up of voluntary referrals from Jobcentre Plus (JCP). 75% of clients had depression or other mental health issues. Many of whom were ill because of workplace stress.	Target is to get people into work, but the office environment is a very supportive one.	Relationship with clients over a series of appointments directed at getting them ready for & into work.	EAs. Not sure how their job will change with the Work Programme (their organisation bid for but did not win a contract).
EA4, JCP.	Signing people on to Incapacity Benefit (IB)/Employment & Support Allowance (ESA) & dealing with complaints (regarding benefit receipt & JCP service).	So many deadlines for answering complaints that could not be kept up as there were so many complaints.	Could refer on to more specialist advisors, courses for skills training etc.	Contract with JCP recently ended.
EA5, third sector.	People with health conditions, are all referred, but come on a voluntary basis. Clients attend a 2 week employment programme (confidence building, CVs, interview skills) & after are required to go in once a week for 2 hours, where they use computers for job search. Each client is assigned to an employment advisor, who works with them for a maximum of 6 months.	Does not have individual targets. The organisation used to be paid for getting people into work, but that has changed, the payment is staggered—payments for getting clients into work & then for them staying in the job for certain periods.	Works with clients on individual basis, helping with job search, arranging interviews & placements (offer 2 or 4 week placements—a practical job interview, unpaid).	Was an EA & role recently changed to post-EA—now follows up on clients' return to work (for up to 2 years). Also previously worked in JCP.
EA6, JCP.	All benefit recipients, particularly lone parents & ESA recipients (none migrated from IB to ESA yet). Regularity of appointments with ESA customers vary as so much legislation is being introduced. ESA clients come for initial meeting & are given a 'prognosis', stipulating when they have to return to JCP (prognosis: a judgement of time expected to be ready to return to work: 3-24 months).	No return to work targets. The only targets are productivity targets—where they have to have a certain contact rate with clients, & targets for getting people off of benefits (but not necessarily into work).	Directs them to provisions & support in the area.	EA. Previously seconded to a private provider about 2 years ago for 3-4 months to do initial ESA appointments.

5.6 Organisation of the following chapters

The following two chapters present the findings from the qualitative interviews. The first findings chapter uses OWIH participant data and the second, findings from GP and EA data. There are discussion sections at the end of both chapters.

5.6.1 Perspectives of those out of work because of ill health

Using an action-theory perspective, the next chapter concentrates on preference, capacity, and opportunity to return to work and how these dimensions relate to individuals' overall motivation to return to work. It explores what issues or factors impact on participants' views of their motivation to work. It also compares the barriers to work for participants with mental and physical health conditions. The discussion section at the end of Chapter six considers the findings from OWIH participants with reference to other relevant literature.

5.6.2 General Practitioner and Employment Advisor perspectives

The second qualitative findings chapter goes on to consider the views of the GP and EA participants. As in Chapter six, this chapter looks at barriers to work under the headings of preference, capacity, and opportunity to work. GP and EA views of other concepts, such as social situation, are also discussed. Chapter seven also looks at the GPs' and EAs' role in their patients' and clients' return to work. The discussion at the end of this chapter draws upon all of the findings presented in Chapters six and seven. It considers similarities and differences between GP, EA, and OWIH participants' perspectives on barriers to work and motivation to return to work and relates the findings to other relevant research.

Chapter six: Qualitative study findings 1: perspectives of those out of work because of ill health

The aim of this chapter is to explore how capacity, opportunity, and preference for return to work interact with each other and relate to the motivation of those out of work because of ill health (OWIH) to return to work. Using data from the primary study introduced in Chapter five, this chapter re-conceptualises barriers to work using the participatory-action-theory framework. To further explore the concept of motivation to return to work, this chapter also presents findings related to the role of two factors that did not fit into the framework: work-role centrality and social circumstance. Data used for this chapter came from the OWIH participants only, therefore when using the term 'participants' it refers only to those OWIH.

6.1 Research questions and objectives

Specific research questions and objectives addressed in this chapter were:

Are the barriers to work identified by people who have been OWIH long-term (>2 years) and receiving health-related benefits in the west of Scotland similar or different to the barriers identified in previous research? A related objective is to explore differences between experiences and perceptions of barriers to work for people out of work because of physical ill health (OWPH) and those out of work because of mental ill health (OWMH).

Do those OWIH need to be motivated to work, and what causes some to be motivated and others not? A related objective is to explore the concept of motivation in relation to: capacity, opportunity, and preference to return to work and work-role centrality.

6.2 Capacity, opportunity, and preference barriers to return to work

The findings are discussed under the three main concepts of participatory action theory. To show how the three concepts are related each section builds on the previous section with the use of illustrative diagrams.

6.2.1 Capacity for employment

Capacity is what the participant perceives that they are capable of doing. Participants mainly discussed their capacity for employment in terms of their health, but sometimes also in terms of other non-health factors.

6.2.1.1 Health and capacity for work

Participants expressed varied feelings about whether return to work would be compatible with their health. The participants' quotes in Figure 6-1 illustrate the range of views on their own capacity for work, related to their health. Using the data from the interviews, each participant was classified into one of these four capacity groups. Four groups were used because they capture how all of the 17 participants felt about their capacity for work. This categorisation was helpful because it showed the variation in participants' views on their capacity and also highlighted that different people OWIH are likely to differ in the support that they require. For example, those who were not ready to return to work were split into two distinct groups (1 and 2) where one group felt that they would never have the capacity to return to work, and the other felt that they may be capable of return to work at some point in the future. Likewise, those who were ready to return to work were split into two distinct groups (3 and 4) where one group required more specific support to find a job compatible with their health, and others required support more generally in finding a job. There was at least one participant with a mental health condition and one with a physical health condition in each capacity group.

Perceived capacity for work—in terms of health—may increase with time but this does not mean that participants moved in a linear fashion through each of the groups in Figure 6-1. For example, participants did not all start their period OWIH at group 1 and may have moved directly from Group 2 to Group 4. Also, an individual's perceived capacity may decrease with time. The arrow in the figure is to illustrate the increasing range in perceived capacity among participants.

Figure 6-1: Capacity for work related to health

GROUP 1: NONE	GROUP 2: NOT NOW	GROUP 3: SOME	GROUP 4: ABLE
"I would love to have work, I would…if it was obviously a job I knew I could do and cope with it…but I just don't ever see that happening." Caroline age 37, OWMH 20 years.	"so eventually I hope one day to get back to work, but I mean I know I'm definitely not ready now." Karen, age 53, OWMH, 2½ years.	"Still having [fluctuating health condition], getting back to work… for me, as someone who can't do a full time job, eh will still potentially not be able to turn up all the time for a part time job …" Dave, age 39, OWPH 8 years.	"[I am able to work, yeah I'm at the stage where I'm able to go back to work]. James, age 38, OWMH 5 years.

Participants in Group 1 of Figure 6-1 said they could not currently consider work because their health meant that they did not have the capacity for it. These participants did not think that they would ever have the capacity to return to work. They did not allow themselves to seriously consider employment because they did not believe that it was a realistic option worth thinking about. Group 2 in the figure were not ready to work, but viewed it as a possibility for the future. Those who said they had some capacity to work (Group 3) had moved from viewing work as a possibility for the future to a stage where they were considering moving into work. However, despite their health improving to this stage, all had lasting health conditions and they remained unsure about their capacity for work. Group 4 in Figure 6-1 represents the participants who felt that they were capable of work and, although had lasting health conditions, no longer felt that their health impacted upon their capacity for work. Participants' perception of their improved capacity for work was not related to total recovery from a health condition—all of the participants had long-lasting health problems and most expected that these would never be completely resolved. However, the extent to which participants thought that they could manage their health in work was important for how they perceived their work capacity.

One of the most obvious reasons that participants felt they did not have the capacity to work was that their health restricted them leaving their house. Almost half of the seventeen participants said that they were not able to go outside alone or were uncomfortable outside of their house, and avoided going to busy places. This was mainly because of anxiety and panic attacks, but one of the participants could not go out alone because he felt he was not physically strong enough. This was clearly a barrier to becoming employed, as Mark (age 38, OWMH 20 years, Group 2) illustrated:

> Biggest barrier is I still struggle to go out. Until I get that sort of fixed, I feel comfortable going out, that sort of thing, that's probably the biggest [barrier to work] so far.

Some participants were not able to judge in detail their capacity to work but 'just knew' that they were not at a stage where they could think about it. Other than talking about restrictions on going out, participants with mental health conditions could often not state what it was about their health that meant they were not capable of work. These participants generally did not feel that they would be able to cope with work, stating that "my mind, my brain's not ready for it" (Karen, age 53, OWMH, 2½ years, Group 2); "my head isn't right" (Sean, age 40, OWMH >20 years, Group 1); "I just, I still don't feel as if I'm able to like, would be able to hold a job down" (Caroline, age 37, OWMH 20 years, Group 1).

Some participants felt that, over time, they moved from having no capacity to work to being capable of work; whereas others felt that their capacity for work got worse over time rather than better. The following examples show that some participants thought that their health had improved such that they had the capacity to work, however when they returned to work their health was negatively affected and they could not sustain the job.

> There was a spell when I went back to work for a while. I tried it but it just wasn't happening. […] As soon as I get stressed it affects my mental health. And then it gets affected really badly and then I become unwell and I have to go on more medication and pretty much it's so strong that you are lucky if you're conscious most of the time, do you know what I mean, so working is pretty difficult to achieve. (Archie, age 29, OWMH 8 years, Group 1)

> But I went in too early. I came off the sick too early, and that kind of knocked me back a bit, so I had to give it up. The hours I was doing. I was trying to get back to work. Went to night shift, which was too many hours, and I just kind of had to explain to them – they tried to get me on day shift, but you couldn't get in day shift, so I had to leave. Things like that, you know? (Steve, age 59, OWPH 2½ years, Group 3)

It was common for participants to be worried about the impact work would have on their health. However, some talked about their health deteriorating—and therefore their capacity for work deteriorating—if they did not return to work soon.

> Yeah I think I need to work now. You know, 'cause I'm gradually getting worse and worse and worse and worse, you know …. 'cause everything's just slowly closing in on me, you know I feel as if - going downhill quite fast you know. (James, age 38, OWMH 5 years, Group 4)

For these participants, returning to work was essential; they felt that work would only improve their health, and were not concerned about it having a detrimental effect. This was the feeling among all of the participants who said they were able to work (in Group 4 of Figure 6-1).

So far this section has concentrated on capacity for work generally; however, it is clear that jobs differ in terms of physical and mental requirements, hours, shift patterns etc. Where participants did feel capable of work (Group 4), or were starting to think about work (Group 3), they either felt that their health condition no longer had an impact on their capacity for work at all, or that they could start looking for a job that they would be able to do despite their health condition. For some participants this raised the question about what they had the capacity for; it was therefore important for them to consider the type of work they could do.

6.2.1.2 Capacity for what?

When thinking about their capacity for work participants tended to talk about their capacity in terms of their former employment. Most of those who thought they would be capable of work at some point in the future expected—because of their health—that they would not be able to return to the same type of job as they previously held.

Some participants said that they did not feel comfortable returning to their previous employment because they could not face the nature of the work, and therefore would not be able to approach it with much enthusiasm e.g. Jenny (age 56, out of employment 2 years, OWPH also on anti-depressants):

> I've just, I've been a [care worker] for twenty-five years, but I don't want to go back to that because you've got to have a happy, smiley face, and I'm not very happy smiley at the minute.

The other participants felt that the fatigue they experienced from their health condition or treatment meant that they did not have the capacity for their old jobs—which required long hours, shift-work, and/or were perceived as highly stressful environments. Participants with mental health conditions and those with physical health conditions talked about such aspects of jobs as barriers to work.

> It would need to be part time, yeah, yeah just, just now, yeah […] mainly because I, I couldn’t do a full time job in terms of the physical energy an everything that’s involved. Em, I pretty much, as it is, need to try and split my week up so that there’s days when I know I’m going to be doing a lot of kind of physical stuff, and then I’ve got rest and recovery days after them, em or after like two or three days together of doing that I’m just kind of wiped out, you know, so … yeah … (Dave, age 39, OWPH 8 years)

Most of those who were thinking about returning to work, but did not think they could return to their former employment, said that they would be open to anything that they were eligible to apply for as long as it was something that would not negatively affect their health.

> Oh no, anything I think I’m capable of to do, I’ll go for it. I mean if it’s there, you know what I mean? I’ll try it. (Steve, age 59, OWPH 2½ years)

Therefore, because of the lasting effects of their health conditions, participants often had to think about different types of jobs to the ones they were used to doing. Since they had to consider a different type of job that they had no experience of, participants identified non-health factors that made them further question their capacity for work.

6.2.1.3 Factors other than health that affected capacity

Participants expressed uncertainty around their capacity to work because of certain personal characteristics or responsibilities. These factors were more often related to opportunity, although occasionally participants mentioned that their capacity was also affected. For example, lack of training and qualifications were sometimes seen as a capacity issue: participants felt that they were not as capable as others with more training or qualifications. Other times they were seen as an opportunity issue: they felt lack of training or qualifications meant that they would not be given the opportunity because they were less attractive to employers.

A recurring issue for participants—in relation to their capacity to work—was their financial capacity to pay for things needed to get or attend a job.

> I mean you couldn't really go for a job anyway just now, because you're dire straits for clothes and everything, because you have to really watch your pennies. I mean, I get a £170 or something a fortnight, but then you've got your council tax, and you've got your gas, electricity, phone, life insurance, […], there's tons. (Karen, age 53, OWMH, 2½ years)
>
> I come up against two barriers, if it’s somewhere far away, I can’t afford it because I can’t afford the bus fares. Right. And if it’s all day I can’t afford to lunch myself or that you know. I can’t afford things like that. And my [work] clothes don’t fit me because I’ve put quite a lot of weight on. (James, age 38, OWMH 5 years)

Participants who felt ready to apply for jobs, or who had applied for jobs, also mentioned that non-health factors such as finance, training, qualifications etc. affected their capacity. However, these barriers were not considered insurmountable. Participants felt that these non-health barriers were more amenable to change given the right support or opportunity; these barriers did not completely put them off thinking about work, whereas health did.

6.2.1.4 Summary: capacity for employment

Participants' views on their capacity to work seemed to be determined by their perception of their health and how they felt it limited their everyday activities. To a lesser extent, perceptions of capacity to work were also influenced by non-health factors. The non-health barriers to capacity that were discussed did not appear to affect motivation to work to the same extent as the health barriers to capacity did.

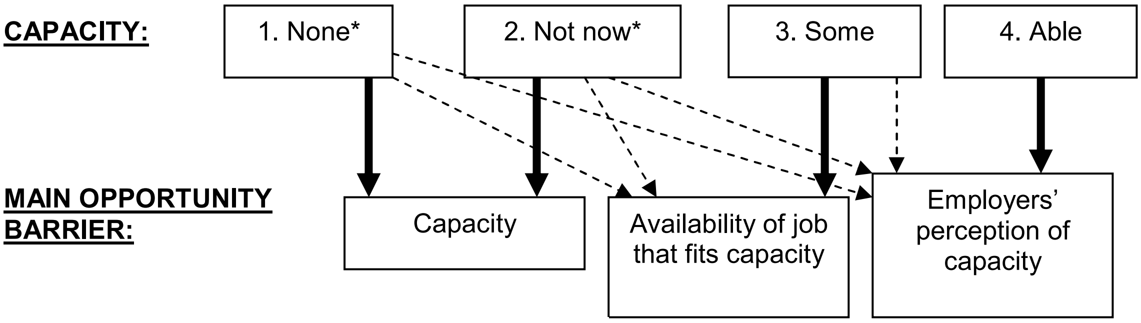
In terms of how they spoke about their capacity for work, participants with physical health conditions were similar to those with mental health conditions in the same capacity groups. The type of job that participants would return to was an issue for those with physical and those with mental health conditions, as were non-health barriers to work. However, those with mental health conditions found it more difficult than those with physical health conditions to articulate what it was about their health that impacted on their capacity for work.

6.2.2 Opportunity for employment

The previous section highlighted a number of examples of health and non-health factors that compromised participants' capacity for employment. However, in some instances, participants felt that their health or other factors did not render them incapable of work, but did mean that they had diminished opportunity to get a job. Opportunity, in this sense, is what the participant perceives that they can get in terms of employment.

The bold arrows in Figure 6-2 show participants' main opportunity-related barriers to work, depending on how they felt about their capacity to work.

Figure 6-2: Capacity-related opportunity barriers to work



* These participants only thought hypothetically about barriers to opportunity.

The dashed arrows symbolise that participants were aware of other opportunity-related barriers to work, but these were not of primary concern to them because of the stage they were at in terms of their health, and what it meant for their capacity.

Although some participants felt that they were capable of moving into work they were still concerned about their opportunity to work because of employers' perception of their capacity. They felt that since they had health conditions and had spent time on sickness benefit their opportunity to work would be reduced because employers may not be willing to consider them. Although Tony felt capable of working, he thought that his job opportunities were poor. Talking about his meeting with an employment advisor Tony (age 45, OWPH >20 years) said:

> 'We'll find it hard to get you anywhere' he says 'you'll maybe need to start volunteering so they see you doing it for a wee while'.

In these cases participants felt that they needed to somehow convince employers that they were capable of work.

Those who were concerned about their capacity—but thought they could do some work—were worried about what opportunities may exist for them, given that they could not work at full capacity. For example, Dave (age 39, OWPH 8 years) said:

> Dave: The big things are the, like where I go from here, for somebody who still has [fluctuating health condition], getting back to work, you know, I think that's going to be, how that plays out over the next wee while's going to be quite interesting to see whether, or how easy it is, for me, […] how employable I'm going to be, you know?

> KS: How do you expect employers to react?
>
> Dave: I, I, in all, in all honesty I think if I get a job it'll be a miracle.

Those who did not think they were capable of work at all spoke in a hypothetical way about their employment opportunities, or talked about finding work as something that they dreamt about rather than as a realistic option. In doing so they raised concern about their opportunity to work based on their health and other characteristics. However, their main concern was always their capacity for work. For example, Joe (age 59, OWPH 2 years) said he was not able to go back to his previous job because his security licence had run out, and he said he did not believe that other employers would take him on because of his age and the time that he would have to spend in hospital appointments. However, in reality he said that he would never go back to work because his health condition meant that he was not physically capable of working.

6.2.2.1 Health and opportunity for work: the issue of disclosure

All participants were concerned that their health condition would make them less attractive to employers than other, healthier, candidates. The main thing that participants talked about in relation to health and their opportunity to work was the issue of disclosure of health conditions on their job applications. Most participants who discussed this were in two minds about whether they would disclose, as they could see advantages and disadvantages of doing so.

Participants were concerned that disclosing a health condition would hamper their job opportunities because of stigma and discrimination—particularly in a time of high unemployment. Some participants had experienced this and others just expected that it would happen.

> And that last [job interview] there, I mentioned the hepatitis, and it was as if, she just, the woman, just changed, just she was like that 'oh, oh, right …' Aye it was as if, it was going, I thought it was going ok, but I mentioned that, an she just kind of looked up an said 'oh', kind of went like that, she went 'do you not think that's kind of dangerous, you having epilepsy an maybe you take a fit an you bleed or something' an I'm like that 'oh … aye, right, aye …' but … You need to be honest, but sometimes you're like that … 'I shouldn't have told them'. Know? But I'd have to get days off work to go to the hospital

> to get checked, check ups an that, and they'd start going 'well why are you going to hospital?'… (Tony, age 45, OWPH >20 years)

Despite this experience Tony continued to tell potential employers about his health conditions, mainly because he was sure that they would find out anyway. However, others were put off disclosing conditions because of the stigma and discrimination they believed they would face. Although they were aware that, by law, employers were not allowed to discriminate, they questioned whether this legislation was heeded.

> Well, on, on paper it's illegal. I know that's illegal, but in the real world it's mm, what can I say, what's illegal does happen; there's real life and legal life I would say. (Alexander, age 40, OWPH 2½ years)

Some participants discussed occasions in the past where they were recruiting employees, an experience that put them off disclosing anything that they thought might hinder their own chances of employment. They were adamant that they would not disclose details of health conditions, particularly depression, to potential employers.

> I was supposed to interview these people, and em, the manager in there went, em what was it, somebody had wrote on [the application], it said religion and it says em … it was like humanist. They went 'don't even bring him in to an interview'. Cos em, of what he'd wrote on this religion bit. It was. 'Oh we're not having him in here'. And then somebody had wrote depressed. 'Oof, that's all we need, a loony bin'. And I'm sitting going … and the manager's like that 'nah don't even interview them, just tell them the job's took'. So, that's what put … that's when I was like that 'you can't write that'. (Karen, age 53, OWMH 2½ years)

Others talked about how they only applied for particular jobs that they thought would be suitable for them. For example, one participant with a physical health condition said that he only applied for 'light work' that he knew he would be capable of; therefore there was no need to disclose.

When participants talked about employers discriminating against people with health conditions it was common for them to also show some sympathy with or understanding of it, as illustrated by Karen (age 53, OWMH 2½ years):

> If I was employed and somebody got brought in, cause I know sometimes how bad I can get, like I can get dead tearful, I can get

> dead angry, em and I could take panic attacks. I wouldn't want somebody like that to work with me.

Similarly, participants held the view that it was understandable that employers would be unlikely to employ people with poor work history who had spent time on sickness benefit, as they thought the employers could probably find more reliable employees, or at least find employees who, on paper, appeared more reliable. The challenge, therefore, was to be given the opportunity to work and to prove themselves on the job.

> I know I'll not get a job straight away, but as long as they see me trying to do something, I think they should give me a chance at something, you know … I don't feel as if I'm getting a chance at anything … (Tony, age 45, OWPH >20 years)

Another opinion, brought up by one participant, was that applicants should disclose health conditions, as this is the "only fair" thing to do (Vincent, age 45, OWMH 5 years).

6.2.2.2 Mental health and opportunity for work

Some participants who were out of work because of mental health felt that a mental health condition was more difficult to explain to employers than a physical health condition, because it was invisible. This left them feeling that they would have less opportunity for work because employers would not understand their condition, and would therefore not want to risk employing them.

