The Norfolk Condition Management Programme: A retrospective evaluation

By

Stephen Roberts

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University of East Anglia

School of Education and Lifelong Learning

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Abstract

This thesis is an evaluation of the Norfolk Condition Management Programme (CMP). The CMP was the health-related component of Pathways to Work, the last Labour government's flagship welfare to work initiative. The programme delivered condition-specific health advice for Incapacity Benefit claimants with mild to moderate mental health problems.

This theory-driven evaluation identifies an explicit programme logic based on seven stages: problem conception, programme concept, programme theory, implementation theory, programme delivery programme outputs and programme outcomes. Using quantitative and qualitative data (see below), the study identifies where CMP delivery deviated from explicit programme logic and the impact of this deviation on the effectiveness of the programme. The study found that the programme yielded positive clinical outcomes but failed to translate these into desired programme outcomes (participants relinquishing benefits and seeking work).

Quantitative data were obtained from Hospital Anxiety and Depressions Score, Occupational Self-Assessment, Work Confidence Questionnaire and predicted return to work timescale. Qualitative data were collected through exit and follow-up interviews with patients and practitioners. Interview transcripts were coded using Interpretative Phenomenological Analysis. This method identified causal mechanisms for change (or non-change) that were not stated explicitly by participants.

Case studies revealed unique formulations of factors maintaining each participant's incapacity. HADS data indicated a weak association between health status and returning to work. Other measures, including increased confidence in ability to **obtain** work, revealed a stronger relationship. Health-specific advice could be regarded as helpful but only when accompanied by a *decision* to seek work.

Delivery of CMP sometimes deviated from explicit programme theory to reflect the interests and needs of group members. This appeared to encourage expression of participants' experiences of receiving Incapacity Benefit. Group dynamics were seen to encourage reappraisal of benefit status and re-consideration of a decision to relinquish or remain on incapacity benefits.

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Preface – The Norfolk Condition Management Programme: A retrospective evaluation

The cost of incapacity

2.45 million UK citizens currently claim incapacity benefits (DWP, February 2017) resulting in a direct cost to the taxpayer of around £16 billion each year (NAU, 2016). In contrast with unemployment rates, which fluctuated according to the economic cycle, sickness-related workless-ness increased steadily throughout the seventies, eighties and early nineties and has remained static since the mid nineteen-nineties (McInnes, 2012; Portes, 2012). The number of incapacity claimants rose from 750,000 in 1979 to 2.7 million in 2005 (DWP, 2006). By 2006, when the Condition Management Programme was implemented nationwide, the cost of administering incapacity benefits was £12.5bn compared to £2.5bn for jobseeker's allowance (DWP, 2007).

The costs of sickness and incapacity are not restricted to benefit transfers and their administration. NHS treatment of working age people who are sick is estimated at £5-11 billion per year (Black, 2008). Lost tax revenues (estimated at £26-36 billion) contribute to an overall cost to the taxpayer of £62-76 billion each year (Black, 2008).

There are further costs to the economy. Employers face lower productivity and the costs of downtime, staff turnover, recruitment and retraining. The cost of lost production and provision of informal care for the sick and disabled is estimated at a further £103-129 billion per year (ibid).

It is not only governments who have an interest in understanding incapacity and its remedies. Incapacity has wider social and cultural impacts. For the claimant, non-employment results in increases in stress and somatic symptoms (Baum, Fleming and Reddy, 1986; Ezzy 1993). Loss of self-worth affects individuals' standing in the community as well as the esteem of claimants' families (Black, 2008). Reduced income can lock families into a cycle of poor health behaviours (Burton and Waddell, 2006; Black, 2008).

Successive governments have sought to reduce claimant numbers and ease welfare expenditure through policy initiatives and welfare to work programmes. Despite considerable investment in such programmes, there remains insufficient understanding of claimants' reactions to them (Purdie and Kellett, 2015). Moreover, when these programmes do not achieve demanding targets, the cost if the failed initiatives add to the overall cost burden of incapacity.

In 2006, the Department for Work and Pensions set out its objective to reduce the number of Incapacity Benefit claimants by one million within ten years. At the time claimants numbered 2.76 million. The 2007 Welfare Reform Act heralded the replacement of Incapacity Benefit with Employment and Support Allowance and the introduction of a new regime of medical assessments (Work Capability Assessment). Alongside this, New Labour's flagship welfare to work programme, Pathways to Work, offered claimants a package of support including a (one-year) £40 per week return to work incentive and the Condition Management Programme (CMP), a health-focused initiative intended to help claimants manage their health condition at work rather than remain on sickness benefit. Three main health areas were addressed: muscular-skeletal, cardio-vascular and, most frequently, common mental health problems.

