Progressive Economics Group (PEG)
Policy Brief

Mental Health in the Social Security System

John Grahl
August 2018

Policy Issue

As the number of unemployed social security claimants has declined, the government's drive for reductions in the benefits bill has focussed increasingly on the chronic sick and the disabled. The government's aim is not to improve the well-being of these claimants but rather to classify as many of them as possible as fit for work and to push them into whatever jobs are available by cutting their benefits and, very frequently, imposing sanctions upon them. This strategy is backed up by a simplistic account of the mental health problems which, today, account for most sickness claims.

The key problem today is that mentally distressed claimants are being offered simplistic and ineffective remedies and are being pressurised by the social security system to seek employment of any kind, including in poor quality jobs which can aggravate their mental health conditions.

How should a progressive government respond to the plight of mentally distressed social security claimants?

Analysis

Over the last two decades mental health problems have become a key issue in social security policy. This is because, first, straightforward unemployment is much lower and state-provided unemployment indemnities are now a very small fraction of social security expenditures so that long-term illness and incapacity, which affect many more people, dominate in terms both of case-loads and spending. Second, long-term illness itself now predominantly takes the form of mental distress, with anxiety and depression more frequent than the physiological problems, such as back pain, which used to account for most sickness-related social security claims.

In Britain and in many other advanced economies social security claims related to illness increased rapidly in the wake of the deindustrialisation of the 1980s. One can trace these increases to labour market conditions and interpret them as a form of disguised unemployment in that they would not have been as severe if labour markets for industrial workers had remained buoyant. The geography of sickness benefits confirms the interpretation: For example, Merthyr Tydfil, devastated by the decline in Welsh heavy industry, was a notorious sickness benefit black spot.

In the 1980s policy-makers tended to accept the increased sickness benefit bill as the lesser of two evils, as preferable to much higher levels of open unemployment and as providing a certain compensation to some of the most vulnerable victims of structural change. However, as high numbers of sickness claims persisted and began to affect more recent generations governments became less passive and started to search for ways to limit the problem. One sign of this switch

was a reformulation of labour market objectives: an increase in employment rates was seen as a better target than a reduction in unemployment as such in that high rates of inactivity (either through sickness or for other reasons) were now seen as in general undesirable. Women were adversely affected by this shift because, in the drive to maximise employment, social security systems became much less supportive of women claimants who were full-time mothers and housewives. From the 1990s on, governments also started to make less use of early retirement as a palliative for long-term unemployment.

These changes should not disguise the continuity both in labour market conditions and in the nature of incapacity. There is certainly an alarming rise in mental health problems across western countries but the musculoskeletal disorders which prevailed in the past were not necessarily a completely distinct phenomenon: in an economy where most jobs were manual they could act as a sickness-induced disqualification from employment in general; in today's service-dominated economy psychological malfunctions can, in a similar way, indicate an inability to meet the typical constraints of existing labour market conditions.

Thus the changing forms of sickness in no way undermine the notion of "disguised unemployment" or, in less tendentious terms, adverse labour market conditions, as a principal source of incapacity. Recent British policy, however, completely inverts this widely accepted causal relationship: current policy is based on the view that the labour market is not the cause of, but rather the remedy for, sickness-related inactivity. This view has led to the imposition of policies towards claimants which needlessly aggravate their distress while leaving untouched the labour market structures and practices which actually disqualify so many people from employment.

Two main developments have led to the policy impasse: the degeneration of the universal credit (UC) social security reforms and the drive within the NHS to address mental health problems through "Improved Access to Psychiatric Therapies" (IAPT).

The original objectives of the UC reforms were to simplify the benefit system, by bringing together six of the most important benefits under a single means-test, and consequently to strengthen employment incentives by reducing the rate at which benefits were withdrawn as claimants re-entered employment or took on more hours of paid work. Because these goals were seen as moving social security in the right direction, UC was widely welcomed by both researchers and organisations concerned with poverty, such as the Joseph Rowntree Foundation and the Child Poverty Action Group.