> Whereas when it's in your head, because you can't see it, I feel like that's the worst thing, they can't see what's going on in here. (Karen, age 53, OWMH 2½ years)

> I think it's probably difficult for them to know how bad your situation is. I mean they don't- I mean unless they see you when you're having like a panic attack or when you're really having a sort of depression, it's maybe difficult for them to see. (Mark, age 38, OWMH 20 years)

> Not many people really understand what's going on with people, because they can't, it's not like if you've got a broken leg and people can see you've got a broken leg, but if you're sitting there and there's crazy thoughts going on in your head or you're wanting to kill yourself or you're wanting to kill other people, or some mad shit is going on in

> your head …they can’t see that … they can’t tell you, ‘you need to go and see a doctor, you need to get medication, or you need to get therapy’ or whatever. They just see somebody who’s not doing their job properly. (Archie, age 29, OWMH 8 years)

However, other than a couple of the participants appearing physically weak, physical conditions were not visible either. For example, Alexander had cognitive problems following an injury and Dave had an autoimmune disease, neither of which were visible or obvious during the interview. These participants did not bring up the (in)visibility of their condition as an issue for explaining their health to potential employers.

The other thing that participants with mental health conditions noted about their health (as opposed to physical health) was that there was an extra stigma against mental health.

> When you say that to somebody, you’ve got a mental health issue, people just, have this irrational fear, it’s you know, it’s- this person’s … crazy, dodgy. You know, something like that. (James, age 38, OWMH 5 years)

In the past when applying for jobs Archie (age 29, OWMH 8 years) said:

> I tend not to mention it in case they have a stigma with it, you know. […] Like the first place I was employed the one boss that owned it at first was really understanding and stuff, and then when it changed hands the other bosses weren’t so understanding and they fired me quite rapidly. So … there’s a stigma right there you know?

Although some of the participants with mental health conditions talked about particular stigma against mental health, participants with physical health conditions also spoke about stigma that they expected or experienced from potential employers because of their health condition.

Vincent, whose primary reason for being out of work was a mental health condition but who also had a physical condition, spoke about disclosing his health to potential employers. He felt that neither health condition would be “anymore of a hindrance than [the other]; it all depends on the kind of job” (Vincent, OWMH 5 years).

6.2.2.3 Opportunity for work and non-health factors

Participants were generally concerned about the labour market; interviews were conducted at a time of high unemployment (2011), and because of this they felt that employers "could be more selective" (Alexander, age 40, OWPH 2½ years). They expected that many more people would be applying for the same jobs at this time, and given that they had spent time out of work on sickness benefits they believed that "there's always somebody better" (James, age 38, OWMH 5 years); or "if there are tons of people going for the job, they're definitely not going to take the one that's got something wrong with them" (Karen, age 53, OWMH 2½ years). Some of the participants were speculating about their chances of employment, given what they had seen in the media, or heard from other people's experiences, but those who had begun to look for work experienced this first hand:

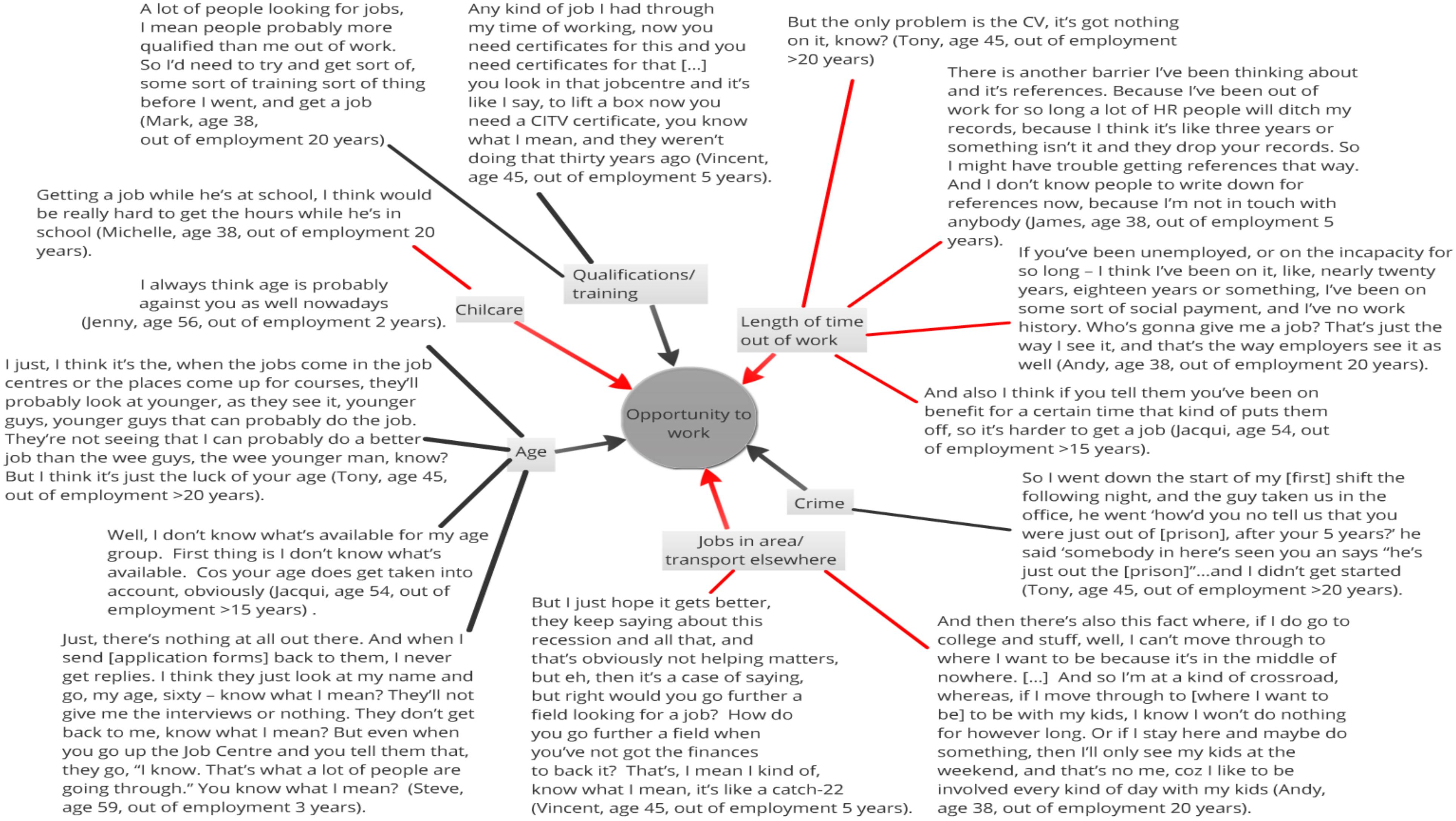
> [I've] been up the jobcentre that many times looking for the stuff, don't get me wrong, I mean I'll look, but 99% of the time there's nothing there to apply for. (Vincent, age 45, OWMH 5 years)
>
> But see really, the couple of times I went down [to the Jobcentre, the staff are] just like 'well, there's not really anything here, come back and see me', so it doesn't really give you much hopes of finding work. (Jacqui, age 54, OWMH >15 years)

A range of other non-health barriers to opportunity for work were discussed in combination with lack of jobs. Examples of these are shown in Figure 6-3. Participants were concerned that their age, lack of qualifications or employment experience and length of time on benefits would make them unattractive to employers. One of the participants also had a criminal record, which he felt would put employers off hiring him, and another said that she thought it would be difficult to find a job with school hours so that she could be home for her young son. Area was mentioned as a barrier to work because of the general lack of jobs available, but participants also felt that they were at a disadvantage because they could not afford to travel to be able to work elsewhere.

As with non-health capacity issues, some of these non-health opportunity issues do actually stem from having a health condition and spending time out of work e.g. lack of experience, time out of work, and to some extent qualifications, training, and age. However, many of them e.g. childcare, age, qualifications, are also barriers that may be experienced by many people who do not have a health condition. Some participants felt that these extra barriers to work were more salient for them because they were no longer capable of working in their previous job. These barriers were in addition to a health condition that they already felt that employers would see as a reason not to employ them.

Discussion of non-health factors varied by participants, and this was related to the emphasis they put on their health. Those who felt that they were not capable of work because of their health talked about health-related barriers to work first and foremost; whereas others who felt they were able to work discussed other reasons for them remaining out of work.

Figure 6-3: Non-health barriers to opportunity for employment



A lot of people looking for jobs, I mean people probably more qualified than me out of work. So I'd need to try and get sort of, some sort of training sort of thing before I went, and get a job (Mark, age 38, out of employment 20 years).

Any kind of job I had through my time of working, now you need certificates for this and you need certificates for that […] you look in that jobcentre and it's like I say, to lift a box now you need a CITV certificate, you know what I mean, and they weren't doing that thirty years ago (Vincent, age 45, out of employment 5 years).

Getting a job while he's at school, I think would be really hard to get the hours while he's in school (Michelle, age 38, out of employment 20 years).

I always think age is probably against you as well nowadays (Jenny, age 56, out of employment 2 years).

I just, I think it's the, when the jobs come in the job centres or the places come up for courses, they'll probably look at younger, as they see it, younger guys, younger guys that can probably do the job. They're not seeing that I can probably do a better job than the wee guys, the wee younger man, know? But I think it's just the luck of your age (Tony, age 45, out of employment >20 years).

Well, I don't know what's available for my age group. First thing is I don't know what's available. Cos your age does get taken into account, obviously (Jacqui, age 54, out of employment >15 years) .

Just, there's nothing at all out there. And when I send [application forms] back to them, I never get replies. I think they just look at my name and go, my age, sixty – know what I mean? They'll not give me the interviews or nothing. They don't get back to me, know what I mean? But even when you go up the Job Centre and you tell them that, they go, "I know. That's what a lot of people are going through." You know what I mean? (Steve, age 59, out of employment 3 years).

But the only problem is the CV, it's got nothing on it, know? (Tony, age 45, out of employment >20 years)

There is another barrier I've been thinking about and it's references. Because I've been out of work for so long a lot of HR people will ditch my records, because I think it's like three years or something isn't it and they drop your records. So I might have trouble getting references that way. And I don't know people to write down for references now, because I'm not in touch with anybody (James, age 38, out of employment 5 years).

If you've been unemployed, or on the incapacity for so long – I think I've been on it, like, nearly twenty years, eighteen years or something, I've been on some sort of social payment, and I've no work history. Who's gonna give me a job? That's just the way I see it, and that's the way employers see it as well (Andy, age 38, out of employment 20 years).

And also I think if you tell them you've been on benefit for a certain time that kind of puts them off, so it's harder to get a job (Jacqui, age 54, out of employment >15 years).

So I went down the start of my [first] shift the following night, and the guy taken us in the office, he went 'how'd you no tell us that you were just out of [prison], after your 5 years?' he said 'somebody in here's seen you an says "he's just out the [prison]"…and I didn't get started (Tony, age 45, out of employment >20 years).

But I just hope it gets better, they keep saying about this recession and all that, and that's obviously not helping matters, but eh, then it's a case of saying, but right would you go further a field looking for a job? How do you go further a field when you've not got the finances to back it? That's, I mean I kind of, know what I mean, it's like a catch-22 (Vincent, age 45, out of employment 5 years).

And then there's also this fact where, if I do go to college and stuff, well, I can't move through to where I want to be because it's in the middle of nowhere. […] And so I'm at a kind of crossroad, whereas, if I move through to [where I want to be] to be with my kids, I know I won't do nothing for however long. Or if I stay here and maybe do something, then I'll only see my kids at the weekend, and that's no me, coz I like to be involved every kind of day with my kids (Andy, age 38, out of employment 20 years).

6.2.2.4 Summary: opportunity to work

Participants all talked about lack of opportunity to move into work, whether expected or experienced. There were some differences in perceived opportunity to work by people with mental and physical health conditions. However, it is difficult to tell whether the extra stigma that those with mental health conditions expected would be realised any more so than it would be for those with physical health conditions.

The factors impacting on opportunity for work appeared to discourage participants in their job search because they believed that their chances of their application being successful were low. None of the participants were particularly optimistic about their opportunity for getting a job. However, barriers to opportunity to work did not appear to impact on participants' motivation to work to the same extent that barriers to capacity did. If participants felt that they had the capacity to return to work then they were motivated to try and get a job, even if they thought that their opportunity was low.

6.2.3 Preference for employment

Preference is what the participant wants in terms of employment. All participants said that in an ideal situation they would prefer to be working. However, participants did not feel that they were in an ideal situation. Given their situations, preference to return to work appeared to be largely determined by participants' evaluation of their alternatives. Taking the context of their circumstances into account, participants weighed up their options—between benefit receipt and employment.

6.2.3.1 Alternative options: work as financial risk?

Much of the evaluation of alternatives was concerned with what would happen to benefit payments with a move into work. There was a feeling of caution or unease about applying for a job and starting work. This was the case particularly among participants who were unsure of their capacity to work, in case they could not sustain the job and they were left without salary or benefit payment.

> I'd be scared to go out to work, to say I'm fit for work and find out I'm not fit for work, and go through all that hassle again of trying to get your benefits again. Em, plus I'd be, aye in case I have a relapse, I'd be scared in case I have a relapse. Because it's the, the problems are trying to get back to your benefits again. I would be terrified.
> (Karen, age 53, OWMH 2½ years)

When thinking about work as an alternative to receiving benefits, participants were also worried about whether they would be able to manage their bills when in work because they would no longer have housing benefit to pay their rent.

> But even that, it's … you would have to get some job to pay your rent and all the other things that get paid for you when you don't work so … been out of work for like twenty-five year or something, you're not going to get a job at four hundred pounds a week or something. So really you'd be better off on benefits unless somebody could give you like four hundred quid a week to pay your rent and your bus fares to work and your pieces [sandwiches] and a lot of other expenses, you know what I mean from just going to work. (Sean, age 40, OWMH >20 years)

This was particularly true when participants were living in private-rented homes, and although they were aware that they could request a council house, they felt that there were problems with doing so e.g. long waiting lists and other problems as Michelle (age 37, OWMH 10 years) highlighted:

> I don't know if I'll benefit from going back to work because this is a private let, and the rent is far too high, if I was in a council house I'd only be about £200, but because this is a private let it's 500 and most of my money I think would go to the rent. So it wouldn't be worth my while just now until I'd got a council house I think, but the school [son's] going to is just there, and it's right next to here and that's why I want to stay here, 'cause it's right next to his school, until he's a bit older he can travel himself [… also] Cos the council houses … weren't that nice, and they were next to drug dealers and stuff and with me using drugs I don't want that, right next to it.

These examples show that participants' preference was to be financially secure. Their feelings about whether this would be the outcome of a transition to employment were related to whether they felt they could cope in work (from a health capacity point of view). Those who were worried about not being able to cope with employment often felt that there was not a viable alternative to benefit receipt and were therefore not motivated to look for work.

> But it's not easy, I'd rather, obviously I'd rather work. D'you know what I mean—I'd rather still be doing [job]—but em just with my health and stuff like that it's more secure for me to live on benefits, you know? (Archie, age 29, OWMH 8 years)

The financial risk of return to work was too great for participants who did not think they were capable of working. Those who thought they were able to work had mixed feelings about whether they would be better off in work. Some of these participants had talked about seeing an employment advisor for a 'better-off calculation', and depending on their situations were told different things e.g.

> So you're in a kind of trap. You know, I want to improve my life, my quality of life, I would love to get a full time job, but I've actually been told that if I get a full time job I'm only working to pay my rent, maybe the only thing that would help me is confidence, I'd maybe meet people, maybe my social life would improve, so maybe that would be a good thing, but see financially I wouldn't be any better off. (Jacqui, age 54, OWMH >15 years)

> [I'd be] better off, aye, that's what it says. It could get my electricity and my messages. And I could maybe start saving up. (Tony, age 45, OWPH >20 years)

Participants who were confident that they would be able to cope in work were motivated to get a job. Although they did voice some concerns relating to in-work finances, this did not change their preference for employment over benefit receipt. However, those who believed that they would be financially worse off in work contemplated finding a job that was below a certain number of hours per week so that they would still qualify for other benefits to keep their income around the same level.

6.2.3.2 Summary: preference for employment

Preference for return to work has been discussed by looking at participants' preference given their situation, rather than their preference in an ideal situation. Participants adjusted their preference to work depending on their alternative options, which were largely based on issues related to perception of their capacity. Hence why some who said that they ideally would want to work, in reality did not intend to move towards employment. It was difficult to explore preference in any depth without considering participants' feelings about their capacity to work.

6.3 Factors that play a role in return to work not covered by the participatory-action-theory framework

Capacity, opportunity, and preference are inter-related. It is unhelpful to think about participants' motivation to work simply as their will or want to work—preference is something that people have in the context of other factors.

However, factors other than preference, capacity, and opportunity, as described above, also played a role in shaping participants' intention to return to work, or perhaps influenced perceptions of these factors. The most striking example of this came from Andy, the only participant who did not intend to start looking for work, despite thinking that he had some capacity to do so. Although he had thought about employment and the type of job he would like to do, he did not really have any intention of moving towards employment:

> KS: How do you feel about work now? Do you have any aspiration to go to work?
>
> Andy: Yeah. I'd like to become a drug counsellor—that would be my ideal job, to become a drug counsellor. But I need to go to college for two years, or something. I know what I've got to do, it's just … […] I've not got motivation, though, to get me up to do anything. I've just not got it. I want to do it, know what I mean, just for all the right reasons, for like, my kids will be proud of me that I'm doing this—it'll give me self-esteem, because I am quite a … I'll just sit in. I don't have any friends, know … so I would like to go and do things, but it's saying it and doing it, as well. (Andy, age 38, out of employment 20 years)

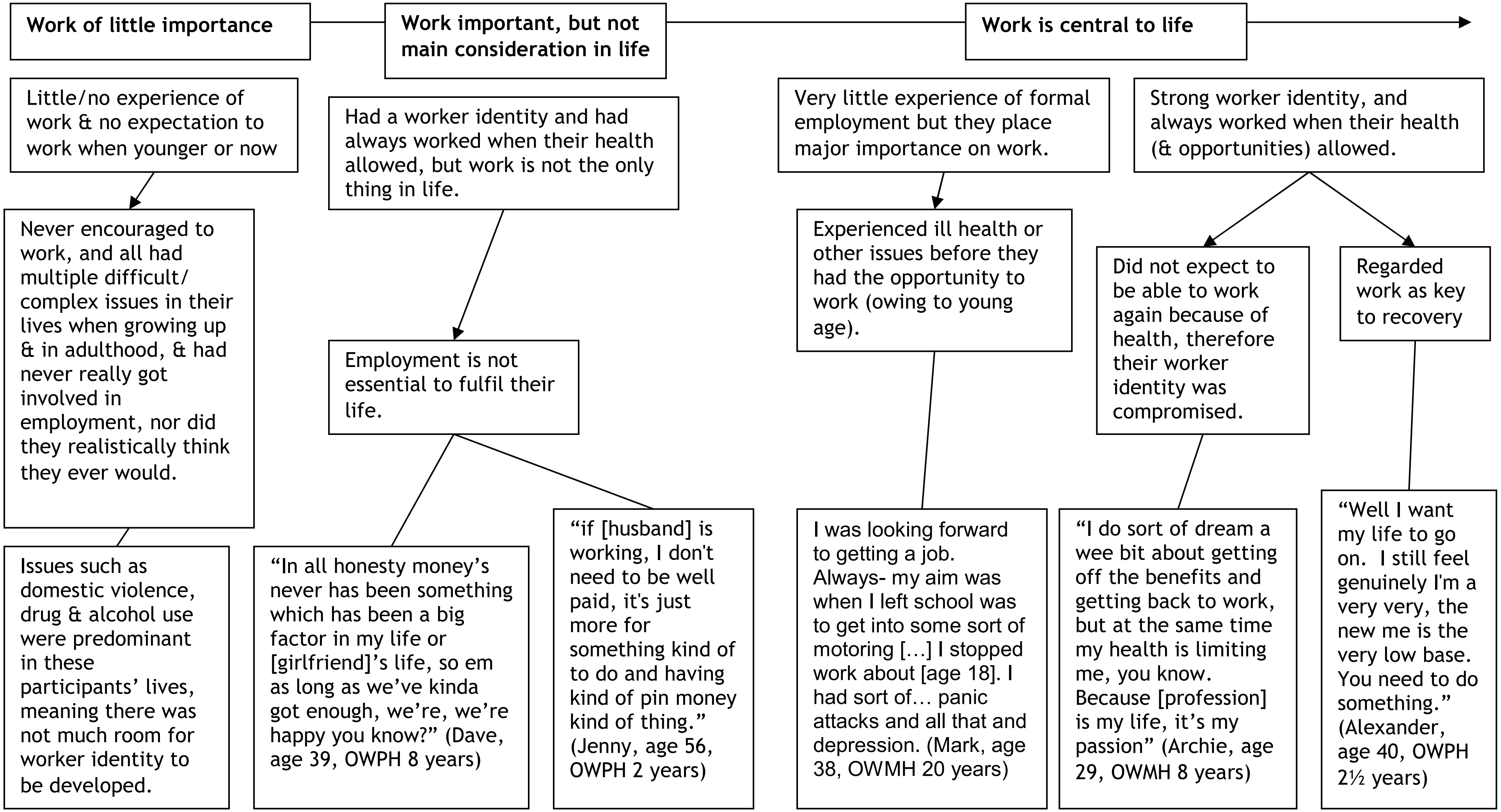
Andy's preference in an ideal situation was actually to work, but his intention was to remain on IB rather than find a job. This example highlights that intention to work was not just a decision made by weighing up capacity and opportunity. Preference was not even altered based on logical weighing up of alternatives. Andy could see that he would be better off in work but he was still unmotivated to move towards employment.

Motivation to return to work was therefore based on other factors as well as capacity, opportunity, and preference (in an ideal situation or weighing up alternatives). Two factors that differed between participants and are worth exploring further were the perceived importance of work in participants' lives (work-role centrality) and the role of social circumstances.

6.3.1 Work-role centrality

Work-role centrality is the general importance of work in a person's life. This concept was explored by using the data to group the participants depending on how important they felt that work had been throughout their lives e.g. at key stages such as leaving education. Work-role centrality did not always appear to be related to work experience that participants had in the past. For example, Mark had never really worked because he was a teenager when he developed ill health, but he placed importance on work, was enthusiastic about starting work after high school, and continued to strive for it. As mentioned previously, all participants said that they would rather be in employment. However, some did not have the same attachment to work as others. Using the data, it was possible to group participants into three categories of work-role centrality. Figure 6-4 shows these categories with some examples from participants to illustrate how they felt about employment.