This study appraises the impact and value of the Condition Management Programme which ran in Norfolk between 2008 and 2011. It will be of use to the policy making community, to designers and providers of welfare to work initiatives and to practitioners working on current and future health-based, welfare to work programmes. The people *most* affected by incapacity are the claimants themselves. It is hoped that the findings of this study will assist in improving the likelihood of returning to work for claimants while providing a better understanding of recommendations for effective support to those for whom work remains an unlikely outcome.

Despite optimism following pilot programmes, Pathways and CMP were a conspicuous failure. The National Audit Office (2010) stated:

> "Apart from the possible contribution of obligatory work focused interviews…there is no evidence that new claimants accessing other elements of Pathways support, at an estimated cost of £94 million in 2008-09, were more likely to find sustainable employment as a result" (p.12).

Of the fall in claimants between 2005 and 2009 (125,000), 80 per cent of the reduction was attributed to early medical assessment rather than Pathways. Claimant numbers increased from 2.59 million to 2.63 million in the twelve months from August 2008. NAU concluded:

> "…jobs achieved through *mandatory* participation in Pathways would have been achieved without the programme… The *voluntary* aspects of support offered through Pathways (including the Condition Management Programme and the Return-to-Work Credit) appear to have no additional employment impact" (p.9).

As stated above, the government hoped to reduce the number of Incapacity Benefit claimants by one million from the existing figure of 2.76 million within ten years (DWP, 2006). When the programme ended in 2011, the claimant total had fallen, modestly, to 2.61 million (McInnes, 2012). The National Audit Office (2010) criticised Pathways to Work and, particularly, the Condition Management Programme for failing to make a greater impact on claimant movements off incapacity benefits.

The importance of this evaluation lies in the fact that, given the annual cost of sickness benefits (£12.6 billion per year at the time of CMP) and the consistent failure of the claimant count to drop, welfare to work programmes will continue to be offered despite the cost and limited certainty of success. Given the distress created by workless-ness (as attested in the literature and by participants in this study) it is incumbent on the policy making community to continue seeking effective solutions to it. This obliges us to learn from recent initiatives (Garthwaite, 2014).

Many CMP evaluations have been sponsored by the Department for Work and Pensions (described in Chapter 1). These have a mainly descriptive emphasis, focusing on delivery and participants' reactions. Their usefulness is restricted to a narrow focus on the outcomes related to the explicit programme concept: changes in health-related behaviour. Specifically, these evaluations did not examine the programme content in detail or relate it to the problem of incapacity as understood by policy makers. There is a paucity of independent (non-DWP-sponsored) evaluation data on CMP. DWP-sponsored research reports into CMP focused mainly on the pilot programmes of 2002-3. These were not representative of the large-scale Pathways provision offered from 2008 nor did they give clear explanation of the mechanisms for change leading to desired outcomes. There is therefore, space for a comprehensive study of CMP, which evaluates the programme in the context of the causes of incapacity, the appropriateness of the design and goals of the programme and long-term effects on participants.

This small scale, retrospective evaluation focuses on the design, delivery and impacts of CMP in Norfolk between March 2008 and March 2011. To establish its effects and to provide explanations for them, it draws on policy documentation, clinical outcomes, customer survey data and participant and practitioner testimonies both at the time of implementation and up to four years later. Unlike previous studies, this evaluation traces the evolution of the programme from broad policy through each stage from problem conception, programme design to implementation and analysis of immediate and long term impacts.

Given that no programmes entirely succeed or fail (Pawson and Tilley, 2007) it is important to identify which aspects of an intervention were helpful, who they helped and the reasons why. This analysis provides an intimate understanding of CMP's participants and the varying effects the programme had on them. It presents robust explanations for these effects which are relevant to current and future health-based programmes. Ultimately, it is individual claimants who move from welfare into work. This study adds to the literature on CMP by penetrating the mechanisms for personal change described by the programme's participants.

This evaluation is not sponsored by any agency with an interest in CMP or similar initiatives. Given the tax burden associated with incapacity, the public has a right to know how effectively such programmes are managed (Black, 2008). The pluralistic focus of this study explores CMP from the perspectives of participants, practitioners and the policy making community without favour to any of these groups. Whilst this thesis cannot be described as a *Democratic Evaluation* (since it differs from this type of evaluation in its design and data gathering processes) it seeks to uphold a significant value of this approach through a belief in the public's 'right to know' and looks to stimulate discussion on policy. It borrows from democratic evaluation in this respect.

This introduction will now outline the development of this study and the structure for the thesis. It begins with a brief disclosure of the author's personal interest in employment and role in the Norfolk CMP.

Background to the study

Prior to involvement with CMP, I was worked as a therapist in an addiction treatment centre and in primary mental healthcare. I had no strong political views on welfare. However, my experience working in addiction (in which patient ambivalence was common), led me to believe that CMP participants might be similarly resistant to change. This view was founded on an assumption that ability to work was based on functional capability.