Gradually the welcome gave way to critical concern. After the election of 2015 the Conservative government stated its intention to reduce expenditures on working-age social security benefits by £12 billion, more than 10%, that is, to claw back some £12 billion per annum from the three largest claimant groups, the unemployed, the chronic sick and the low-paid. It is an indication of social attitudes towards social security claimants, even though many are in employment, that the Labour opposition did not at that time condemn these cuts but decided to abstain when they were debated in Parliament, though some, including many now in leadership positions in Labour, did vote against them.

While positive incentives to seek and retain employment were reduced, an increasingly harsh and oppressive treatment of claimants was substituted. The conditions for benefit payments were tightened continually, while breaches of these conditions were increasingly met with frequent and severe sanctions. Claimants with health problems were subjected to repeated

assessments of their capacity to work – often crudely administered by unqualified staff in the service of revenue-hungry corporations. It was clearly intended to re-designate as many sickness-related claimants as possible as actually or potentially fit for work.

Unemployed claimants had to sign contracts committing them to often futile hours of job search and to participation in often badly-designed "work experience" and training schemes – both of these outsourced to corporations more concerned with profit than either high quality services or accurate reporting of their own performance. The explosion in the numbers resorting to food banks and the arbitrary benefit reductions following from the "bedroom tax" (the so-called "spare room subsidy" removal) can both stand as emblems of the increased pressures on claimants.

Meanwhile, actual conditions on the labour markets towards which claimants were being impelled continued to deteriorate in terms of both wage rates and job security. Indeed the increasingly harsh regime imposed on those without employment may be leading people to accept worse pay and conditions rather than become claimants. The roll-out of UC in place of previous benefits became in itself a source of concern as new and renewed claims now attracted substantially lower levels of benefit.

Now the epidemic of mental distress became ever more central to the drive for social security spending cuts since, with falling rates of open unemployment, Employment and Support Allowance (ESA) and the corresponding sickness-related benefits under UC became a key item in social security spending and, at the same time, mental health problems increasingly predominated in these claims. The resulting policy difficulties could seem complex and intractable; they also called into question the punitive treatment of claimants which had in practice emerged from the UC reforms. If claimants are suffering from anxiety and/or depression it is hard to see how suspending their benefits can improve their situation and growing awareness of the severe consequences of sanctions – including suicides – may well have been a factor behind the unannounced but rapid and clearly policy-driven reduction in the use of sanctions after the peak they reached in 2014.

In this conjuncture the programme "Improving Access to Psychiatric Therapies" (IAPT) seemed to offer a silver bullet. Mental health problems could be easily overcome because:

1. They were individual and not socio-economic in origin (after all, there are lots of people who cope);
2. Thus the undeniable correlation between mental distress and socio-economic disadvantage should be interpreted as showing that mental health problems lead to disadvantage and not the other way round (the social security agenda does not require structural change in the sphere of employment);
3. Most psychological problems can be easily dealt with by brief "talking therapies";
4. The essence of such "behavioural therapy" is not to improve the socio-economic situation of the sufferer but simply to alter their patterns of thought so that they cease to dwell on alarming or depressing features of their experience and so that they become – such is the hope – more likely to seek or retain employment;
5. No great level of skill or knowledge is required to administer such therapy;
6. Thus it can be provided cheaply;
7. There will be a big pay-off in terms of employment and fewer claims for benefit since employment as such promotes psychological well-being and mental health.

One sign that this approach was completely unrealistic has been the failure to deal with many cases of depression and anxiety among claimants at the level of the least qualified mental health workers – the only group of workers in the field who have seen recruitment increase. Nor has the rolling out of IAPT led to any fall in the incidence of mental illness nor any slowdown in the increasing prescription of psychotropic drugs in response to it.

Policy Framework

There is mounting evidence that current policies are aggravating the material and mental problems of many of the most vulnerable social security claimants. Social security reforms in the future must take fully into account their impact on mental health.

A complete refocus of policy on the well-being of the long-term sick and disabled is needed in the context of strategies which address the socio-economic determinants of poor mental health. Meanwhile, resources could be released by curtailing the frequently dysfunctional "assessments" and "work preparation" programmes to which mentally disturbed claimants are subjected, and by ceasing to contest large numbers of perfectly valid claims for sickness benefits.

John Grahl is Emeritus Professor of European Economics at Middlesex University.