Figure 6-4: Work-role centrality



Work of little importance

Little/no experience of work & no expectation to work when younger or now

Never encouraged to work, and all had multiple difficult/ complex issues in their lives when growing up & in adulthood, & had never really got involved in employment, nor did they realistically think they ever would.

Issues such as domestic violence, drug & alcohol use were predominant in these participants' lives, meaning there was not much room for worker identity to be developed.

Work important, but not main consideration in life

Had a worker identity and had always worked when their health allowed, but work is not the only thing in life.

Employment is not essential to fulfil their life.

"In all honesty money's never has been something which has been a big factor in my life or [girlfriend]'s life, so em as long as we've kinda got enough, we're, we're happy you know?" (Dave, age 39, OWPH 8 years)

"if [husband] is working, I don't need to be well paid, it's just more for something kind of to do and having kind of pin money kind of thing." (Jenny, age 56, OWPH 2 years)

Work is central to life

Very little experience of formal employment but they place major importance on work.

Experienced ill health or other issues before they had the opportunity to work (owing to young age).

I was looking forward to getting a job. Always- my aim was when I left school was to get into some sort of motoring [...] I stopped work about [age 18]. I had sort of... panic attacks and all that and depression. (Mark, age 38, OWMH 20 years)

Strong worker identity, and always worked when their health (& opportunities) allowed.

Did not expect to be able to work again because of health, therefore their worker identity was compromised.

"I do sort of dream a wee bit about getting off the benefits and getting back to work, but at the same time my health is limiting me, you know. Because [profession] is my life, it's my passion" (Archie, age 29, OWMH 8 years)

Regarded work as key to recovery

"Well I want my life to go on. I still feel genuinely I'm a very very, the new me is the very low base. You need to do something." (Alexander, age 40, OWPH 2½ years)

Participants appeared to vary in terms of the role employment had played in their lives up to the point of the interview. There was an obvious divide between some who said that employment had never really been a subject of discussion or an expectation, and others for whom employment was expected or really stressed as important. Those who said that work had never been emphasised to them were those who fell into the first box in Figure 6-4 (work of little importance). Some expected that having a working role model would have made a positive difference to their lives:

> Nobody ever sat me down and said to me, “this is what you need to do,” and know what I mean? Nobody, ever. Yeah, my whole life, from I was three month old, right up to I was sixteen [I was in care]. Maybe lived with my mum for, like, about three years out of that – like, sporadically, three years out of that sixteen years—and then, when I was sixteen, they told me to go back and stay with my mum full time, and when I went back to stay with my mum, I could do whatever I wanted. It didn’t matter what it was, I could do it. You know, my mum wasn’t telling me to go out and get a job, know what I mean? […] Why didn’t people tell me [to get a job] when I was bloody young? (Andy, age 38, OWMH 20 years)

The opposite experience was clear when participants stressed—often without being asked about their families—that the importance of work was emphasised to them in their upbringing. For these participants work was a vital part of their lives (Figure 6-4: work central to life).

> And I don't, that's my dad in me as well, my dad was always a worker. And dad worked all his days. And it's just obviously what you were brought up with. By nature, that's how it's always been, me as well I like to work. (Alexander, age 40, OWPH 2½ years)

Some talked about being employed as part of their family’s “morals and values” (Jacqui, age 54, OWMH >15 years), and implied that work ethic was part of a family trait: “grafting’s always been in the family” (Vincent, age 45, OWMH 5 years).

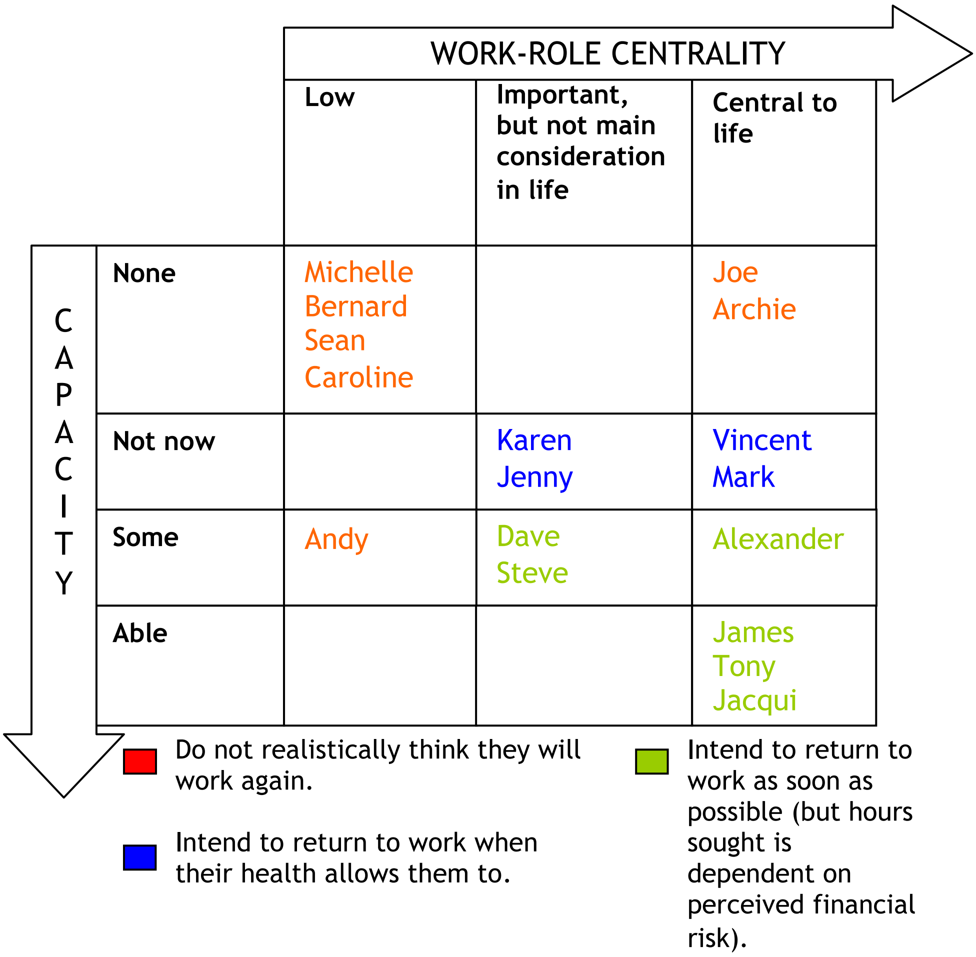
For some participants, the importance of work was related to an expectation to work and to provide for their family. This was an issue that some brought up as a reason that they wanted to get back to work. Their time out of work led to a feeling that they had been a disappointment to their families. This was particularly true of participants who felt that they were unable to provide financially for their children. Talking about being unable to provide for his young family, Alexander said:

> It's, it still hurts me, but ... well what can I say, I just have to accept it. Simple as that. Course it's, it's not nice. (Alexander, age 40, OWPH 2 1/2 years)

On the other hand, one participant highlighted that because they were not the main earner in the family it was not so essential for them to return to work, and talked about the importance of their other roles within the family and home.

Perception of capacity and work-role centrality appeared to play a role in shaping participants' motivation or intention to return to work. Although opportunity to work played a role in whether participants would be successful in returning to work it did not seem to be as important a factor in motivation to look for work as capacity was. Figure 6-5 brings importance of work and capacity for work together in an attempt to look at what factors were important with regards to intention to work.

Figure 6-5: Capacity by work-role centrality



	WORK-ROLE CENTRALITY		
CAPACITY	Low	Important, but not main consideration in life	Central to life
None	Michelle Bernard Sean Caroline		Joe Archie
Not now		Karen Jenny	Vincent Mark
Some	Andy	Dave Steve	Alexander
Able			James Tony Jacqui

🟥 Do not realistically think they will work again.

🟦 Intend to return to work when their health allows them to.

🟩 Intend to return to work as soon as possible (but hours sought is dependent on perceived financial risk).

Those who felt that they did not have the capacity to work did not intend to return to work, even if work was an important aspect of their lives. However, the importance placed on work did make a difference upon how participants felt about their situation. Where work was central in participants' lives their 'worker identity' was compromised by spending time out of work. Most of those who felt that work was vital in their lives were trying to regain work, but had not found the opportunity to do so. However, Archie and Joe felt that they would never get back into employment, and Vincent and Mark did not think they were yet ready for work.

> That's where you are - in a rut, sitting in the house, and your lifestyle changes completely, you know? There's not a lot you can do about it […] forget the incapacity and get me out, out and about. 'Cause you're meeting different people instead of, you're stuck in a rut when you're on incapacity. You're not seeing anybody, just seeing the same people. You're not travelling about or anything, you know? (Joe, age 59, OWPH 2 years)

> Well I always grew up with my, em, both folks, both parents working very very hard to provide em a roof over our heads, and food in our bellies, and clothes on our back, and I never ever thought that I would be stuck on benefits with a mental health disorder that hindered me to work, d'you know what I mean. I kinda feel like it's a cop out sometimes, that I should just go back to work. (Archie, age 29, OWMH 8 years)

Those who did not think they would work again but felt work was central to their lives (Joe and Archie, Figure 6-5) differed from the others who did not realistically think they would work again (shown in red in Figure 6-5). None of the participants were content with their situation. However, the participants who had low work-role centrality had a more complicated situation in that they had not 'simply' experienced a change in health that led to a change in employment status. Although their health was the reason that they could not now contemplate returning to work, it was not the reason that they initially stopped working, and none of them had much experience of being in work in the first place. The obstacles they talked about in their lives went beyond health-related factors and beyond other more common barriers e.g. age, childcare etc. These participants had numerous negative life events and experiences that contributed to their situation at the time of interview. Participants' narratives were often desperate; they talked about being stuck and not being able to change. They were largely unhappy with their situations, did not know what to do about them, and in most cases despairing for something more positive to happen in their lives. They often expressed embarrassment, but also put across a feeling of bitterness about what they had had to deal with in their lives.

> Well, my kids know, it does bother me that my kids are like, "what do you do, dad?" Know what I mean? No I don't do nothing, but I still bring my kids up in the right way, where I'm telling them that you need to stick in at school, and I'm telling them all the right things. I might not be showing them, but their mum's showing them, and like, they know that their mum works hard, and she gets a car and she gets her big house, and so they are seeing it. They're no seeing it from me, but they're seeing it—and to me, it's all about, that's one step better than what I had, so they're progressing. Maybe slowly, but they're still progressing down the line, 'cause like, I've progressed from … To me my, all I can do is be better than my father before me, and if I'm better than my father, then my kids have got a better chance than I had. (Andy, age 38, out of employment 20 years)

6.3.2 Social circumstances

To highlight numerous concurrent life events, Table 6-1 provides details of some of the issues that the participants with more complex social situations were facing alongside being out of work. Some participants faced difficult home life as children and this followed into adulthood, where relationship break-ups, violence, and substance abuse were common.

The participants who did not talk about a complex build-up of health and social issues were mainly in long-term stable relationships (with the exception of two who had not been in serious relationships), had social support around them, had a stable upbringing, did not talk about problematic alcohol or drug use, and did not mention any violence in their lives. Although these participants were those with seemingly more ‘straightforward’ situations—in that they had a health condition that culminated in them stopping work—their return-to-work journey was not quite as simple as to recover from the health condition and get a job. Table 6-2 provides details of why these individuals’ situations were not simple cases either, showing that the interaction between health and work can complicate the journey back to work.

Table 6-1: IB participants' build up of health and social issues

Participant	Social/health issues in culmination with worklessness
Tony	Injury at work. Drugs, alcohol, crime and time in prison. Physical conditions stemming from drug use, and subsequently became depressed. Relationship break-up*.
Vincent	Culmination of alcohol and bereavement led to job loss. Subsequent relationship break-up and depression.
Jacqui	Alcohol use, depression, unstable and violent relationships, eventual relationship break-up and living as lone parent.
Michelle	Domestic violence, relationship break-up, lone parent, drug addiction, depression and young son put in foster care.
Karen	Bereavement, depression, alcohol use, relationship break-up, rape, physical attack, suicide attempts.
James	Domestic violence as a teenager, period of homelessness, back injury, which led to addiction to pain medication, relationship break-up, other drug addiction, suicidal thoughts.
Caroline	Domestic violence when growing up and in her own relationships, relationship break-up, physical attack, lone parent, attempted suicide, drug addiction.
Andy	Domestic violence and mental health problems of parents when growing up, lived in social care up to age 16, drug addiction, hepatitis, relationship break-up, homelessness.
Bernard	Physical injury, alcoholic, relationship break-up, homelessness.
Sean	Drug addiction, relationship break-up, lone parent (could not cope so children moved in with their grandparents), housing problems, physical health conditions as a direct result of drug use.

*All relationship break-ups mentioned in the table involve one partner having to move out of the shared home, and all relationships involved young children.

Table 6-2: Initial trigger to stopping employment and other health-related issues that affect the possibility of them considering a return to work

Participant	IB trigger	Other issues related to their initial health condition that are relevant to the possibility of their return to work
Dave	Physical health deteriorated until he could no longer work.	Have chronic conditions and are unlikely to make a 100% recovery therefore they are conscious that any job that they find would always have to be compatible with reduced capability and would have to be flexible.
Archie & Mark	Mental health deteriorated until they could no longer work.	
Joe & Steve	Sudden change in physical health in late 50s meaning they could no longer work.	Their health conditions and treatment have left them permanently physically less capable of the type of work that they were previously doing, and therefore if their conditions were to improve to the stage that they could return to work they would have to consider different & lighter roles/hours. They have the added concern that they are nearing retirement age; therefore feel that their job opportunities would be limited.
Jenny	Sudden change in physical health meaning she could no longer work.	Having a serious physical health condition led to depression, which is now the primary health reason she is not working.
Alexander	Sudden change in physical health meaning he could no longer work.	He has been told he is very unlikely to make 100% recovery, and cognitively he will not be able to work in the profession that he had done all of his adult life, therefore with any return to work there would be a forced career change.

The presence of multiple negative life events did not equate to low work-role centrality or low perceived capacity to work. However, the five participants who were grouped as having low work-role centrality also had complex social situations. It appeared that some participants developed strong worker identity despite their complex social situations from a young age, and that other participants' social circumstances declined after they had developed strong worker identity. Amongst those who experienced multiple deprivation from a young age it is not clear what distinguished those who developed strong worker identity and those who did not.

The participants who had experienced multiple negative life events all had mental health conditions that they directly related to their social circumstance (including those who had high work-role centrality). For example, participants attributed their poor mental health to negative events in their lives that had a lasting impact:

> My life could've been so different if [partner had not been violent, had not been pregnant with his child, had not have started using drugs] … but that's what happened. (Michelle, age 37, OWMH 10 years)
>
> When I was with my son's father he like physically and mentally abused me […] and throughout the years other things have happened and it's … I kind of just don't leave the house and that much anymore and … (Caroline, age 37, OWMH 20 years)

Participants identified related issues for treatment of such common mental health conditions, which they felt had consequences related to return to work. Lack of treatment, or what they felt was suitable treatment, was indirectly a barrier to work because it was a barrier to their improved capacity to return to work.

6.3.2.1 Treatment for common mental health conditions related to social circumstance

Thirteen of the seventeen IB participants talked about having an anti-depressant prescription. As discussed in the previous section, many of the participants who were receiving anti-depressant medication directly attributed their depression to something else in their lives e.g. bereavement, guilt, childhood abuse, domestic violence, lack of job, and/or physical health problems. These participants all talked about issues surrounding their medical treatment in a way that the participants with physical health conditions—or those with mental health conditions that they did not attribute to social situation—did not. They were concerned that they were prescribed anti-depressant medication habitually from their General Practitioners (GPs) despite never really making any improvement. Some of the participants felt as though they were rushed through appointments, and this routine was never broken.

> Jacqui: And then the doctor said that I was definitely depressed, so they put me on anti-depressants.
>
> KS: So that was, what, 17 years ago?
>
> Jacqui: Yeah. And see to this day the doctor just puts me on them. I'm still on them […] you just feel as though they're just giving you tablets the whole time. Sometimes I don't even take them, you know and that feels as though it's a waste of money but you just feel as though 'there's your tablets'.
>
> KS: Did you feel like they made a difference?
>
> Jacqui: No. Feel as though it's just like 'here's your tablets, how's your panic attacks?' 'Yeah a wee bit better now', 'ok, I'll see you in another couple of months'. Right.

This example shows that there was some dissatisfaction with the service received from the GP, and this was apparent among other participants who were taking anti-depressant medication. However, these participants seemed nervous about initiating any conversation with their GPs in order to try to change the routine—either because they felt unease about questioning their doctor's opinion, or because they felt like they were stuck in a rut and could not think of any way out.

> I don't seem to get much feedback off of [my GP] either, I kind of … I don't, when you're in there they kind of just want to know what you're in for and then get you back out […] I definitely think I maybe need to see somebody or talk to somebody about the things that are going on in my head. I know there's … everybody else seems to have like a counsellor or a worker or something that is quite good with them or talk to them and I've, I says, I've seen a CPN before, the psychiatric nurse but I don't really, nobody seems to put me in touch with anybody or … I don't know if maybe I don't tell them enough that

> they think that I might need to do that. (Caroline, age 37, OWMH 20 years)

Counselling was thought to be the best form of treatment. After years of being on anti-depressants the participants who had been referred on to a counsellor talked about a slight change in the way they were feeling—they were generally positive about the counselling sessions, seeing “light at the end of the tunnel, even with just that wee glimmer” (Karen, age 53, OWMH 2½ years). However, there were some issues with long waiting times and continuity of care.

> It’s just that, it’s just because it’s new, it’s like … a start again. You know what I mean, it’s as if you’re going back like to square one, to then you have to go through the issues again, […] suss out what’s going on. (Vincent, age 45, OWMH 5 years)

6.4 Summary of findings

This chapter has highlighted several factors that contribute to participants’ motivation to return to work. Perceived capacity was related to how participants felt about their health and was associated with their motivation to return to work—those who perceived that they did not have the capacity to work were not motivated to work. However, this does not mean that their preference was to remain OWIH, but rather that they lacked alternative options. Although perception of opportunity to work was associated with participants’ expectation of whether they would be successful in finding a job, it did not seem to affect their motivation to look to the same extent as capacity did. Other issues related to the importance of work and social circumstances throughout life also seemed to be related to motivation to return to work. However, it is not possible to say to what extent.

6.5 Discussion

This section considers how the findings presented in this chapter relate to results of other relevant studies. The barriers to work that were brought up by participants were similar to those identified in the qualitative synthesis in Chapter four. However, analysis by capacity group and work-role centrality and more in-depth consideration of social circumstance and multiple deprivation led to findings that were not explored in previous research.

6.5.1 Complex pathway to return to work

One issue brought up in the qualitative synthesis was that there was a difficulty of interpretation of participants' views on their barriers to work, whereby some authors appeared to discount health barriers and explain them as barriers related to participants' confidence or motivation (Dekkers-Sanchez *et al.*, 2010; Magnussen *et al.*, 2007). The use of the participatory action theory as a framework to organise barriers to work for people OWIH has helped to consider the barriers to work from the participants' point of view and be clear about how the data were used. It has also helped to make sense of the data, and to some extent to better understand the factors that influence people's motivation to return to work.

Similar to the research reviewed in Chapter four (qualitative synthesis) and the evidence from quantitative research (presented in Chapters two and three), there were different domains that influenced how people felt about returning to work. These related to the individual, their health, psychosocial factors, and the macro-context. Participants were not a discrete group in terms of their motivation to return to work or their perceived capacity to do so (Conolly and Hales, 2009). The 'complex pathway' was, therefore, related to different factors for different participants.

6.5.2 Barriers to return to work by personal characteristics and health condition

6.5.2.1 Age

Looking at participants' characteristics, personal factors did not appear to have a large bearing on their perception of their readiness to work and their motivation to work. After taking capacity and preference into account, age was not an important factor in motivation to return to work. Although age was not important for motivation to return to work, it was perceived by participants to be a barrier to opportunity for work, perhaps helping to explain the association between age and return to work in quantitative analyses (Chapter three; Audhoe *et al.*, 2012; Sejersen *et al.*, 2009; Vermeulen *et al.*, 2009). There are different reasons why age may be a barrier to opportunity to work e.g. views of employers (Taylor and Walker, 1998) and of employability professionals, who sometimes lack encouragement for return to work for older benefit recipients because they do not always see older working-age people with a disability as being “compatible with a working identity” (Kirkpatrick, 2012; Riach and Loretto, 2009, p.11).

6.5.2.2 Gender

There was not an obvious gender divide in feelings about receiving benefits and on readiness to work; gender was not clearly related to participants’ work-role centrality or motivation to return to work. This was similar to the findings from quantitative and qualitative research in the previous chapters. Although studies found that in some cases ‘gendered roles’ had an impact on feelings for employment (Allen and Carlson, 2003; Beatty *et al.*, 2009; Mettavainio and Ahlgren, 2004), this was not apparent in the data in this study. There was some sense that participants had to provide for their families, particularly if they had children, but this was true for both men and women. In saying that, the females who talked about having to provide for their families were lone parents; it is not possible to say whether evidence of gendered roles would have been evident with a more diverse sample.

6.5.2.3 Type of health condition

In terms of differences between health conditions, participants with conditions that were chronic and fluctuating had the additional barrier of being unable to commit to set hours or days of work, and often experienced poor health with little warning. These participants felt that they had few opportunities to return to work because of the way that employment is usually offered. Hedges and Sykes (2001) noted similar barriers for participants with mental health conditions. However, in the study presented in this chapter, some participants had chronic, fluctuating mental health conditions, and others had chronic, fluctuating physical health conditions. Other participants who felt that their capacity for work was reduced—but who had a stable level of health—were not concerned about their reliability, but were conscious that they would have to find employment that they knew they were capable of doing. Fluctuating health has been shown to be a concern for employers when employing new staff, because of disruption of work routines from the need to take absences (Davidson, 2011).

Regardless of type of health condition, most of the participants talked about the likelihood that they would be discriminated against by potential employers because of their health conditions. Previous research shows that this expectation may be realised for many disabled job applicants (MacRae and Laverty, 2006). Participants with mental health conditions often talked about how they felt that employers discriminated against mental health in particular. This made them believe that it would be more difficult for them to return to work than those with physical conditions. Employer attitudes were an issue for people with any type of condition, making it difficult to tell whether this was something that was experienced more among people with mental rather than physical health conditions. However, previous qualitative and survey research with employers provides some evidence that employers are less willing to take on employees with mental health conditions than those with physical health conditions (Bunt *et al.*, 2001; Davidson, 2011; Roberts *et al.*, 2004). Also, there may be differences in the ways that employment advisors work with people with mental and physical health conditions, owing to beliefs about their ability to support them and the belief that those with mental health conditions are less employable than others (Hudson *et al.*, 2009). This could result in lower referral of clients with mental health conditions to employers (Hedges and Sykes, 2001).

Although there were some differences in opportunity to work, a physical/mental health distinction could not be made about participants’ motivation to work. However, there were other issues related to common mental health conditions that participants identified as barriers to them getting better—and therefore returning to work—which other participants did not mention. Some of those with mental health conditions attributed their poor health to the multiple deprivation experienced throughout their lives. Looking at the nature of the condition, in terms of the broader context of participants’ lives, brought out some differences between the barriers to work for those who had ‘reactive’ mental health conditions (in that they felt their mental health was a reaction to their situation) and those who did not (Macdonald *et al.*, 2009).

One issue for those with ‘reactive’ mental health conditions was their contact with their GP and the treatment that they received. Pink *et al.* (2007) suggested that GPs are the principal source of comfort for people who face issues related to social circumstance and negative life events. Although there was evidence that participants did consult their GPs when they felt as though they could not cope with social circumstances, there was little evidence that they were particularly comforted by their GP. In fact, they raised concerns about the routine nature of their consultations, often feeling as though they were rushed through and never really provided anything that was going to help them. They therefore felt that they did not get support to tackle the barriers to work that they faced. Participants with other health conditions—although often accepted that they would not make a full recovery—did not talk about their treatment being unsuitable or inaccessible in this way, conversely, these participants who spoke about contact with health services were positive about their experiences.

Barriers to work for those experiencing multiple deprivation and associated mental health conditions was something that was not explored in depth in the qualitative studies reviewed in Chapter four; therefore, much of the discussion in the following sections focuses on the findings from these participants. Additionally, this is the group that fall into the category of ‘troubled families’—those who the Government have described as having multiple disadvantages such as low income, poor health, housing, and education (Social Exclusion Task Force, 2004). As Levitas (2012) pointed out, these families have moved from being labelled ‘troubled families’ to ‘troublesome families’ and are increasingly targeted with interventions to prevent them causing “serious problems for their local communities" (Department for Communities and Local Government, 2012; DWP, 2012, p.8). It is important to provide evidence on the lived experiences of this group of people rather than assume that multiple deprivation equates to ‘causing trouble’.

6.5.3 Culture of worklessness and multiple deprivation

Participants all said that in an ideal situation they would be employed. They identified multiple benefits of returning to work including both ‘latent’ benefits e.g. improvements in self-esteem, social life, as well as the 'manifest' benefit of increased income (for some) (Jahoda, 1981). As in other research, however, such aspiration to work was 'undermined' by barriers to doing so (Patrick, 2011; Wolfe, 2012). This presents an alternative view to the dominant narrative in the media of benefit recipients as 'shirkers and scroungers' who need to be motivated to return to work (Baumberg *et al.*, 2012; Garthwaite, 2011). Participants, even those for whom work had not been a main feature of their own lives, stated the importance of employment in general, and of their children moving into fulfilling jobs. This also goes against arguments that there exists 'cultures of worklessness', which have been promoted by government policy documents (Collins *et al.*, 2009; Freud, 2007; Houston and Lindsay, 2010). Targeting attitude change without focus on experienced barriers to work is therefore unlikely to have the desired effect of increasing numbers moving into employment. Nonetheless, role models do have a place in encouraging people into work, whether that is in childhood or later in life (Allen, 2003). Absence of a positive role model while growing up can leave someone with no encouragement or support, as explained by one of the participants who felt that he was capable of some work but had little intention of trying to find any.

Shildrick (2012) described a culture of worklessness as "familial inheritance of values and practices that discourage employment and encourage welfare dependency" (p.3). Although there was little evidence of such culture amongst participants discussed in my study, there were participants who were from families with members from two or three generations who experienced significant periods out of work. Longitudinal research using British and English cohort studies have found evidence that intergenerational worklessness exists (Barnes *et al.*, 2012; Macmillan, 2010). Generations of worklessness are not in themselves evidence that a culture of negative attitude, or a lifestyle choice, are the main barriers to work (Jowit, 2012; Wintour, 2009). They do, however, highlight that different members of a family may be affected by similar barriers to work. Macmillan's (2011) longitudinal research could not evidence the causal pathway between worklessness and parental worklessness but posed different explanations for the relationship—describing it as a 'deprivation story' versus a 'dependency story'. There was little evidence in my qualitative study that fitted with a dependency story; however, some participants fitted into a deprivation story. In line with previous quantitative longitudinal research it was clear from the qualitative study that some participants experienced “complex needs and numerous socioeconomic risks” (Barnes *et al.*, 2012, p.11).

Participants did not need to be motivated towards employment as they could clearly see the benefits. However, this does not mean that they all were motivated to return to work. A previous qualitative study investigated attitudes to work amongst people with depression and found that some participants assumed an ‘illness identity’—where they were consumed by their symptoms and could not think about their lives beyond their illness (Millward *et al.*, 2005). The feeling of not being able to contemplate a positive future resonates with some of the participants in the qualitative study described in this chapter. However, this was not limited to their health, but also involved concurrent negative aspects of their lives beyond, and sometimes linked to, their health. Millward *et al.* (2005) explained the difference between participants with an ‘illness identity’ and those who were ‘recovery orientated’ as differences in how the participants chose to define themselves. However, they did not consider the wider context of people’s social lives beyond who they socialised with. People do not always have a choice in this sense because their reality is more complex, involving a wide collection of external influences (Blustein, 2011). The results from the qualitative study presented in this chapter show that feelings related to return to work need to be considered in the wider context of a person’s life. In some cases, but by no means all, the context is poverty, deprivation, negative childhood experiences, bad relationships, low self-esteem etc. None of the participants chose to continue being OWIH and receiving welfare benefits because it was an easy lifestyle or a better way of life. Not one of the participants felt as though they had an easy life or better life than people not OWIH—it was entirely the opposite.

6.5.4 Adaptation to being out of work because of ill health: a barrier to work?

Factors such as determination and work-role centrality appeared to aid motivation to return to work, however, like findings of previous studies (Dekkers-Sanchez *et al.*, 2010; Gilworth *et al.*, 2009; Hedges and Sykes, 2001) it was clear that these factors were not sufficient for a successful return-to-work outcome. Some participants were determined to return to work, but other factors were stopping them e.g. their capacity or their opportunity to do so. In these cases participants had adapted to their situation because they did not think that return to work was a realistic option. This was not evidence that adaptation to a ‘sick role’ was a barrier to return to work as other authors suggested (Beatty *et al.*, 2009; Magnussen *et al.*, 2007). If it is unrealistic to return to work because of health, it may be best for psychological well-being to adapt to the new situation rather than making unsuccessful attempts to return to work (Booker and Sacker, 2012).

On the other hand, for those who experienced a lasting change in health—and felt that they had the capacity to do some work—adaptation to their new situation did appear to facilitate their pathway to return to work, because it helped them to consider alternative options in terms of type of job etc. (Dekkers-Sanchez *et al.*, 2010; Mettavainio and Ahlgren, 2004).

All participants had chronic conditions or had experienced a significant change in their capacity owing to the experience of a health condition—none had a temporary period of ill health that they expected to completely recover from. In these cases, adaptation to new capacity either means adapting to being OWIH or adapting to allow consideration of jobs that they would be capable of doing. Adaptation depends on the nature of the condition, and return to work is not the only positive outcome for those OWIH.

It did not appear that these participants required motivation to return to work, but required appropriate healthcare and suitable opportunity to get on with their lives. Successful adaptation does not necessarily equate to return to work, but could be adaptation to a new way of life (Edwards and Gabbay, 2007). Eden *et al.* (2007) categorised people who were out of work into different adaptation patterns. They showed that people could change their adaptation patterns e.g. starting as ‘go-getters’, but because of the pressure faced whilst working with a disability they became ‘realist’ or ‘indifferent’ (Eden *et al.*, 2007). This may reflect people’s original optimism turned to pessimism in the face of reality (unsuccessful return to work) and highlights that adaptation patterns are not a personal trait but are changeable based on experience.

6.6 Chapter summary

This chapter has added to the literature on the situation of those OWIH and the drivers of their motivation (or lack of) to return to work. None of the participants discussed in this chapter had straightforward pathways to return to work, and all faced multiple barriers to doing so. This includes those who were motivated and felt that they had the capacity to return to work—these participants had not made a successful move into employment either. Poor health and multiple deprivation alone do not equate to poor attitude regarding work. However, there were issues related to some participants' social situations that needed to be addressed for them to be able to even consider trying to move into employment.

Chapter seven: Qualitative study findings 2: General Practitioner and Employment Advisor perspectives

The previous chapter focused on findings from participants who were out of work because of ill health (OWIH), showing that a variety of factors were likely to impact upon whether a person was motivated to look for work. This chapter presents the perspectives of the six General Practitioner (GP) and six employment advisor (EA) participants. After exploring GP and EA perspectives on the capacity, opportunity, and preference barriers to work, this chapter goes on to discuss the pressures that GPs and EAs felt that they faced in supporting their patients and clients who were OWIH. Finally, the chapter discusses the findings in relation to the OWIH participant findings from the previous chapter, as well as in relation to the existing literature.

When mentioning ‘participants’ in this chapter, it refers to the GP and EA participants as opposed to the OWIH participants, unless otherwise stated.

7.1 Research questions

Specific research questions addressed in this chapter:

What are the barriers and facilitators to work for those OWIH from the perspective of GPs and EAs?

What pressures do GPs and EAs face in terms of supporting their patients and clients who are OWIH?

7.2 Capacity, opportunity, and preference barriers to return to work

Drawing upon their experience of working with patients or clients who were OWIH, GPs and EAs discussed the factors that they felt were barriers to a successful return to work.

7.2.1 Capacity for employment

The GPs and EAs all shared the view that their patients' or clients' health conditions did not generally mean that they lacked the capacity to work. They mentioned that there were obvious exceptions, but they felt that—despite their health—"most people can do something" (GP3).

> I mean there's a small minority of people who are just clearly malingering and don't have anything wrong with them. There's a much larger group of people who have a genuine illness, whether it's physical or mental, but they could work if they were really motivated or really pushed into it. And there's another group of people who are just too ill to work really. So, tend to see a spectrum. (GP5)

Although some people were said to be unable to work because of health, lack of capacity to work was not viewed by GPs or EAs as a major barrier to return to work for most patients and clients.

7.2.2 Opportunity for employment

Available and accessible jobs—and the likelihood that employers would take on people who had been OWIH—were regarded by EA and GP participants to be both barriers to work and barriers to them supporting their clients and patients into work.

7.2.2.1 Workplace and employment factors

All but one of the GP/EA participants spoke about the labour market as a barrier because of the general lack of jobs. Some talked about the poor labour market owing to the economic climate (data collection in 2011), and others about lack of opportunity because of the historically poor local labour market. There was also the feeling that employers would be concerned about how reliable those who had experienced being OWIH would be because of health, time out of work, and also non-health factors such as age and skills. These issues are illustrated with some quotes from GPs and EAs in Box 7-1. In thinking about employment chances for this group, GP3 drew on his own experience as an employer, in a way justifying employers' decisions to look for employees who seem, on paper, to be more reliable.

Box 7-1: Poor labour market and employer concern over reliability as barriers to employment: GP and EA verbatim examples

Labour market

GP2

KS: What would you say that their main barrier to work is?
GP2: Can't get a job.
KS: For what reason?
GP2: There's no economy.
KS: Do you think that's the main thing?
GP2: Yeah. I mean, I think if there were jobs out there, our patients would be up for them.

I think it's more sociably acceptable to be idle and sick, than to be idle because no-one will give you a job.

GP6

[Lack of jobs] is huge. I mean part of the problem is all this thinking about getting people back to work and all the rest of it is there are just not jobs to go to.

EA1

Just were finding it impossible to get people into work. There was a period of time where we couldn't get anybody into work or very few people and [we] were all being threatened with redundancy or whatever as well if [we] didn't start to pick up so it was tough you know.

EA4

Do you know, like there's not really anything and it's almost too, because of the market right now, because of the recession, anything that they could do all those areas are over-subscribed like everywhere, there're so many people that want to be HGV drivers, there's so many people that wanted to be you know, brick-layers and plasterers … those kinds of things, but they're all over-subscribed.

Employers

EA1

I think [employers] just assumed because they were on Incapacity Benefits there was a reliability issue, perhaps because of experiences that they have had in the past or whatever.

Say you get a couple of people to go for the same job, you can quite quickly see a pattern forming if you're… if you've got a twenty year old guy going up against a fifty-five year old guy, more often than not the younger… if they've both you know, if they're both equally capable of doing the job, more often than not it's going to be the younger guy that gets the job.

GP3

As a small organisation disability discrimination doesn't apply in the same way, so you know if you're an organisation of more than ten people you have to have positive discriminatory policies for employing staff, but if you're a small organisation you can't easily manage that, you know, particularly where you've got a very small staff group who are having to cover for each other's absences and so on. So we'll ask people about sick leave. [...] But to have somebody who's going to be taking time off, I'm sorry, it just—it's no good.

GP1

An employer has to show that they are not discriminating against this applicant because of a health condition. […] it shouldn't be held against them. That's what the law is meant to be. Obviously, it's different. Every employer's different, and they can use another excuse for not employing the person.

One EA’s opinion on employers and available jobs was very different to other participants’ views. EA5 was a lot more positive about the labour market, and about employers’ interest in employing people with health conditions who had been OWIH:

> The employment market is very, very strong at the moment […] I think it’s one of those things that if you have a [potential employee with a] health condition and you’re an employer and you’re aware of this, you know, you have to be realistic enough to know that sometimes this [time off] is going to happen. I do think, certainly with the larger employers that we deal with, they’re very conscious of this, from my experience they’ve been fantastic in trying to get people back to work, and trying to manage a phased return back into work. They’ve been very supportive … and I think a lot of companies these days have a social responsibility to take on people that have a health condition.

One explanation for EA5 having a different opinion on employers and the labour market is that he worked in an organisation that dealt with specific employers. These employers know that the clients put forward for interviews are receiving Incapacity Benefit (IB); therefore, this pool of employers is obviously open to employing people who are OWIH. EA5 described his organisation as similar to a recruitment agency, where employers benefit as they do not have to pay fees. Since EA5 was of the opinion that there were willing employers and a strong labour market, he attributed not getting a job to the individual:

> I think that the biggest barriers that people have to work is themselves. Because we can do a lot for candidates when they come in here, we really can bend over backwards for them. And all the help and the support that they need, we liaise with a lot of organisations that are prepared to take on people with a health condition. But the one thing we can’t do is give people will. If they have a strong will we will get them a job. (EA5)

Although the other participants were more concerned about the labour market, they also talked about lack of motivation or will as another barrier to work; this theme is discussed further in section 7.2.3.

7.2.2.2 Stigma as a barrier to work

As discussed in the above section, participants felt that some employers would not be interested in employing people who had been OWIH because of reliability issues. There was particular concern around mental health; GPs and EAs felt that there was likely to be increased stigma surrounding mental health, making it more difficult for people with mental health conditions to get jobs. This equated to a further barrier to work for people with mental health conditions:

> I still think people who have got depression and mental health problems probably do get more stigma against them. And people, 'cause they're worried they are going to go off with stress or stuff like that whereas people with a sore elbow they can work around or whatever. And I think if they have got a sore elbow they're still happy and willing, they probably think they have probably got a better mental ability to cope rather than the other way around. (GP6)
>
> Because I suppose people don't necessarily fully understand mental health as much as you know, a physical ailment is something that you can see whereas mental health … I suppose they [employers] had a little bit less of an understanding. (EA1)

However, some participants were unsure about whether the increased stigma towards mental health was expected or experienced; "patients feel stigmatised" (GP2), but it was not clear whether they actually were, or if the expectation affected their likelihood of looking for work:

> I'm not sure whether it's a real barrier or a perceived barrier. Patients are often a bit wary that if they've been off work for years with depression, for example, that employers are not going to consider them. Whether that's the case or not, I don't know. (GP5)

7.2.2.3 Job type

Participants identified patients and clients who they did not think could not return to their previous employment. They felt that these patients and clients would have to consider other types of jobs if they were going to return to work. There were two reasons given for the need for a change in job type: industry and health. Firstly, the job industry has changed in the area, from manufacturing to service, therefore there are a lot of people out of work who had previously worked in manual jobs, but who could not find any vacancies in this type of work. Secondly, some people could not return to their previous job type because their health did not allow it, although they were able to work in some type of job. Examples given tended to be of men who had worked in physical jobs, but who could not return to the same job because they were not physically fit, or because they had been out of work too long and employers were not willing to take them on because of their age.

> We saw quite a few people, older guys actually in their fifties who had been in a trade and they'd had some sort of physical injury or they had back problems, massive, massive thing [...] they could be really difficult to get back to work because they had skills, they'd recovered from their injury but because of their age people weren't interested in employing them. (EA1)

> Men in their late fifties, who've done heavy physical jobs since they left school at fifteen, and they haven't worked for a couple of decades, and they've got rotten joints, and they're depressed, 'cause they've had no economy in their family for all that time, as the bread winner, and they get to their late fifties, almost in sight of their bus pass, and such economy and income as they have is pulled from under their feet. (GP2)

Participants also linked type of job with socioeconomic status. Opportunity for return to work differs by person—depending on their health condition and its interaction with particular jobs. Several participants talked about some of their patients and clients having certain resilience to cope with poor health—provided by socioeconomic status. GP2 highlights this, suggesting that occupation and education plays a role in providing the opportunity to return to work or stay at work in the first place:

> But someone who comes in, say, they're in their late twenties, early thirties, and they've got a university degree and professional training, and they've got multiple sclerosis—I can immediately think of two people in that position—and they're in a different job market from the guy … I've got a lady, as well, with multiple sclerosis who left school at fifteen, and worked as a cleaner. Now, the two first people we mentioned, with university degrees and professional training—they can get work in an office, sitting in a level floor with a wheelchair, centrally heated, safe environment, sitting in front of a TV screen, video screen, computer screen, and they can cope with quite advanced multiple sclerosis in those circumstances, in the way that the lady I'm talking about, who worked as a cleaner, you can't, you know, you don't need much multiple sclerosis to end your cleaning life, do you? But you can operate at quite a high level in ... one is in the banking industry, or was in the banking industry, with a disability - quite a high level. (GP2)

7.2.2.4 Job suitability and quality

Although most of the GPs and EAs were concerned about the lack of employment opportunities for many of their patients and clients who were OWIH, they also recognised that finding a job would be a positive step for those who were able to work. Among GPs, this was related to the recognition that work could be good for health. However, they were not always enthusiastic about encouraging patients or supporting clients into work: some felt that the quality of available jobs was not good for people's health, or that there was no skill or job match involved, which created a dilemma surrounding whether patients and clients should still be encouraged to apply for these jobs for the sake of having a (any) job.

Some participants were purely focused on the main aim of getting people into a job; these participants believed they should encourage clients and patients to consider applying their skills to a different type of job. Others felt uneasy about the general aim of getting people back to work, concerned that it meant losing sight of any preference or prior skills that clients had (see Box 7-2). It is difficult to make any analysis of why there was a difference in opinion on this issue, or draw conclusions about why EAs reacted differently to encouraging their clients into particular jobs. It is possible that the EAs who saw mandatory clients had a different experience to those with only voluntary clients (as those who had mandatory clients seemed to be more concerned about this issue, and it is possible that mandatory clients had less desirable job opportunity than those who were voluntarily obtaining EA support to return to work). However, given that the six EAs had quite different roles, this explanation is only one possibility.

Box 7-2: GP/EA views on considering preference for type of work

A job is a job	Consideration of skills/interests may be important
GP1 I think maybe some of the patients are actually fit for that, specifically, but it's telling them that and getting them round to that way of thinking. They won't, they'll be like, "no, but I used to be a labourer, but I can't labour anymore, so I can't do anything else." So it might not be the same as putting a postage stamp on an envelope. They don't think of that as a job, specifically. **EA3** A lot of people are not interested in doing call centre and care work, so it's getting people round to that way of thinking. It's quite a challenge to get people to re-think. To show people they do have skills that could be used in other jobs.	**EA1** [There were] big drives to really just get people into a job so quite often we'd have big clients like Tescos or some sort of supermarket chain and they would say right, well we're doing a mass hiring at the moment. Have you got clients that you think would be interested in this? And very often I think people were being put into jobs like that and you know, I don't really know why. You know, there was no sort of … there wasn't necessarily a correlation between what their skills were and what we were trying to sort of get them to do. **EA4** Really, it's really, really disheartening actually because a lot of the jobs that come on like that, you know how you can register jobs with Jobcentre Plus, a lot of them are not great jobs right, a lot of them were really, really menial jobs. **EA5** If someone's highly skilled and qualified and they have a career, we'd probably—maybe we're not the best place for them […] but a lot of the employers that we deal with would be kind of … maybe your entry level jobs, you know stacking shelves or that kind of thing.

Furthermore, there was concern surrounding the actual conditions of the available jobs, with some participants being reluctant to encourage clients and patients towards them.

> Safe working environment, good working practices, I think there are lots of jobs that fall short of that—some of which aren't actually good for people, and I think my patients, who've got particularly low education or attainment, tend to be dumped in these kind of jobs, with no security, poor working environment, no long-term contract—probably no contract at all—and dull, repetitive routine. (GP2)

This was a problem that most GPs and EAs felt was not considered by the welfare system. Measures put in place to encourage individuals into work did not do anything to improve the quality of the jobs that they had the opportunity to get. Furthermore, the actual rules of the benefit system made it very difficult to get even these jobs: fixed-term or part-time jobs were not thought to be compatible with the inflexibility of the benefit system. EA2 summed up the problem when he said:

> Employment has changed [there are more temporary or zero-hour contracts], but the benefit system hasn't changed enough to deal with it. It is not geared up to processing things.

In terms of the welfare system and labour-market context, GPs and EAs were concerned about the support that they could provide, given benefit rules did not always match up to the available jobs. In addition, participants felt they were in a predicament because in order to achieve results they had to encourage clients and patients into roles that were not necessarily in their best interests.

7.2.3 Preference

Most participants discussed their clients' or patients' lack of motivation as a barrier to work. However, where participants differed in opinion was in how they explained this lack of motivation. As discussed in the previous chapter, social circumstance appeared to play a role in the OWIH participants' experience. Although it does not necessarily align with the heading 'preference', social circumstance is discussed here because it was used by participants as an alternative explanation to preference for lack of motivation to return to work. Leading on from this, GP and EA participants also had views on the association of social circumstances with mental health conditions that were relevant to the perceptions of barriers to work for this group and to the pressures they faced in supporting them.

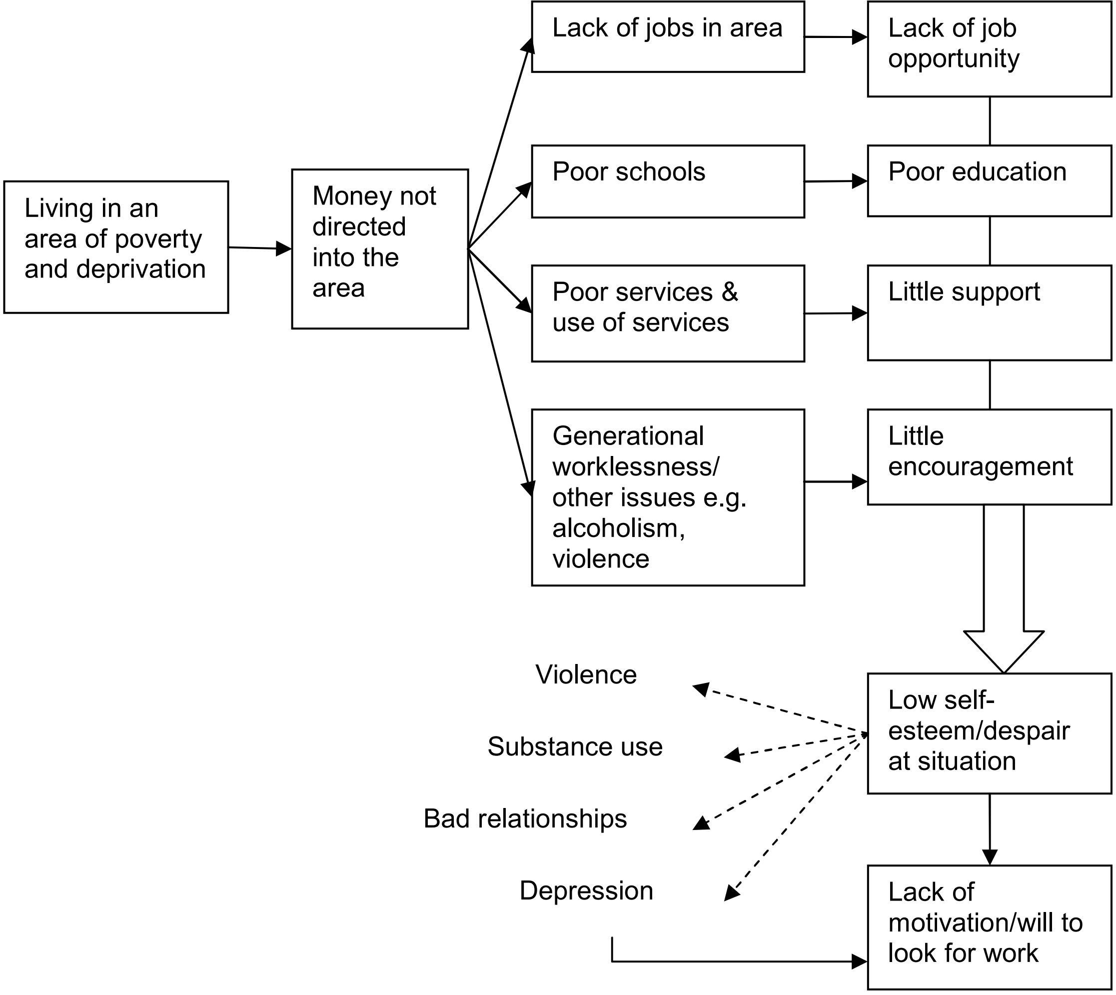
7.2.3.1 Lack of will: "basic human nature" or complex social situation?

Some participants put individuals' lack of motivation as "basic human nature" (GP5), "the wrong attitude" (GP1), or because "people just don't want to work" (EA4). Although these participants often also talked about patients' and clients' poor social situation they did not directly link the two. This was in contrast with the other participants, who explained that they felt that their clients' and patients' social situation was associated with their current worklessness and lack of motivation to return to work, essentially because "they're not given any chances in life" (GP6). For example:

> GP2: [life expectancy and average household income] put this neighbourhood, relatively speaking, at the bottom of the poverty ladder, and, in terms of absolute poverty, it's pretty hard evidence, you know? So, in terms of things like educational attainment, and the ability to get good jobs in this neighbourhood, there's not much prospect. I think it leads to despair, I think it leads to the Anglo-Saxon curse of low self-esteem, which we're all afflicted with—but this is a particularly pernicious form of low self-esteem. It leads to frustration which, in turn, leads to desperation and disregard.
>
> KS: Do you think that motivation is a factor that's affected by the things that you've just talked about?
>
> GP2: Absolutely—self-motivation and self-esteem, I think, are directly tied up, you know?

The variety of socioeconomic factors that GP and EA participants identified in relation to worklessness is illustrated in Figure 7-1 (the figure presents all of the different socioeconomic factors that GP and EA participants talked about as reasons for lack of motivation to look for work).

Figure 7-1: Socioeconomic circumstance and worklessness



There were no obvious differences in characteristics between those participants who attributed worklessness to the individual and those who attributed it to the wider social situation e.g. GPs with the same level of experience, in similarly deprived areas, had different views; EAs who worked in positions where they had time to form relationships with clients did not necessarily share the same views etc. It was clear that all of the GP and EA participants were frustrated with the issue, but the direction of their frustration differed slightly. Those who attributed worklessness to the wider social situation were frustrated with the system e.g. the political system, and more specifically the welfare system. Those who attributed worklessness to the individual were frustrated with their patients or clients, but also with the welfare system.

The OWIH findings in the previous chapter showed that there were complex reasons for being out of work in the first place, and complex issues that obstructed return to work. All of the OWIH participants that had complex social circumstances had depression or anxiety issues that they attributed to their situation. This link between mental health and social circumstance was highlighted by the GPs and EAs, and regarded as a problem for them supporting their patients' and clients' return to work. They often felt that they were unable to provide assistance to the complex and persistent barriers behind worklessness and poor health.

7.2.3.2 Treatment for common mental health conditions related to social situation

The GPs recognised repeated or automatic anti-depressant prescribing as a problem—and acknowledged it unacceptable—but nonetheless mentioned that they could think of instances where it had happened in their consultations. They explained this was the result of routine, pressure, or because they were not sure of what else to do that would help these patients.

> But they need to be empowered and say to their GP "I don't want to take Prozac anymore, what else can I do?" And, it takes more time for the GP if the GP is stressed, or miserable or again it is familiarity breeding not necessarily contempt but just sort of "oh it is so and so, the last ten times we have done this, this is a quick consultation, I have got so and so coming in next". And sort of breaking that cycle can be difficult. (GP6)

> Their lives haven't changed or moved forward and they don't know how to move their lives forward and we don't know what to do with them. (GP4)

Part of the reason that GPs did not know what else to do was because referral services were poor, giving GPs few opportunities to support their patients further.

> Yeah I mean [routine anti-depressant prescribing is] what tends to happen in real life. In an ideal world mental health services would both be adequately resourced, and of a helpful frame of mind. Because most patients would actually benefit a lot more from psychological therapies than from medication. Medication will control symptoms but it won't address problems. Patients generally would benefit greatly from support—emotional, psychological, social, employment support. (GP5)

Some of the EAs also brought up the issue of problems with treating people with depression, having seen this in their clients. For example, EA5 said:

> Doctors are very, very keen to give anti-depressants out you know without really getting to the crux of the problem. Because of their circumstances and maybe because they're not in work kind of thing.

Likewise, the GPs talked about depression as being entrenched in other socioeconomic issues e.g. worklessness: "they're depressed, because they've had no economy in their family for all that time" (GP2), or a complex combination of deep-rooted issues stemming from their social environment:

> They might present with anxiety and depression, but fundamentally they have problems with social interactions […] as likely as not they'd had alcoholic parents, and/or parents with major mental health problems, and [were] brought up in chaotic environment. (GP2)

Recognising that there are social aspects to depression, rather than simply a biological cause, there were connected issues related to the treatment of depression; GPs suggested that anti-depressant prescription was "only half of the treatment" (GP5). However, the issues with referral services meant that they were left in a difficult position—they knew that anti-depressants were not a cure for their patients' problems, but often felt powerless in terms of the support that were able to offer.

> GP5: Whether any of these supports are actually available is another question.
>
> KS: Ok. Are they?
>
> GP5: Really? No. Mental health services in this part of the world are appallingly bad. Very, very poor service. And they've got worse over the years. Both waiting lists, the attitude of the services, and the actual quality of service. I've been here for nearly twenty years and mental health services are worse than they were twenty years ago.
>
> KS: So would it be at the point where you just wouldn't refer people on or you just wouldn't know what to …?
>
> GP5: No, we always refer people. But, we know deep down that if they get help they're lucky. It's quite likely that they won't be seen at all, or they'll be fobbed off, or they'll be on a waiting list for several months. I know exactly who to refer to with mental health services but they just won't provide a service.

7.2.4 Summary

Participants all mentioned numerous barriers that their patients or clients faced to return to work. These barriers were largely to do with opportunity, preference, and social circumstance. Capacity was not thought to be a barrier for the majority of those OWIH. However, some differences were notable between participants' explanation for their patients' and clients' lack of motivation to return to work. Where some explained lack of motivation as an issue of preference, others explained it as stemming from difficult social circumstances. Some mental health conditions were mentioned directly in relation to social circumstances, and in these cases GPs felt that there was a reliability issue with the treatment options available to them. Some of the participants viewed the welfare system as incompatible with the labour market, and with the range of social circumstances people OWIH were experiencing. The following section moves on to consider how the participants viewed the welfare system itself as a barrier to them being able to support their patients and clients.

7.3 The welfare system as a barrier to supporting return to work

Participants talked generally about the welfare system and how it did not always match up with the context of worklessness in the UK e.g. the labour-market and social context. Additionally, GPs identified problems with their role in the welfare system, which they felt caused difficulties that they faced to supporting their patients who were OWIH.

7.3.1 General Practitioner role in welfare system

GPs discussed their frustration regarding the amount of work that was generated for them from the Benefits Agency, particularly when the work was time consuming and rewarded no remuneration. They described this, and the work derived from patients who were out of work and required support with benefits or sick notes, as "an integral part of being a GP" (GP6) and "the bulk of a GP's workload" (GP5).

The GPs identified their role principally as the patients' advocate, and discussed this as being contradictory to their expected role in the welfare system, as shown in Box 7-3. One reason that they felt the workload related to welfare benefits conflicted with their duty to the patient was that they believed the way the benefit system was set up often did not allow them to do the best for their patients; GP3 explained that they are put in a position where they have to "make people fit into a benefit system that is not really fit for purpose".

Box 7-3: GP role in welfare system

I look after their health, in the widest possible sense. What I don't do is police the welfare benefits system. These two jobs are mutually incompatible. (GP2)

It puts doctors in a rather invidious position. (GP3)

Right well, first and foremost, I think we're patient advocates. We're here working for the patients rather than working for anybody else, and doing what is best for the patients. (GP4)

Puts us in a difficult position because we're expected to be the patient's advocate and to be working on their behalf really. But equally well, we don't want to be assisting people to defraud the Welfare State. So there's a fine balance again. (GP5)

Some GPs felt that although the Department for Work and Pensions (DWP) seemed to place some responsibility with them for welfare-to-work issues, they were not actually best-placed to provide such services to their patients who were OWIH.

> I don't have time to learn their [Citizen's Advice, benefit advisors, welfare officers] job as well as my job. (GP4)
>
> I'm happy to deal with medical problems, but when you leave the medical area and get into sort of social government politic type things, we're on less secure ground there. Especially if there are other people or organisations that are there to help and can do it a lot better. If for example there is a job club or I think it's called a Condition Management Programme they had a while ago, don't know if it's still going or not […] If the GPs had the ability and the training and the inclination to do these things, fine, but realistically we can't do these things. We're not social workers, we're not jobs counsellors; we have no idea how to do these things. (GP5)

In order to help their patients, GPs therefore relied on referral services, but this brought about a separate set of issues. They talked about services that they had found useful being withdrawn without much notice—like the Condition Management Programme referred to above—and often not replaced.

> Well they change all the time, they keep changing all the time, and so you just have to try and keep up-to-date with them. (GP6)

> That's quite typical of the initiatives [DWP] bring up, quite often they're very good initiatives, and after a few weeks the funding is withdrawn and they just disappear. That's happened a lot over the past twenty years or so. We've no idea. And we may get a letter or an email when these services are first set up and so, great, new service. But we generally won't be told if the service is withdrawn. And the amount of communication to and fro is usually pretty minimal if it exists at all. (GP5)

GPs generally seemed frustrated with their role, feeling that they could not do the best for their patients if they had to fulfil a role for the DWP. They felt there were further problems in best supporting their patients because of the lack of continuity of services, which often meant that they did not know which resources to draw upon to support their patients to return to work. This left them feeling at a loss on how best to help patients who were out of work, and particularly those with mental health conditions.

7.3.2 Return to work, the welfare system, and welfare reform: "a benefit system that is not really fit for purpose"?

Participants highlighted a number of issues about the welfare system that they thought made it more difficult to support their patients and clients towards work. In this sense, the welfare system placed a pressure on the GPs' and EAs' roles.

Rather than create a welfare system in line with the context of worklessness i.e. with reference to the social and labour-market context, political influence was thought by some participants, mainly GPs, to play an important role. As has been reflected throughout this chapter, worklessness and health-related benefit receipt was seen to be a multi-factorial issue. GP participants generally felt that little consideration was given to the causes of worklessness when creating solutions. They tended to say that they could not see how recent reforms would make any positive difference, describing them as "same-old, same-old" (GP4).

The EAs did not speak so strongly about the political reasons for welfare reform, and did not concentrate as much on this as a reason for the system being 'unfit for purpose'. They tended to think more about the workings of the system on the ground, and felt that it was "just so convoluted" (EA4), with services becoming "generic" (EA3) and lacking continuity. Although, generally agreement that welfare reform was not going to create much positive change, GPs and EAs gave different reasons for this, which could have been to do with their roles i.e. EAs were much more directly involved in the services on a day-to-day basis. However, this may also have been something to do with the fact that the GPs had all (apart from one, who did not talk about welfare reform in much detail) been in their current jobs for over 20 years, and were used to welfare changes that appeared to them to have made no difference, whereas EAs were relatively young and had spent less time in their jobs.

7.3.3 Summary

GPs and EAs face a number of different pressures in their jobs, in terms of how they support people who are OWIH. GPs felt that they were asked to take on contradictory roles, particularly when they did not view the welfare system as beneficial to their patients' health. The welfare system itself was thought to compound the pressures faced; neither GPs nor EAs were optimistic about the welfare system, the services available, or the proposed welfare reforms. Lack of referral opportunities and uncertainty about what to do to support some patients were further difficulties faced by GPs. For EAs, there were issues related to availability and suitability of jobs and lack of good quality referral services.

This chapter has highlighted that GPs and EAs regard the main barriers to work for those OWIH as related to opportunity and preference or social circumstance. Participants did not dispute that their patients and clients who were OWIH had legitimate health conditions, but felt that most had health conditions that would not singlehandedly prevent them from working. However, they saw other barriers to work as insurmountable for some. Context played a role in whether participants felt that their patients and clients were likely to be motivated to work and to get a job. Contextual factors such as job opportunities and the social environment were highlighted as important, as well as personal preference.

7.4 Discussion

This section relates the findings from this chapter to the findings from the OWIH participants that were presented in the previous chapter, as well as to other relevant literature.

7.4.1 Barriers to a successful return-to-work outcome

Opinions on opportunity for getting a job were similar between the three participant groups, with most EAs, GPs, and OWIH participants seeing the labour market and employers' lack of enthusiasm to hire people with poor health or poor employment records as the main barriers. Lack of jobs was not directly related to presence of a health condition; however GP and EA participants felt that in a poor labour market the chances of those OWIH getting a job were low because they were less employable than other jobseekers who had not been OWIH. Lack of opportunity was intrinsically related to the health conditions that people experienced e.g. employer discrimination and/or the need to change jobs because of ill health. This resonates with the 'job queue' metaphor proposed by Beatty *et al.* (2000). In times of high unemployment there is a bigger pool of potential employees, therefore employers can be selective about who they take on; those with poor health are less appealing to employers, so are at the back of the job queue. It is thought that health would not play such a big role in whether people would be able to return to work from a period OWIH in times of high demand for labour (Alcock *et al.*, 2003).

Despite that all three participant groups were asked similar questions related to barriers to return to work, there were differences in the way the participant groups talked about the weight of the various barriers. GPs and EAs identified barriers to opportunity as reasons why those OWIH were not motivated to return to work as well as why they could not get a job. Although the OWIH participants did identify similar issues in relation to whether they got a job or not, barriers to opportunity did not appear to impact on motivation to return to work to the same extent as other barriers, in particular perceived capacity to return to work.

7.4.2 Barriers to motivation to return to work: capacity, preference, or social circumstance?

Some GPs and EAs felt that the main barrier to work for some of their patients and clients was their lack of responsibility to get a job (the dominant view in policy documents e.g. DWP, 2008). This opinion amongst the participants draws parallels with the deprivation/dependency story discussed in Chapter six (Macmillan, 2011). Similarly, another recent (2013) qualitative study with stakeholders showed that some of those who work with IB recipients group clients into 'deserving' and 'undeserving' categories (Bambra and Smith, 2010; Garthwaite *et al.*, 2013). This was not true of all GP or EA participants but reflects the difference between those who saw personal will or want—as opposed to factors situated beyond the individuals' control—as the main reason people were OWIH. Although all GP and EA participants saw motivation as a barrier to return to work, not all attributed it to personal lack of responsibility. However, the findings in this chapter have added that even GPs and EAs who viewed all (or the majority) of their patients and clients who were OWIH as 'deserving' did not do so because of a health condition alone. They considered health in context of other social factors, and explained lack of motivation as a consequence of social disadvantage.

7.4.2.1 Personal will or social disadvantage: does either help to explain the experience of participants who were out of work because of ill health?

As found in Chapter six, participant data did not fit well with a dependency story. However, the deprivation story did resonate with some OWIH participant data. The "chaotic environment" (GP3) or "chaotic lifestlyes" (EA1) could be recognised in some of the OWIH participants. Some of the OWIH participants expressed that a culmination of negative factors led to their period out of work and to their ill health, and continued to make it difficult for them to return to work.

GPs and EAs recognised that not all of their patients or clients who were OWIH had difficult social situations. This too was evident among those OWIH. Furthermore, to clarify, not everyone with negative life events and difficult social circumstances was unmotivated to work. There were OWIH participants who were unmotivated to work because they did not think their health allowed it, but who had not experienced multiple deprivation. Equally, there were OWIH participants who had experienced multiple deprivation but were motivated to return to work because they felt their health allowed it. This is where a difficulty of interpretation lies. However, the fact that the OWIH participants who were not motivated to return to work and who had low work-role centrality also attributed their poor mental health to circumstances in their lives signals that social circumstance is important in some way.

Although many OWIH participants said that their social circumstances had contributed to their ill health and/or workless situation, they also emphasised their lack of capacity to work, whereas GPs and EAs were of the opinion that very few actually lacked the capacity to work.

7.4.3 Pressures faced by General Practitioners and Employment Advisors in supporting their patients and clients

Participants felt that they faced pressures in supporting those OWIH with regards to their role (GPs) and with respect to supporting people into jobs where they were unconvinced of the benefit to the patient or client.

7.4.3.1 General Practitioner role

Consultations with patients who asked for advice with benefits or work were significant in the GPs' jobs. Previous qualitative studies exploring GPs' role in sickness certification for IB found that GPs experienced tensions between their role for the DWP and for their patients (Hiscock *et al.*, 2005; Hussey *et al.*, 2004). GPs still sign off some IB and ESA appeal forms for the DWP, but no longer complete sickness certification forms for IB or ESA claims. Despite this, evidence of role tension remained in the interviews with GPs.

Previous research has shown that GPs commonly felt that they were the only professionals that their patients talked to about how social problems affect their lives (Macdonald *et al.*, 2009). One source of tension for GPs was their role in treating patients who were OWIH who they felt had largely social problems.

The rate of prescribing of anti-depressants by GPs in the UK, and Scotland, has increased since the beginning of the 1990s (Middleton *et al.*, 2001; Philp *et al.*, 2002). However, analysis of the Scottish Health Surveys has shown that prevalence of psychosocial morbidity has remained fairly constant in Scotland, as have initial presentation of depression-related symptoms to GPs, and GP diagnoses of depression (Munoz-Arroyo *et al.*, 2006). Pilgrim and Bentall (1999) discuss the 'medicalisation of misery', arguing that medical treatment for depression fails to uncover relationships in need of social treatment methods. They also criticise treatment solely by psychological therapies—as this focuses exclusively on cognitive process—therefore stresses that the construction of reality, rather than reality itself is the problem. GPs recognised that treatment of depression for their patients OWIH, particularly where it was clear that social circumstances played a role in the patients' health, was less than ideal. However, they felt that there were few options available to them given that the referral links were poor. These findings were similar to another qualitative study with GPs in Scotland, which found that GPs were frustrated with the issue: they acknowledged that anti-depressants could not solve the social circumstances at the root of the depression, but stated that few satisfactory alternatives were available (Macdonald *et al.*, 2009).

As discussed in Chapter six a number of the OWIH participants also identified issues with their anti-depressant treatment. It was clear that neither party was satisfied with the situation. Therefore, this research supports the recommendations of another study: better links with community resources to allow GPs to make use of 'social prescribing' where appropriate, with an easily accessible list of current referral resources (Watt, 2011). This study has found that there are tensions on both sides—for GPs and patients—and shows that patients who are out of work because of depression, as well as GPs, have identified the need for change.

7.4.3.2 Job quality

GP and EA participants were concerned about the quality of jobs available to their patients and clients who were OWIH. EAs faced a dilemma about whether they should encourage clients into any available job or should hold out for a more suitable alternative. This decision created pressure if the EAs faced targets relating to the number of clients they were required to move into work. Other research has shown disadvantages of having performance-based contracts for welfare-to-work providers because of the unintended consequences they often have (Finn, 2009; Wright, 2011). One problem is that employment advisors intuitively put the most effort into assisting those who are most likely to get a job in the first place (Dickens *et al.*, 2004; Garthwaite *et al.*, 2013). This has been referred to as 'cream-skimming' and can result in 'parking'—those furthest from the labour market are given very little help to move towards employment. People furthest from the labour market, in terms of the barriers they face, are most likely to be 'parked' because traditionally services that have been contracted to provide welfare-to-work support have only been paid for an employment outcome, and have received nothing for providing support to people to get closer to employment, unless the work outcome is fulfilled (Clayton *et al.*, 2011a).

Also related to job quality is the way that employment is organised and offered. GP and EA participants felt that the welfare system had not changed in line with changes in employment e.g. the existence of more temporary, rather than permanent, contracts. Although the number of temporary workers actually fell between 1997 and 2008, the number of people in temporary work because they could not find a permanent job increased by 40% from the start of the 2008 recession to 2010 (Institute for Public Policy Research, 2012). The increasing trend of temporary workers following the 1990 recession carried on until 1997, suggesting that the impact of a recession on available employment can carry on for years. This again highlights that macro-level factors have an impact on worklessness and return to work.

There is evidence that psychosocial work stressors have been increasing over the last twenty years (Chandola *et al.*, 2011). Steeper increases in job insecurity, intensity of work, and conflict at work have been apparent since the 2008 recession. This has been reflected in the findings reported in this chapter, whereby the anticipation of transitions from OWIH to jobs of poor quality has meant that GPs and EAs are sometimes reluctant about encouraging those OWIH into work. Although GP and EA participants acknowledged that good work could be a positive outcome for some, because of the quality of the jobs available there was concern about whether work would in fact always be good for the health of their patients and clients. This is consistent with other research showing that GPs view the work-health relationship as complex. There is particular apprehension that jobs with low pay and low social status are not necessarily beneficial to the health of those transitioning from OWIH (Beatty *et al.*, 2009; Mowlam and Lewis, 2005). Previous research has found that when doctors advise on return to work it tends to be to recommend against it for health reasons (Conolly and Hales, 2009). GPs in the current study did not talk about advising against return to work for their patients, just that they would not necessarily encourage it because (1) they did not particularly know how, and (2) they had concerns about the quality and availability of suitable employment. Similar findings related to the promotion of health benefits of employment have been found with employment advisors—during Work Focused Interviews advisors rarely point out health benefits of working to their clients (Drew *et al.*, 2010).

7.5 Strengths and limitations of the qualitative study

It was decided after 17 interviews with the core participant group, and six with both GPs and EAs, to stop interviewing. The main participant group, those OWIH, reflected a range of experiences and health conditions. At this stage participants were bringing up similar issues in terms of barriers to work, and patterns emerged related to their different experiences. However, the majority of the sample was male (12 males and five females), and four of the five women were single parents. This may be seen as a limitation of the study. However, there was a practical (time) consideration to stop at this point; in order to recruit more OWIH participants more GP practices would have to have been recruited—a process that initially took four months from first contact with GP practice to first interview with OWIH participant. Furthermore, analysis by gender was not an aim of the study, but nonetheless findings were similar to many previous studies.

It proved difficult to recruit EAs. The request to recruit EAs from Jobcentre Plus was turned down because “in the current economic climate [they were] unable to release staff resources for any research activities that are not commissioned by ourselves or DWP” (email response to request received 02/06/11). Only two of the other five organisations that were contacted agreed to tell any of their employees about the study. Partly because of this, it is difficult to provide explanation for the differences in opinions among the GPs and EAs. EAs were quite different in terms of their job roles, making comparison difficult. The opposite was true of GPs who, with one exception, had similar characteristics in terms of age and experience, making it difficult to explain differences in opinion. Larger samples of EA and GP participants would perhaps have made interpretation and explanation of GP and EA perspectives more feasible. However, as stated in the methods chapter, GPs and EAs were recruited to supplement the OWIH participant data and to make comparisons between the three participant groups, and in these terms the sample achieved its aim.

The study was conducted in and around Glasgow, which differs from many of the other qualitative study locations discussed in Chapter four. Glasgow, an old industrial city, has a high rate of worklessness, with a higher proportion of IB recipients out of work because of mental health (Brown *et al.*, 2008), and low general levels of health compared to the wider UK and Scottish populations (Hanlon *et al.*, 2005), and even compared to other seemingly similar cities (Walsh *et al.*, 2010). In saying that, there were comparable findings in terms of feelings about barriers to work of those OWIH; broad themes are likely to be similar across populations. However, a similar extent of multiple deprivation was not discussed in other qualitative studies. Other researchers have argued that certain things are very rare e.g. generational worklessness and lack of work-role centrality (Shildrick, 2012), that were found in my data. It is not clear whether this was because recruitment was via health services, including a psychologist and a mental health clinic. The study can only provide the range of experiences of the participants who were interviewed, without drawing any conclusions about how prevalent such experiences are.

Where the research presented in this chapter has asked GPs and EAs about transitions from OWIH to employment, previous research has more often explored transitions in the opposite direction (e.g. Beatty *et al.*, 2009; Shiels and Gabbay, 2007; Whittaker *et al.*, 2010). Such research is useful in that it provides evidence for what to concentrate on in stopping people moving on to long-term benefit receipt in the first place. However, it does not address how to support the large ‘stock’ of people on IB and ESA who are currently being re-assessed for their benefits, many of whom will be mandated to look for work under the new Work Programme. The current research provided information on the motivations of this group. Also, recruitment via GP practices allowed identification of an otherwise hard to reach population, who are not often given the chance to voice their perspectives on these issues.

The benefit of qualitative research is that it allows an in-depth exploration of people's experiences and perspectives. This study benefited from having three different groups of participants; analysis of the GP and EA data informed the final interpretation of data from IB participants. Use of qualitative rather than quantitative research enabled more in-depth exploration of participants' views on capacity, opportunity, and preference for work for those OWIH than has previously been done.

7.6 Chapter summary

This chapter has provided some indication about how the two main contacts for those OWIH feel about their patients' and clients' return-to-work pathway. GP and EA views are important because they are the ones who have first-hand contact with people who are OWIH. They are, therefore, in a position to support and refer, and will do so in accordance with their beliefs about the patients and clients that they see. By analysing the factors that GPs and EAs discussed in the same participatory-action-theory framework that was used with the OWIH participant data, it was possible to compare the perspectives of the different groups.

Chapter eight: Discussion

Previous chapters have presented findings from statistical analysis of employment and health outcomes for those out of work because of ill health (OWIH), a qualitative synthesis of barriers to return to work for those OWIH, and a primary qualitative study further exploring some of the issues related to return to work for those OWIH. The studies presented in this thesis have contributed to the understanding of the motivations and barriers to work for those OWIH, as well as the evidence on the relationship between employment and health. This final chapter summarises the main findings under the headings of the over-arching questions that were set out in the introduction. Implications of the research and recommendations for future research are then discussed.

8.1 Is the focus on activating benefit recipients who are out of work because of ill health appropriate, or are there barriers to return to work that this approach cannot address?

Chapter three showed that only 6.6% of those OWIH were employed five years later, with large variation by cohort (only 2.4% of the 1930s cohort compared to 24% of the 1970s cohort returned to work). The majority (70%) remained OWIH and the remainder described their employment status as retired/looking after the household/unemployed/other. Such low figures of return to work imply that there are considerable barriers to return to work for this group. Health-related, socioeconomic, and period factors were significantly associated with return to work. Health was the most important factor in the relationship, and all measures of health were significant. The qualitative synthesis also found that health was usually the most important factor affecting whether those OWIH experienced successful return to work. However, it highlighted that individual-level barriers are often difficult to interpret. It was not always clear whether the health condition itself or factors associated with it—such as confidence—were important in the relationship.

The primary qualitative study provided more detail on people’s motivation to work. It showed that those OWIH were unmotivated to return to work for a number of reasons—largely related to their perception of their capacity to work. Motivation to return to work is not simply about will and want. Participants all felt that in an ideal situation they would rather be employed. However, none of them were living in an ideal situation that had allowed them to get a job. Those who were motivated to work lacked the opportunity to do so because of workplace and macro-level factors e.g. employer discrimination, availability of jobs, particularly those that would be compatible with their capacity. Those professionals who worked closely with people who were OWIH emphasised the same barriers to opportunity for their patients and clients.

There is some evidence that people with mental health conditions face more or greater barriers to return to work than those without. The primary qualitative study found that a physical/mental health distinction was not important when looking at motivation to work. The effect that the health condition had on the person's capacity at a day-to-day level was what mattered—if it was unpredictable then they felt it was harder to get work. However, there were some links between 'reactive' mental health conditions and multiple deprivation. Those who had not developed a worker identity and had mental health conditions that they associated with poor social circumstances did not have the motivation to return to work. They all felt that their health meant they could not work; however, they also felt that the cause of their ill health was their negative social circumstance and/or numerous negative life events. General Practitioners (GPs) and Employment Advisors (EAs) also identified patients in this situation. GPs in particular felt that these patients were very difficult to help, largely because they did not think that they had the skills, time, or resources to tackle the root cause of their patients' mental health conditions: the social problems they experienced. All participants who had experienced numerous negative life events or complex social circumstances had associated mental health problems such as anxiety, depression, and panic attacks. However, as mentioned, not all felt that they lacked the capacity to return to work, yet all faced multiple barriers to return to work.

Barriers to return to work are numerous and complex. In focusing on individual deficiencies that prevent people moving into employment, and primarily on the need to motivate the individual, welfare policies mean that interventions aimed at moving people from IB and ESA into work largely ignore the complexity of disability, and the range of barriers that people who are out of work because of ill health may face in terms of moving into employment, not least the health condition itself. Making benefits conditional on return to work activity may reduce numbers on IB and ESA, but may not increase numbers in employment at a similar level. This would result in those already at the bottom of the income scale having their income further reduced.

8.2 Is work always good for health?

At a population level, those who are employed are healthier than those who are not employed. However, the longitudinal analysis presented in Chapter three suggested that there may be a difference in health depending on the type of job obtained—indicating that the quality of the job obtained is likely to be important in the relationship between work and health. There was no difference in anxiety or depression between those who remained out of work and those who moved into a low-quality job. However, there were different findings depending on the health outcome used—self-rated health was better among those who moved into a low-quality job compared to those who remained workless.

OWIH participants in the qualitative study had mixed feelings on whether work would be good for their health. Some said they could not return to work because it would result in a deterioration of their health. Those who were unsure about the effect of work on their health, coupled with the fear that they would be left with no income if they could not cope, meant that they were very apprehensive about attempting to return to work. Others were motivated to return to work for the main reason that they believed it would benefit their health. Differences in opinion were largely related to whether participants believed that they had the capacity to return to work. Even those who thought that paid employment would be good for their health had requirements for the type of job they could do, with reference to hours and physical and/or mental job demands. They wanted to ensure that a job would be compatible with their health and capacity—otherwise they felt they would not be able to sustain it. GPs also raised concerns about work being good for health, meaning that they were often uncertain about encouraging patients to return to work. Welfare policy focus is to move people into work but GPs felt that this was sometimes discordant with their main focus of improving their patients' health.

Moving into work from a period OWIH is unlikely to always be good for health. There is a particular problem with mandating people with on-going health conditions into work without consideration of how suitable or compatible the job is for them and their health.

8.3 Research implications and recommendations

This section considers the main findings from the thesis and makes related recommendations.

8.3.1 Complex barriers to return to work

Finding: There are complex, inter-acting barriers to return to work.

This thesis has shown how health, employment, labour-market, social-context, and individual factors act as barriers to work for those OWIH. In-depth exploration of the experiences of those OWIH showed that this was true even for the seemingly more 'straightforward' cases.

Recommendation: Tackle the range of barriers rather than placing the majority of the focus on the motivation of the individual who is OWIH.

The increasing stipulation placed on benefit recipients—and the extension to those receiving health-related out-of-work benefits—fails to recognise that many people OWIH lack alternative options. For some, low motivation may be a barrier to work; however, reasons behind this lack of motivation tend to be beyond the individuals' control. Rather than mandate those OWIH into looking for work, effort should be targeted at improving access to local social services and improving the job opportunities for those who are trying to find employment.

This is also linked with time-limited benefits, which assume that stopping benefit receipt will motivate people to move into employment. Those in the work-related activity ESA group have had their benefit receipt time-limited to one year since May 2012. However, stopping benefit receipt does not necessarily mean return to work. It is clear that time is not always likely to change the situation i.e. for those with chronic and/or fluctuating conditions. Not everyone expects to recover or adapt to new capacity. The premise that stopping benefits is that it will encourage people to return to work, but it is clear that there are barriers to work beyond individual attitude.

Worklessness—particularly because of ill health—can be thought of as a ‘wicked issue’. “A problem that is complex, difficult to define, with no immediate solution, one where every wicked problem can be considered to be a symptom of another problem” (Petticrew *et al.*, 2009, p. 454). It is a complex problem, and has to be considered with reference to its social and spatial concentration. The undertaking of ‘activating’ those OWIH to employment is also complex. Interventions to target behaviour change or individual attitude will not be ‘magic bullets’ (Petticrew *et al.*, 2008). Interventions also need to be targeted where wider-level barriers to work exist, such as access to education, local job opportunities, and tackling discrimination in access to employment.

Recommendation: Consider the overall experience of those OWIH when judging whether they are capable of work.

The Work Capability Assessment (WCA) currently used in the UK assesses individuals’ capability to work based on their functional limitations. It does not take account of any factors beyond functional limitations, such as the type of job previously held, that may have an effect on whether a person is able to return to work. An independent review of the assessment in 2010 recommended making the WCA more relevant to capacity in the ‘real-world’ i.e. considering individuals’ health in the context of their lives and opportunities for work (Harrington, 2010). However, conclusions on how a real-world test would work were not reached by the second independent review, therefore change in this respect was not be implemented (Harrington, 2011). The evidence that health conditions interact with other barriers to work makes the case that the WCA does not capture the full experience of those OWIH. As in other welfare policy, the WCA appears to under-represent the views of those who are OWIH (Patrick, 2011). Furthermore, the test does not consider the possibility that working could be detrimental to health; therefore, even if an individual was capable of work they may not be able to sustain a job.

8.3.2 Multiple disadvantage or complex social situations

Finding: Some of those OWIH have faced a multitude of disadvantage throughout their lives, which has aggravated, contributed to, or caused poor health and periods OWIH, as well as acting as a barrier to return to work.

This is by no means the case for all those OWIH. However, it appeared to be a major source of concern for professionals involved in the return-to-work process. It is likely that none of the single social issues faced by participants were the cause of being OWIH, but the relationship with social circumstance is complicated and cumulative.

A related finding is that there does not appear to be a mental/physical health divide for barriers to work, but one based on fluctuating health and social circumstance. Either of these things could be true for those with mental or physical health conditions, but perhaps more regularly for those with mental health conditions.

Recommendation: Tackle multiple disadvantage in people’s lives.

There is a need to tackle the range of barriers that people face, including the multiple disadvantage that some participants faced. Worklessness was only one challenge in some participants’ lives; they had many other needs to be addressed before they could even consider return to work.

The Department for Work and Pensions (DWP) has suggested that a new approach is required to address multiple disadvantages that is “based on tackling the root causes of these social issues, and not just dealing with the symptoms” (DWP, 2012, p. 10). However, it is argued in the same document that income from benefits risks “bolstering welfare dependency and feeding social problems” (p. 10). The discourse within policy documents on families with multiple disadvantages has shifted from ‘troubled families’ to ‘troublesome families’; there is a danger of focusing on blame, choices, and attitudes whilst largely ignoring issues related to poverty, poor housing, and ill health (Levitas, 2012). Policies to address these issues and stop people falling into poverty in the first place are required; wider factors are important in determining disadvantage in many aspects of life (Katikireddi *et al.*, 2013). For example, policies to improve availability and quality of social housing and accessibility of jobs for young people (Fishwick *et al.*, 2011).

The 'deprivation story' for some of those OWIH aligns with previous longitudinal evidence that 'life gets under your skin' (Bartley, 2012). Childhood environment is related to health in adulthood (Taylor *et al.*, 2004); risk factors in early life e.g. maternal separation, parental divorce, abuse, may lead to chronic anxiety or depression in adulthood (Repetti *et al.*, 2002). Tackling multiple disadvantage that leads to or coexists with worklessness is a life-course issue, therefore needs to be addressed from early life. In some respects this is an individual-level argument, but rather than focusing on job search when people are already out of work it tackles the previous step—supporting people to be able to move into employment from education.

Recommendation: Improve access to social prescribing for GPs.

All of the OWIH participants talked about contact with their GPs, sometimes as the only source of advice that they relied upon. GP practices are therefore key facilities for tackling some of the issues that those OWIH face. One national initiative, a website (Healthy Working UK) for GPs to learn about welfare and work issues was set up in 2008 (Cohen, 2012). However, this largely focuses on welfare-to-work rather than providing links to services for patients who are OWIH and face issues beyond being out of work. Additionally, GPs already feel pressurised to get through appointments in allotted time slots, and may make more use of an easy and accessible local referral service rather than a learning or information aid. The referral system for GPs would be improved if they could make appointments within local organisations that could provide necessary support for their patients. This would bypass the need for patients to make initial contact, which can be intimidating for vulnerable patients who are, for example, nervous about losing benefits and being judged (Canvin *et al.*, 2007). Other GPs have previously supported the need for such 'social prescribing' (Cawston, 2011; Watt, 2011). There is a need for implementation and evaluation of interventions to support social prescribing.

8.3.3 Job quality

Finding: Job quality is important in determining whether moving from OWIH to employment will have a positive health effect. There is concern surrounding the quality of jobs that those OWIH are likely to obtain; the opportunities for those who are OWIH are thought to be fewer than for other groups.

Recommendation: There is a need to consider return to work for those OWIH (and others) as multi-dimensional. Return to work from IB or ESA may not be a positive outcome for all.

There does not appear to be a distinction between high and low job quality in welfare-to-work policies, which instead have the mantra any job is better than no job. There is concern that work may actually be detrimental to those with chronic conditions, particularly if they move into a poor quality job. It is relevant that in the British context there is declining job control and increasing job demands (Chandola *et al.*, 2011; Green and Tsitsianis, 2005). It has also been noted that there is little focus on legislation in the area of work stress (Chandola, 2010).

8.3.4 Transition from out of work because of ill health to employment

Finding: Few people move from a period OWIH into employment. Many of those who stop receiving health-related benefits move into unemployment or other forms of worklessness.

This finding about low rate of return to work links with the findings noted in previous sections, however also leads into broader consideration of what the relevant outcomes of welfare policy are, or should be.

Recommendation: Welfare policy should target outcomes other than employment.

There are problems with return to work as the only positive outcome of welfare policy: employment may not be practical, desirable, or healthy for those who are OWIH. As noted in the previous section, work is not necessarily good for health, but is also sometimes undesirable because of interactions between available work and health for people with chronic health conditions. Some of those OWIH see the leap into work as too much of a risk because they think it will be unsuccessful or unsustainable. As well as tackling the issue with availability of jobs suitable for people with health conditions, there is a need to support those who cannot return to work in other ways. Examples include support into volunteering work (that may or may not lead to paid employment), support with condition management (for those who feel as though they need help coping with their health conditions), local social and learning opportunities (many of the participants in the primary qualitative study were lonely and felt helpless). Making a distinction between work (good) and non-work (bad) undermines those who do not work, even if they contribute to society in other ways e.g. as volunteers, carers, parents (Patrick, 2012).

8.3.5 Evaluation of welfare policy and other recommendations for further research

There are some recommendations from the findings that are relevant to future evaluation of welfare policy. The DWP has commissioned a lot of research into the welfare-to-work interventions that they provide, however it is clear from the systematic reviews that attempt to bring all of this together that there is still not sufficient evidence about what works. A 2010 DWP report echoed this sentiment (DWP, 2010a).

The number of people moving off IB and ESA is likely to increase in the current welfare reform because higher numbers are being judged fit for work or are reaching their time limit for benefit receipt. However, counting the success of welfare-to-work initiatives as the reduction in the number of people receiving IB and ESA misses the fact that people do not always move from IB and ESA into employment. When people involuntarily move off of IB or ESA receipt they are even less likely to move directly into employment. Return-to-work outcomes should therefore be obtained. Other outcomes that should be monitored are suitability, sustainability, and quality of the job, as well as evaluating the differential impacts for certain groups (Whitehead *et al.*, 2009). Also, interventions that affect employment outcomes have the potential to affect health and therefore should be evaluated for health as well as return-to-work outcomes (Bambra *et al.*, 2010).

More research is needed on the role of job quality in the health impact of transitions from worklessness to employment. Although it is clear that job quality is important for health, there is less evidence on whether a low-quality job is worse for health than remaining out of work. Research that includes more measurements of job quality, and can breakdown the impact for different groups of worklessness e.g. OWIH, is required.

There is evidence to suggest that social prescribing would benefit GPs as well as some of those OWIH, but interventions to support it, and evaluations of them, are needed. Qualitative as well as quantitative evaluation of such interventions would be required to evaluate GPs’ use of such a system and the referral services’ acceptability of it, as well as outcomes for individuals who are OWIH.

8.4 Conclusion

This thesis has presented findings and discussion from analysis of longitudinal data, a systematic review and qualitative synthesis of previous literature, and a primary qualitative study. The strength of the multi-method approach of the thesis was that it was able to draw on findings from different sources to address the research questions i.e. qualitative and quantitative research using primary and secondary data.

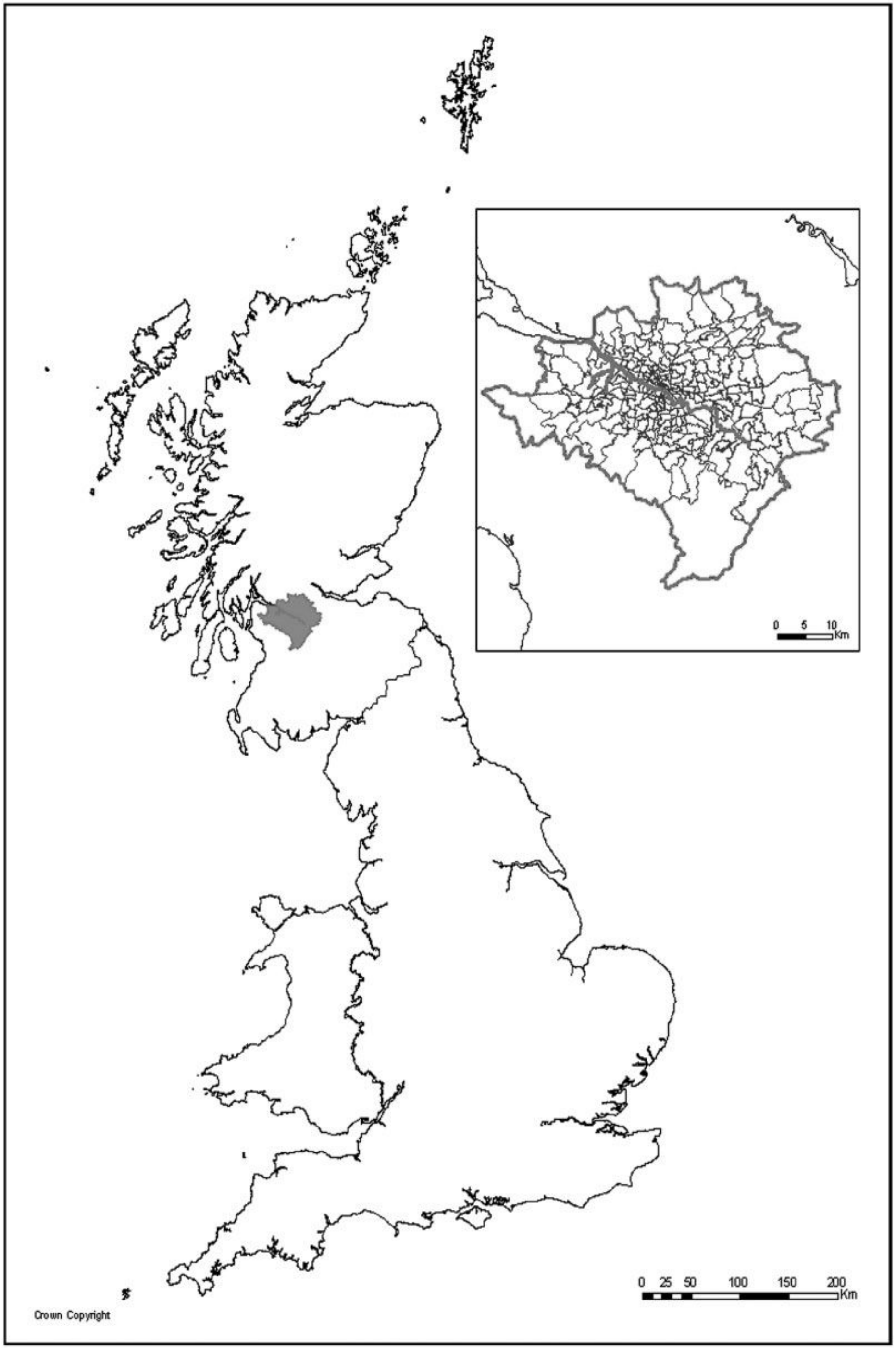
The findings indicate that those OWIH are not a homogeneous group. Personal circumstance—including health—and social context play a role in the experience. Some of those who are OWIH feel that they are capable of return to work. However, few do, and even those who feel capable of working face many barriers to doing so—for reasons related to, but also beyond, their health conditions. Welfare policy does not always reflect the range of experiences of those OWIH. There is a need to focus on improving demand for employees as well as the supply of employees, and to take account of where people are in terms of getting back to work.

Appendix A

Information in this appendix relates to Chapter three: Transitions into employment.

Map of Twenty-07 Study area

Figure Appendix A 1: Central Clydeside Conurbation



Source: Benzeval, 2009 p.1217

Differences between the Twenty-07 Study samples

Table Appendix A 1: Attrition by sample

	Sample n (% of baseline)*		Significance
Missing at:	**Region**	**Locality**	**×2 p-value**
Wave 2	375 (12.5)	229 (15.8)	0.003
Wave 3	759 (25.9)	586 (42.2)	<0.001
Wave 4	968 (34.6)	510 (38.1)	0.027
Wave 5	1254 (31.1)	652 (33.1)	0.215

** % of baseline n minus participants who had died before the interview date

Table Appendix A 2: Comparison of region and locality samples at baseline (Chi square/t-test)

	REGION	LOCALITY	Significance
BASELINE MEASURES	**Sample n (%)**	**Sample n (%)**	**p-value**
Female	1635 (53.9)	779 (52.8)	0.526
Cohort:			0.640
1970s	1009 (33.2)	506 (34.3)	
1950s	985 (32.4)	459 (31.1)	
1930s	1042 (34.3)	509 (34.5)	
Employment status*			0.757
Out of work because of ill health	169 (8.3)	84 (8.7)	
Other inactive	412 (20.4)	190 (19.7)	
Active	165 (8.2)	89 (9.2)	
Employed	1278 (63.1)	602 (62.4)	
Housing tenure			<0.001
Own/mortgage	1550 (51.5)	625 (42.7)	
Rent/other	1460 (48.5)	839 (57.3)	
Deprivation area	**Sample mean (sd)**	**Sample mean (sd)**	
Mean carstairs	1.47 (4.36)	3.51 (4.33)	<0.001

* Proportion of working-age sample

Classification of qualifications

See Figure Appendix A 2 and Box Appendix A 1. Qualifications at Scottish Credit and Qualifications Framework (SCQF) level 6 and below were classified as low, and those above level 6 were classed as high. Qualifications e.g. City and Guilds and foreign qualifications, were placed into this framework based on the most similar qualification listed.

Box Appendix A 1: List of qualifications at wave 5

- Standard Grades/O-levels/GSCEs/CSEs
- Higher/A-Level
- Higher Education access course
- University first degree
- Postgraduate degree
- Higher National Certificate (HNC)
- Higher National Diploma (HND)
- Recognised Trade Apprenticeships completed
- Level 1/Foundation level vocational qualification (e.g. SVQ, GSVQ, NVQ, GNVQ, other)
- Level 2/Intermediate level vocational qualification (e.g. SVQ, GSVQ, NVQ, GNVQ, other)
- Level 3/Advanced level vocational qualification (e.g. SVQ, GSVQ, NVQ, GNVQ, other)
- Level 4 vocational qualification (e.g. SVQ, NVQ, other)
- Level 5 vocational qualification (equivalent to a degree, e.g. SVQ, NVQ, other)
- Vocational qualification- level not specified (e.g. SVQ, GSVQ, NVQ, GNVQ, other)
- SCOTVEC National Certificate Modules not leading to qualification
- Non-Advanced SQA (SCOTVEC) Certificate or equivalent
- SQA (SCOTVEC) Certificate comprising HN units only
- SQA (SCOTVEC) Advanced Certificate (bridge to HNC/D)
- SQA (SCOTVEC) Advanced Diploma
- SQA (SCOTVEC) Diploma (HNC/D level for diplomates and degree holders)
- Combination of SQA (SCOTVEC) National Certificate Modules and other qualifications
- Clerical or Commercial Qualifications (e.g. typing, bookkeeping, commerce)
- Nursing Qualification (SRN, RGN, RMN, SEN, RSCN, RM, RHV)
- Teaching qualification
- Other Academic Qualifications
- Other Vocational or Professional Qualifications

Figure Appendix A 2: Scottish Credit and Qualifications Framework

SCQF level	SQA National Units, Courses and Group Awards	Higher Education	SVQs 1	SCQF level
12		Doctorate		12
11		Masters	SVQ 5	11
10		Honours degree Graduate Diploma/Certificate**		10
9		Ordinary degree Graduate Diploma/Certificate		9
8		Higher National Diploma Diploma in Higher Education	SVQ 4	8
7	Advanced Higher Certificate in Higher Education	Higher National Certificate		7
6	Higher		SVQ 3	6
5	Intermediate 2 Credit Standard Grade		SVQ 2	5
4	Intermediate 1 General Standard Grade		SVQ 1	4
3	Access 3 Foundation Standard Grade			3
2	Access 2			2
1	Access 1			1

Source: Scottish Credit and Qualifications Framework:

http://www.sqa.org.uk/sqa/4608.html

Classification of conditions

Conditions were classified into physical/mental using the Royal College of General Practitioners Morbidity classification (Royal College of General Practitioners, 1986). Condition codes less than 1000 or greater than 1225 were coded as physical health conditions, and condition codes greater than or equal to 1000 and less than or equal to 1225 were coded as mental health conditions.

Unadjusted models: odds ratios of return to work for those out of work because of ill health at t-1

Table Appendix A 3: Odds ratios for employment status at t for those OWIH at t-1 (binary logistic regression using GEE, unadjusted), by individual characteristics (separate models for each)

INDIVIDUAL CHARACTERISTICS (n=408 transitions/302 participants)	Employed at t		Significance
	OR	**95% CI**	**p-value**
Sex			
Female	1		
Male	0.83	(0.37, 1.85)	0.643
Year*			
1990-1992	1		
1995-1998	1.43	(0.30, 6.9)	0.653
2000-2004	7.09	(2.17, 23.23)	0.001
2007/2008	4.03	(1.13, 14.77)	0.032
Age			
Each increase of one year	0.93	(0.90, 0.96)	<0.001
Marital status at t-1 (407/302)			
Not currently married/cohabiting	1		
Currently married/cohabiting	1.18	(0.53, 2.63)	0.689
Qualifications (405/299)			
High	1		
Low	0.70	(0.14, 3.42)	0.656
None	0.25	(0.05, 1.36)	0.109
Housing tenure (407/302)			
Own/mortgage	1		
Rent/other	0.48	(0.21, 1.08)	0.075

* Adjusted for age

Table Appendix A 4: Odds ratios for employment status at t for those OWIH at t-1 (binary logistic regression using GEE, unadjusted), by different measures of health (separate models for each)

	Employment at t		Significance
HEALTH at t-1 (max n=408 transitions/302 participants):	**OR**	**95% CI**	**p-value**
Self-reported health (403/298)			
Excellent/good	1		
Fair or poor	0.97	(0.35, 2.67)	0.955
Limiting health condition (407/301)			
No limiting illness	1		
Has a limiting illness	0.23	(0.09, 0.58)	0.002
Type of health condition (405/300)			
No condition	1		
Physical condition only	0.24	(0.09, 0.65)	0.005
Mental condition only	0.14	(0.02, 1.20)	0.073
Both physical and mental condition	0.22	(0.07, 0.76)	0.016
N GP visits (401/297)			
0-11	1		
12+	0.89	(0.38, 2.10)	0.792
HADS (355/279)			
HADS not anxiety or depression case	1		
HADS anxiety or depression case	0.63	(0.27, 1.47)	0.287
Alcohol intake (407/302)			
Does not exceed recommended weekly intake	1		
Exceeds recommended weekly intake	1.29	(0.48, 3.49)	0.62
Physical disability (201/163)			
Increment of one unit of OPCS score	0.83	(0.73, 0.96)	0.011
Self-esteem (209, 166)			
Increase of one standard deviation	1.24	(0.91, 1.67)	0.171

Unadjusted models: odds ratios of return to work for those out of work (any reason) at t-1

Table Appendix A 5: Odds Ratios for employment status at t (unadjusted*), for those out of work (any reason), by individual characteristics (separate models for each)

	Employed at t		Significance
n=1835 transitions/1295 participants	**OR**	**(95% CI)**	**p-value**
Sex			
Female	1		
Male	0.85	(0.69, 1.06)	0.149
Year*			
1990-1992	1		
1995-1998	1.13	(0.85, 1.50)	0.397
2000-2004	1.80	(1.32, 2.45)	0.001
2007/2008	1.69	(1.22, 2.34)	0.002
Age			
Each increase of one year	0.92	(0.91, 0.93)	<0.001
Housing tenure (n=1832/1293)			
Mortgage/own	1		
Rent/other	0.49	(0.40, 0.61)	<0.001
Employment status at t-1			
Other inactive	1		
OWIH	0.14	(0.09, 0.21)	<0.001
Unemployed	1.88	(1.49, 2.36)	<0.001
Marital status at t-1 (n=1832/1294)			
Currently married/cohabiting	1		
Not currently married/cohabiting	1.24	(1.00, 1.54)	0.049
Qualifications			
High	1		
Low	0.54	(0.40, 0.73)	<0.001
None	0.21	(0.15, 0.29)	<0.001
Study sample			
Locality	1		
Region	0.93	(0.73, 1.18)	0.526

* Year was adjusted for age because of the nature of the (birth-cohort) data

Table Appendix A 6: Odds Ratios for employment status at t (binary logistic regression using GEE, unadjusted), for those out of work (any reason), by different measures of health (separate models for each)

	Employment at t		Significance
(n transitions/participants)	**OR**	**95% CI**	**p-value**
Self-reported health (1817/1286)			
Fair or poor	1		
Excellent/good	2.74	(2.22, 3.38)	<0.001
Limiting illness (1833/1293)			
Has a limiting illness	1		
No limiting illness	3.66	(2.93, 4.59)	<0.001
Type of health condition (1827/1290)			
Both physical and mental condition	1		
Mental condition only	1.72	(0.99, 2.99)	0.056
Physical condition only	2.24	(1.09, 4.59)	0.028
None	6.06	(3.57, 10.29)	<0.001
N GP visits (1806/1283)			
12+	1		
0-11	3.04	(2.14, 4.33)	<0.001
HADS anxiety or depression (1396/1095)			
HADS anxiety or depression case	1		
No HADS anxiety or depression case	1.86	(1.47, 2.37)	<0.001
Alcohol intake (1832/1294)			
Does not exceed weekly intake	1		
Exceeds weekly intake	1.22	(0.93, 1.58)	0.149
Physical disability (757/594)			
Increment of one unit of OPCS score	0.78	(0.72, 0.84)	<0.001
Self-esteem (950/731)			
Increase of one standard deviation	1.17	(1.02, 1.33)	0.023

Appendix B

This appendix relates to Chapter four: Systematic review and qualitative synthesis.

Search terms

After initial scoping in database platforms (CSA and Ebsco), a list of possible terms were identified. Certain terms were removed because of the number of irrelevant hits they produced e.g. the keyword 'work'. The terms were then modified for use in each of the databases; different terms were used in different databases to reflect the specific subject headings or index terms that the databases employ.

CSA Illumina Platform

The search platform CSA Illumina was used to search databases Applied Social Sciences Index and Abstracts (ASSIA), Sociological Abstracts, Social Services Abstracts, Worldwide Political Sciences Abstracts, and International Bibliography of the Social Sciences (IBSS). The search date for each of these databases was 29/03/11.

ASSIA

((DE=(employment or work or (return to work))) or (DE=((labour market) or (job searching))) or (KW=(employ* or job)) or (KW=labour)) and (DE=((incapacity benefit) or (sickness benefits) or (disability allowances) or (invalidity benefit)) or ((KW=incapacity benefit*) or (KW=employment and support allowance) or (KW=disability benefit*)) or (DE=((sick people) or (disabled people))))

Limits : 1995-2011 and English only – 473.

Sociological Abstracts, Social Services Abstracts, Worldwide Political Science Abstracts

(((KW=incapacity benefit*) or (KW=employment and support allowance) or

(KW=disability benefit*)) or (DE=((disability recipients) or benefits or (welfare recipients)))) and ((DE=Employment) or (DE=labour market) or (DE=employment opportunities) or (DE=job search) or (DE=job training) or (DE=employability) OR (DE=labour force participation)).

Limit: 1995-2011, English only – 485.

IBSS

((DE=Disability benefit) or (DE=benefit plans) or (DE=social welfare) or (DE=social support) or (DE=incapacity benefit) or (DE=disabled persons) or (KW=incapacity benefit*) or (KW=employment and support allowance) or (KW=disability benefit*)) and (((KW=Employ*) or (KW=labour) or (KW=job)) or ((DE=Access to employment) or (DE=employment opportunities) or (DE=employment) or (DE=labour market) or (DE=job search))).

Limits: 199-2011, English only – 1455.

EBSCO Host platform

The EBSCO host platform was used to search the databases Cumulative Index to Nursing and Allied Health Literature (CINAHL), Psychology and Behavioural Sciences, Psych INFO, SOCINDEX and MEDLINE. These databases were searched on 6/04/11.

CINAHL

1. (MH "Employment") OR (MH "Employment of Disabled") OR (MH "Employment, Supported") OR (MH "Job Re-Entry") OR "return to work" OR "job search" OR (MH "Job Market") OR "fit for work"

2. (MH "Insurance, Disability") OR "incapacity benefit" OR "employment and support allowance" OR (MH "Disabled") OR (MH "Economic and Social Security") or "disability recipient" or "welfare recipient" or "disability benefit" or "sickness benefit"

Combined searches 1 and 2 with AND, then limited to English, Human and 1990-

2011: 443 hits.

MEDLINE

1. (MH "Disabled Persons") OR (MH "Mentally Disabled Persons") OR (MH "Insurance, Disability") OR "disability benefit" OR "incapacity benefit" OR "employment and support allowance" OR "welfare recipient" OR "sickness benefit"

2. (MH "Employment") OR (MH "Employment, Supported") OR "job search" OR "return to work" OR "fit for work"

Combined searches 1 and 2 with AND then limited to English, Human and 1990-2011: 1602 hits.

Psych Info and Psychology and Behavioural Sciences

1. (incapacity benefit) OR (DE "Disabilities") or (DE "social security") or (employment and support allowance) or (disability benefit) or (sickness benefit) or (welfare recipient)

2. (DE "Employment Status" OR DE "Employability" OR DE "Job Applicants" OR DE "Reemployment" OR DE "Supported Employment") OR (DE "Job Search") or (job search) or (return to work) or (fit for work)

Combined searches 1 and 2 with AND then limited to 1990-2011 and English: 647 hits.

Soc Index

1. ((DE "EMPLOYMENT") OR (DE "LABOR market")) OR (DE "EMPLOYABILITY") or (return to work) or (fit for work) or (job search)

2. DE "PEOPLE with disabilities" OR DE "DISABILITY recipients" OR DE "WELFARE recipients" or (incapacity benefit) or (employment and support allowance) or (welfare recipient*) or (disability benefit*) or (sickness benefit*)

Combined searches 1 and 2 with AND then limited to 1990-2011: 290 hits.

Social Care Online

Country terms were used in this database as articles tend to be indexed by countries (and where they are not it is because it is not clear where the research was carried out). The search could also be refined by content type as this database includes a lot of circulars, events etc. and the indexing by content type is comprehensive. This search was conducted on 7/04/11.

(topic="benefits" or topic="mental health problems" or topic="physical disabilities" or topic="physical illness" or topic="disabled people" or topic="mentally ill people" or topic="people with mental health problems") AND (topic="employment" or topic="labour market" or topic="department for work and pensions") AND publicationdate>1990 AND (Content type="good practice" or Content type="government publication" or Content type ="practice" or Content type="research" or Content type="research reviews" or Content type="statistics") AND (Format="article" or Format="book" or Format="journal" or Format="online resource" or Format="research register" or Format="SCIE publication") AND (Country="United Kingdom" or Country="England" or Country="Scotland" or Country="Wales" or Country="Northern Ireland") = 191 hits.

Critical appraisal

Table Appendix B 1: Example of a completed critical appraisal form

Methodological area	Key criteria	Yes/no	Details	Quality score
Background of research	Source of funding (relationship to findings?)		Norwegian Foundation for Health & Rehabilitation funded the study (but it was conducted by a university).	
	Is the connection of the research to an existing body of knowledge or theory clear?	Yes		A
Aims & objectives	Is there a clear statement of the aims of the research?	Yes	To explore perceived barriers for return to work, based on the experiences & beliefs in a group of disability pensioners with back pain. Over-arching aim was to influence future efforts to encourage pensioners to return to working life.	A
	Are the research questions clear?		Can be deduced from the aim.	
Context	Is the context or setting adequately described?	Not entirely	Does not give information on the disability pension in Norway, information about the intervention is given in the discussion - but whether they were referred/volunteered, & who was eligible for it (other than those with chronic back pain) was not given. All participants lived in the city - rural participants were not included.	B
Appropriateness of design	Are qualitative methods appropriate?	Yes		A
	Is the research design appropriate to address the research aims? Is it ‘fit for purpose’?	Yes	Focus groups chosen rather than interviews to gather broad information, although likely to have different results from individual interview studies -but this is considered in the paper.	

Methodological area	Key criteria	Yes/no	Details	Quality score
Sampling	Sampling strategy:		Purposive sample from participants of an intervention.	C
	Is the sampling strategy appropriate to address the research aims?	Yes	Disability pensioners (DPs) with low back pain. Participants were recruited from a vocational rehab scheme, which may have meant they were more open to return to work than DPs generally, although this is considered in the paper, & concludes that individual interviews may provide more representative information.	
	Criteria used to select the sample:		Participants of a vocational rehabilitation intervention for people with chronic back pain. Participants chosen to reflect a range of ages & length of time on benefit & gender. But no specific details given on these participant characteristics (other than gender).	
	Does the sample include an adequate range of possible cases or settings?	?	Don't know because there is no information given on this, other than gender.	
	Sample size:		17 (12 female; 5 male).	
	Is the sample size justified? (Data saturation.)	No	Don't say why they don't invite more participants but do say that more individual interviews could be illuminating. Also that it was difficult to make too much comparison between males & females.	
	Did any participants choose not to take part in the study?	Yes	Yes, 23 were invited & agreed, but 6 (3 male; 3 female) dropped out before the focus groups.	
	If so, why?		They didn't show up to the focus groups & didn't give a reason why not.	

Methodological area	Key criteria	Yes/no	Details	Quality score
Data collection	How data were collected, & by whom?		2 authors moderated, took field notes & transcribed. Data collected via focus groups with 8/5/4 participants, split by gender.	A
	Is the form of data clear (e.g. tape recordings)?	Yes	Yes - fieldnotes & focus groups transcripts.	
	Were any methods modified during the process?	?		
	If so, why?	?		
	Does data collection involve triangulation (of multiple methods or data sources)?	No		
	Is there evidence that data collection was systematic (e.g. an 'audit trail')?	Yes	Discussions with DPs & authors; then piloted.	
Data analysis & findings	How was the analysis carried out?		Thematic analysis carried out separately by 2 authors, then discussed. Key themes picked out.	B
	Are sufficient data presented to support the findings?	Yes		
	How were data selected for inclusion in the report?	?	Doesn't explicitly say, but I think the key themes from the data were identified & used as headings.	
	Are data annotated with demographic details of contributors?	To some extent	Only with sex & sometimes age - would be useful to have more information.	
	Do the findings directly address the research question?	Yes	Identifies barriers to work for people with chronic low back pain, from their perspective.	
	Does the research privilege subjective meaning?			
	What steps were taken to demonstrate the trustworthiness of the findings (e.g. negative cases, respondent validation)?		Doesn't really discuss this although the discussion reflects on the study & talks about the moderator trying to encourage discussion in one of the focus groups where one participant was dominant, & that there were only disagreements in a few instances.	
	Have the limitations of the study & their impact on the findings been taken into account?	Yes	Discussion section on strengths & limitations.	

Methodological area	Key criteria	Yes/no	Details	Quality score
Reflexivity	Has the relationship between researchers & participants been adequately considered?	Yes		A
	Do the researchers reflect on their personal viewpoints & experience that they bring to the research setting?	Yes		
How valuable or useful is the research?	Does the research add to knowledge, or increase the confidence with which existing knowledge is regarded?	Yes		B
	Is there discussion of how findings relate to wider theory; consideration of rival explanations?	Yes		
	What are the implications for policy & practice – how is it 'fit for purpose'?		Provides information on key barriers to return to work for DPs in Norway, & gives some broad recommendations for return-to-work support.	
Ethics	How have ethical issues been taken into consideration (e.g. consent, confidentiality, anonymity, distress to participants)?		Written consent is mentioned. Doesn't talk about ethical approval or any other ethical issues. Participants' identities were protected by giving few details about the participants (although not sure if this is why they don't give much info).	B
			Overall quality score	B

Table Appendix B 2: Overall critical appraisal and relevance grades (and grades for individual items)

First author	Background	Aims	Appropriate	Sampling	Data collection	Data analysis/ findings	Context	Reflexivity	Value	Ethics	Overall	Agreement	Final grade	Relevance: Focus /country /employment status
Patel	B	A	B	C	B	C	C	C	B	B	C	1	C	A/A/A
Magnussen	A	A	A	C	A	B	B	A	B	B	B	1	B	A/B/A
Allen	B	A	A	A	A	A	A	B	A	B	A	1	A	A/B/A
Alaszewski	A	A	A	B	B	B	C	C	C	A	B	1	B	A/A/C
Braveman	C	A	B	B	B	B	C	B	C	A	B	1	B	B/C/A
Dekkers	B	A	A	A	A	C	C	C	A	A	B	1	B	A/B/A
Eden	B	A	A	A	B	B	C	C	A	A	B	1	B	C/B/A
Edwards	B	A	A	B	A	A	C	A	A	C	A/B	0	B	B/A/C
Gilworth	B	A	A	B	A	B	B	C	A	A	A/B	0	B	A/A/B
Chouinard	B	A	C	C	C	C	C	C	C	C	C	1	C	C/B/B
Duckett	A	B	C	D	D	D	C	B	B	C	D	1	D	-
Freeze	A	A	C	B	C	D	C	C	C	C	D	1	D	-
Timmons	B	A	A	C	B	C	C	C	C	B	C	1	C	B/C/B
McGinn	B	A	A	D	D	D	C	C	D	C	D	1	D	-
Lock	A	A	A	B	A	B	C	B	B	B	B	1	B	A/A/C
Edwards	A	A	A	B	B	B	B	A	A	A	B/A	0	B	B/A/C
Mettavainio	A	A	A	B	B	B	B	B	A	B	B	1	B	A/B/A
Korzycki	A	A	A	B	B	B	B	C	A	A	B	1	B	C/B/A
O'Day	B	A	A	B	B	C	B	C	B	C	C	1	C	A/C/A
Helfrich	B	A	A	C	A	C	B	C	B	A	C	1	C	B/C/B
Macaden	B	A	A	B	A	B	B	C	A	A	B	1	B	C/A/B
Ville	A	A	A	C	B	B	B	C	A	C	B	1	B	B/B/C
Kitchin	A	B	B	D	D	C	B	C	B	C	D	1	D	-
Shaw	B	A	A	B	B	B	C	B	C	C	B	1	B	C/B/B
Morgan	B	A	B	C	D	D	C	C	C	C	C/D	1	D	-
Vick	A	A	A	C	B	C	C	C	B	A	C/D	0	C	A/B/A
Shier	B	B	B	C	C	C	C	C	B	C	C	1	C	B/B/B

Hernandez	A	A	A	B	A	B	B	C	B	B	B	1	B	B/C/B
Pittam	B	A	A	B	A	B	B	C	A	A	B	1	B	C/A/B
Eley	B	A	A	C	B	C/D	B	C	B	B	C	1	C	B/A/A
Bauld	A	A	B	C	B	C	C	C	B	C	C	1	C	C/A/A
O'Day	B	A	A	C	B	B	B	C	A	C	B	1	B	B/C/B
Corden	A	A	B	B	A	C	C	C	C	B	C	1	C	C/A/A
Heenan	B	A	A	A	B	C	C	C	C	C	C	1	C	B/A/A
Easterlow	A	C	C	C	B	C	B	C	B	B	C	1	C	B/A/C
Arthur	B	B	A	C	B	B	B	A	B	B	C	1	C	B/A/B
Prior	A	A	B	C	C	C	C	B	C	A	C	1	C	B/A/B
O'Day	C	C	C	B	B	C	C	C	C	C	C	1	C	B/C/A
Glenn	A	A	B	B	B	C	C	C	B	C	C/B	0	C	B/C/A
Beatty	A	A	A	B	A	C	C	C	B	C	B	1	B	B/A/A
Olney	A	A	A	B	B	B	C	B	A	A	B	1	B	B/C/A
Ghaziani	B	A	A	B	A	C	C	C	B	C	B/C	0	B	B/C/A
Costello	A	A	A	C	B	C	C	B	B/C	B	C/B	0	C	C/A/A
Lewis	A	A	A	B	A	C	C	C	B	C	B/C	0	C	B/A/A
Hudson	A	A	A	B	A	B	B	C	B	B	B/C	0	B	B/A/A
Sainsbury	A	A	A	B	B	C	C	C	C	C	C	1	C	C/A/A
Molloy	A	A	A	B	A	B	C	C	C	B	B	1	B	C/A/C
Hedges	B	A	A	A	A	C	C	C	B	B	B	1	B	B/A/B
Medin	B	A	A	C	A	B	C	C	B	B	C/B	0	C	A/B/C
Robinson	A	A	A	C	C	C	C	C	C	C	C	1	C	C/A/A
Boyce	A	B	A	B	B	B	C	C	B	A	B	1	B	B/A/A
Secker	A	A	A	C	B	C	B	C	B	A	C/B	0	C	C/A/A
Nixon	B	A	A	B	B	B	B	B	B	A	B	1	B	C/B/A
Koch	A	A	A	C	A	A	B	B	B	B	B	1	B	B/C/C
Conyers	A	A	A	C	A	A	B	B	B	B	B	1	B	B/C/A
Svajger	B	A	A	C	B	B	B	B	C	A	C	1	C	C/B/A
Jakobsen	B	A	A	D	B	B	C	C	B	B	C	1	C	B/B/C
								Total agreement				**46 (80.7%)**		

Appendix C

This appendix relates to Chapter five: A qualitative study with those out of work because of ill health (OWIH), General Practitioners (GPs), and Employment Advisors (EAs). It provides the forms given to participants for information and consent, as well as some further details about the OWIH participants.

Participant information and consent forms

The following pages provide:

The initial information sheet (Participant Information Sheet 1) and consent to contact forms (Contact Details) sent to potential OWIH participants from GPs.

The information sheets given to the participants at the time of interview (Participant Information Sheet 2, Information Sheet for GPs, and Information Sheet for EAs).

The consent form for all participants (the same form was used for all three participant groups).

CHIEF SCIENTIST OFFICE
MRC Medical Research Council

Participant Information Sheet 1

Introduction

You are being invited to take part in a research study. It is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information (contact details at the end). Take time to decide whether or not you wish to take part. To thank you for your time, you will be given a £20 high street shops voucher if you decide to take part.

Purpose of the study

In recent years benefit receipt has been continuously reformed, and there have been changes to receipt of out of work ill health benefits such as Incapacity Benefit. Conditional aspects of benefit receipt have been introduced e.g. people may be required to show some sign of progress that they are moving towards work. Despite these changes, fewer than expected have moved off of Incapacity Benefit and into work. This study aims to explore the experience of people receiving Incapacity Benefit, their barriers to work, and barriers to looking for work.

Why have you been chosen?

The research is about exploring the experiences of people who receive Incapacity Benefit. You have been asked to take part in the study because a member of your healthcare team has identified that you may receive Incapacity Benefit.

Do you have to take part?

No; it is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form before any information is collected from you. If you decide to withdraw, or not to take part, the standard of care you receive, and your benefits will not be affected. If you decide to take part you can withdraw from the study at any time, without giving a reason.

What will happen to you if you decide to take part?

If you are willing to find out more about taking part in the study you need to fill in the contact form enclosed with this letter and return it to the person who gave it to you. Your contact details will then be passed on to the researchers at the Medical Research Council who will then contact you. You will have the opportunity then to ask any questions about the study before deciding whether to take part. If you would rather ask questions about the study now then you can call the phone number provided at the end of this Information Sheet (note that this number is to the Medical Research Council, but by phoning it you are not committing yourself to take part in the study). If you do decide to take part the researcher will contact you to arrange a suitable time to meet you. The researcher will then visit you in your home (or another place if you prefer). You will have a chance to ask them any questions about the study before taking part. After you have consented to take part, the researcher will conduct an interview with you (this will take between 45 minute and 1 hour). She will be asking about your experience of claiming Incapacity Benefit and about your feelings in relation to into employment. You are free to skip any of the questions (if you do not wish to answer them all then you do not have to).

Will the JobCentre Plus or my GP know if I have taken part in the study?
No, no one other than the researcher will know.

What will happen to the results of the research study?
The researcher will send you a copy of the report if you request it. A report will be published in a journal which will be available for anyone to access. You will not be identified in the report. The information collected will be anonymised (meaning that it will not be linked to your name or any other personal details). None of the information collected by the researchers about you individually will be shared with the Jobcentre Plus or your GP. In the event that insufficient numbers of participants are recruited then the data collected up to that point will not be used.

Who is funding and carrying out the research?
The study is being funded and organised by the Medical Research Council/Chief Scientist Office Social and Public Health Sciences Unit (www.sphsu.mrc.ac.uk).

Contact for Further Information
If you would like further information about this particular study, or independent advice about taking part in the study, please contact the survey manager Catherine Ferrell on 0141 357 7561, or at:

MRC Social and Public Health Sciences Unit
4 Lilybank Gardens
Glasgow
G12 8RZ

Who has approved the study?
The study has been reviewed by the National Research Ethics Committee and is being monitored by the National Research and Development Directorate.

Thank you for reading this information sheet and for considering taking part in the study.

CHIEF SCIENTIST OFFICE

MRC Medical Research Council

Contact Details

A qualitative study into the barriers to work for people receiving Incapacity Benefit

I (insert name) ………………………………………………………… agree for my contact details to be passed on to the researcher (Kathryn Skivington) at the MRC Social and Public Health Sciences Unit for the above study.

The researcher will only contact you about this study. Your contact details will not be held on file for other research.

By passing on your contact details you are not agreeing to take part in the research. The researcher will first get in touch with you to tell you more about the study and to answer any questions you may have before you decide whether to take part.

The researcher can contact me at/on:

Address:
………
………
………
………
……………………

Telephone number:
…………………………………………………………………………………………………….

Signed
……….

Participant Information Sheet 2

Introduction

You were recently contacted by a healthcare professional about a research study into the experience of receiving Incapacity Benefit. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information (free-phone contact details are at the end of this Information Sheet). Take time to decide whether or not you wish to take part. To thank you for your time, a £20 high street shops voucher will be given to you if you take part.

Purpose of the study

In recent years benefit receipt has been continuously reformed, and there have been changes to receipt of out of work ill health benefits such as Incapacity Benefit. Conditional aspects of benefit receipt have been introduced e.g. people may be required to show some sign of progress that they are moving towards work. Despite these changes, fewer than expected have moved off of Incapacity Benefit and into work. This study aims to explore the experience of people receiving Incapacity Benefit, their barriers to work, and barriers to looking for work.

Why have you been chosen?

The research is about exploring the experiences of people who receive Incapacity Benefit. You have been asked to take part in the study because your healthcare professional has identified that you may receive Incapacity Benefit.

Do you have to take part?

No; it is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form before any information is collected from you. If you decide to withdraw, or not to take part, the standard of care you receive, and your legal rights will not be affected.

What will happen to you if you decide to take part?

If you are willing to take part in the study you do not need to do anything at the moment. The researcher, Kathryn Skivington, will phone you with further information about the study. This will give you the opportunity to ask any other questions you may have. The researcher will then arrange, with you, a suitable time to take part. The researcher will then visit you in your home (or another public place if you would prefer). You will have a chance to ask them any questions about the study before taking part. The researcher will then conduct the interview with you (this will take between 45 minutes and 1 hour). She is interested in finding out about your experience. You are free to skip any of the questions whilst doing the questionnaire (if you do not wish to answer them all then you do not have to).

Will the JobCentre Plus or my GP know if I have taken part in the study?
The JobCentre Plus and your GP will not know whether you have consented to take part in the study or not.

What will happen to the results of the research study?
A copy of the report will be sent to you if you request it. A scientific report will be published in a journal which will be available for anyone to access. You will not be identified in the report.

Who is funding and carrying out the research?
The study is being funded and organised by the Medical Research Council's Social and Public Health Sciences Unit (www.sphsu.mrc.ac.uk).

Contact for Further Information
If you would like further information about this particular study, or independent advice about taking part in the study, please contact the survey manager Catherine Ferrell on 0141 357 7561, or at:

MRC Social and Public Health Sciences Unit
4 Lilybank Gardens
Glasgow
G12 8RZ

Who has approved the study?
The study has been reviewed by the National Research Ethics Committee and is being monitored by the National Research and Development Directorate.

Thank you for reading this information sheet and for considering taking part in the study.

Information sheet for GPs

Incapacity Benefit/Employment and Support Allowance in Scotland

In 2008, 7.1% of the UK working age population was claiming Incapacity Benefit (IB) or Employment and Support Allowance (ESA). In Scotland the rate was 9.1%, and in Glasgow 13.6%. Worklessness for health reasons is a significant national and local issue. Barriers that this group, who receive IB in Glasgow, face to moving into work are the main focus of this study.

Purpose of the study

In recent years benefit receipt has been continuously reformed, and there have been changes to receipt of out of work ill health benefits such as IB, with the introduction of ESA. This study is interested in barriers to work for different people who receive ESA, particularly the barriers faced by people with mental health conditions, which may differ from those with physical health conditions. Interviews with GPs aim to find out what the GPs see as barriers to work for these people and to explore the role of the GP in IB/ESA receipt and welfare to work.

In addition to interviews with GPs and employment advisors, interviews are being conducted with benefit recipients. This aims to explore the experience of people receiving Incapacity Benefit, their barriers to work, and barriers to looking for work. It is particularly interested in exploring barriers to work from benefit recipients' point of view, and exploring differences that may arise as a result of a physical or mental health condition.

Who is funding and carrying out the research?

The study is being funded and organised by the Medical Research Council's Social and Public Health Sciences Unit (www.sphsu.mrc.ac.uk).

Contact for Further Information

If you would like further information about this particular study, or independent advice about taking part in the study, please contact the survey manager Catherine Ferrell on 0141 357 7561, or at:

MRC Social and Public Health Sciences Unit
4 Lilybank Gardens
Glasgow
G12 8RZ

Who has approved the study?

The study has been reviewed by the National Research Ethics Committee and is being monitored by the National Research and Development Directorate.

Thank you for reading this information sheet and for considering taking part in the study.

INVESTOR IN PEOPLE

CHIEF SCIENTIST OFFICE

MRC Medical Research Council

Information sheet for employment advisors

Incapacity Benefit/Employment and Support Allowance in Scotland

In 2008, 7.1% of the UK working age population was claiming Incapacity Benefit (IB) or Employment and Support Allowance (ESA). In Scotland the rate was 9.1%, and in Glasgow 13.6%. Worklessness for health reasons is a significant national and local issue. Barriers that this group, who receive IB in Glasgow, face to moving into work are the main focus of this study.

Purpose of the study

In recent years benefit receipt has been continuously reformed, and there have been changes to receipt of out of work ill health benefits such as IB, with the introduction of ESA. This study is interested in barriers to work for different people who receive ESA, particularly the barriers faced by people with mental health conditions, which may differ from those with physical health conditions. Interviews with employment advisors aim to find out what the employment advisors see as barriers to work and to explore their experience with supporting people receiving IB/ESA towards to work.

In addition to interviews with employment advisors and GPs, interviews are being conducted with benefit recipients. This aims to explore the experience of people receiving Incapacity Benefit, their barriers to work, and barriers to looking for work. It is particularly interested in exploring barriers to work from benefit recipients' point of view, and exploring differences that may arise as a result of a physical or mental health condition.

Who is funding and carrying out the research?

The study is being funded and organised by the Medical Research Council's Social and Public Health Sciences Unit (www.sphsu.mrc.ac.uk).

Contact for Further Information

If you would like further information about this particular study, or independent advice about taking part in the study, please contact the survey manager Catherine Ferrell on 0141 357 7561, or at:

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Glasgow
G12 8RZ

Who has approved the study?

The study has been reviewed by the National Research Ethics Committee and is being monitored by the National Research and Development Directorate.

Thank you for reading this information sheet and for considering taking part in the study.

CHIEF SCIENTIST OFFICE

MRC Medical Research Council

Consent forms for all participants

Please initial	I confirm that I have read and understood the Participant Information Sheets of [DATE] for the above study. I have had an opportunity to consider, ask questions and have had these answered satisfactorily.
Please initial	I understand that I do NOT need to answer any question if I do not wish to, that my participation is voluntary and that I can withdraw at any time, without giving any reason and without my medical care or legal rights being affected. I understand that any information I provide will be treated in confidence.
Please initial	I agree to this interview being audio recorded using a digital recording device. I understand that the audio recording is confidential, and that information replicated in text will be anonymised.
Please initial	I agree that the researchers may contact me again in the future to provide me with feedback about the study or to discuss continuing to participate in research with the MRC. I am aware that I may withdraw at any time in the future by writing to the above address.
Please initial	I agree to take part in the above study.

Participant			
	Name (please print)	Signature	Date
Researcher			
	Name (please print)	Signature	Date

Participant characteristics

Table Appendix C 1: Characteristics of participants who were out of work because of ill health (OWIH)

Participant	Sex	Age	House	Work	Main health conditions*	Current benefit situation
Tony	M	40	Private rent (housing benefit), alone.	Manual jobs as a teenager, black market jobs on & off since.	Lasting physical health conditions as a result of drug use; & depression.	Incapacity Benefit (IB) for 10 years; JSA for 5 years prior to IB.
Dave	M	39	Owned with mortgage, with partner.	Continuously employed/self-employed to age 31, mainly in retail.	An autoimmune disease.	IB for 8 years.
Joe	M	59	Local Authority (LA) rent, with partner.	Mainly employed to age 57, mainly security guard work.	Cancer.	Employment & Support Allowance (ESA) support group for 1 year.
Archie	M	29	LA rent, alone.	Mainly employed/self-employed up to age 21, as an artist.	Severe (diagnosed) & persistent mental illness.	IB for 8 years.
Vincent	M	45	LA rent, alone	In & out of employment in manual jobs up to age 40.	Depression, leg & shoulder injuries.	IB for 4 years.
Jenny	F	56	Owned with mortgage, with partner.	Mainly employed part-time, care worker, up to age 54.	Cancer & depression.	IB/ESA (she was not sure which) for 1 year.
Alex	M	40	Owned with mortgage, with partner & young children.	Employed as a manager trainer in retail (professional), up to age 37.	Injury causing cognitive problems; & depression.	ESA support group for 2 years.
Jacqui	F	54	LA rent, with adult children.	Not much employment experience, currently a cleaner 4 hours per week (permitted work).	Depression.	IB for approx 10 years.

Participant	Sex	Age	House	Work	Main health conditions*	Current benefit situation
Michelle	F	37	Private rent (housing benefit), alone.	Not much employment, but some as an administrator (as a teen).	Drug addiction, leg injury and depression/psychosis.	IB for >5 years.
Steve	M	59	Private rent (housing benefit), alone.	In & out of manual work up to age 57.	Heart problems following a heart attack.	Jobseeker's Allowance for <1 year having transferred from IB.
Karen	F	54	LA rent, alone.	Mainly employed (mostly in retail), but with periods OWIH.	Depression.	Income Support for approx 3 years.
Sean	M	43	LA rent, alone.	Only employed when age <19.	Drug addiction, physical conditions related to drug use, diabetes, ('head not right').	IB for 22 years.
Andy	M	38	Homeless (living with brother).	Employed as a teenager & one 18 month period since then.	Drug addiction, physical condition related to drug use, ('not in such good health').	IB for 6 years.
Bernard	M	41	LA rent, alone.	Building trade; driver. Had short placement 2 years ago (through a work-support organisation).	Alcoholism (since age 21), shoulder & neck problems.	IB for 15 years.
Mark	M	38	LA rent (mother's house), with mother.	Employed/YTS for 2 years after school, none since then.	Depression, panic attacks & obsessive compulsive disorder.	Income support/IB for 20 years.
James	M	40	LA rent, alone.	Employed on & off (mainly in retail), but not since age 35.	Depression, drug addiction & back pain.	IB for 5 years.
Caroline	F	35	LA rent, with her 16 year old son.	Employed for one year after Youth Training Scheme (as a teenager).	Depression, drug addiction, diabetes & other physical problems.	Out of work health benefits for 17 years, but have currently been stopped following a medical.

* Specific health conditions not given to protect participants' identities.

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