My contact with programme participants belied my original expectations. Participant's apparent loss of confidence and accounts of stigma and marginalisation indicated that incapacity was more complex than I had imagined and that re-employment was more than a matter of choice or ability to manage health. Secondly, I was responsible for the delivery of CMP in Norfolk. Delivering CMP successfully required a greater understanding of participants' problems and how the programme

could assist them. Desire to do my job well and pressure to make the programme effective, led me to question the key assumptions of the programme.

Direct quotations are used for different purposes throughout this thesis. Extracts from interview subject transcripts are included as part of the convention for interpretative phenomenological analysis. Interpretations should be demonstrated within specific passages (Smith and Osborne, 2004). In addition, they seek to deepen understanding of the findings and give 'voice' to the case study subject. In these situations, spoken words may convey the passion or, alternatively, indifference of the person's viewpoint in ways which the researcher's narrative may fail to portray adequately.

Direct quotations from academic and other sources are similarly used where the point being made is emphatic or evocative and paraphrasing would be bland by comparison. Some quotations are used for economy when a point has been made a succinct way that cannot be expressed more effectively. They are also used to illustrate alternative views within discursive analysis for example on the relative merits of experimental and theory-driven evaluations.

Initially, I did not see this undertaking as 'evaluation.' Influenced by training and experience in addiction and rehabilitation, my focus was on the meaning of employment and health and the psychological constructs of fear and avoidance at work. Had I considered this study as evaluation from the outset, I would have approached it differently. Specifically, I would have adopted a quasi-experimental design. For example, many CMP customers attended an assessment but chose not to progress to the main intervention. This group would have constituted a suitable counterfactual. As will be explained further, I had to rely heavily on naturally occurring data collected during the CMP process and supplement this with additional qualitative data collected during and after CMP provision. Consequently, this evaluation is a largely historical undertaking. Given the necessity to evaluate CMP retrospectively, I have used a theory-driven rather than an experimental design.

Role of the author as participant and observer.

The dual role of practitioner and researcher posed challenges and dilemmas. The first relates to the principle of beneficence in which the researcher is obliged to protect research subjects from potential harm. The second relates to the process of data gathering and analysis.

As practitioner, my role is to provide compassion, guidance, unconditional positive regard and respect for dignity of the client. I am positioned to help them. Where I am the researcher and the

research subject attends an interview, the roles are reversed. They are present to help with the study whilst I observe, question and explore with a potentially sceptical or critical eye. However, the interview subject may have quite different expectations of the relationship which, if dealt with insensitively, could cause harm. The practitioner-researcher holds the dual role of maintaining care for the client and the integrity of the research (Judkins-Cohn et al, 2014). Risk of harm was minimised by providing the research subject clear information on the purpose and benefits of the research, the potential causes of harm and useful advice regarding what to do and who to contact in the event of distress. Advisory information provided in advance of each interview indicated the distinction between research and therapy to avoid potential for misinterpretation.

It was essential that research subjects gave informed consent. This was done by providing detailed information in advance of the interviews (appendices 2-4). If they felt obliged to participate, this could result in skewed or uninformed data. The interviewees had previously been participants on CMP events that I had delivered. This may have influenced their responses to my interview questions to be 'positive' or avoid giving offence. For this reason, refusal to participate needed to be a genuine option with no adverse consequences (Homan, 1991).

As practitioner and manager, the desire to obtain 'good' clinical and 'return to work' outcomes could have led to alterations to programme delivery with potential to alter the nature of the 'treatment.' Chapter 6 explores how the programme did, in fact, evolve in this manner. Interviews with other clinicians indicated that they also delivered the programme inconsistently. The evaluation framework allowed for alterations to the delivery method to be regarded as data itself. As manager and lead clinician for the Norfolk CMP, there was potential to influence the style and direction of delivery which could similarly shape clinicians' responses to interview questions.

Overview of thesis chapters

Chapter 1 charts the growth in claimant numbers and explores how welfare to work came to be the government's primary policy response.   The increase in claimant numbers is discussed in the context of previous failed policy measures and the impact of globalisation. Provision of psychological assistance for incapacity claimants was based on a belief that large-scale social programmes could help solve the problem of 2.7 million incapacity claimants. Alternative views on incapacity, notably the notion of 'hidden unemployment' suggest that this programme conception may not have been appropriate for all claimants. Outcome data from CMPs are discussed in this chapter. In spite of promising qualitative research into pilot CMP programmes, numbers of those who returned to work

were lower than predicted. In light of this, Chapter 1 queries the rationale for offering a welfare to work programme to all claimants.

Contemporary evaluations of CMP focused on two key areas; the impact of CMP on participants' beliefs and behaviour and clinical outcomes (Corden and Nice, 2006; Pittam et al, 2008; Ford, 2008; Warrener et al, 2009). To a lesser degree, they also examined return to work outcomes (Ford and Plowright, 2009; Kellet et al, 2010). A weakness of these studies is that they did not relate changes in beliefs and behaviours associated to the problem conception of incapacity as outlined by Smith (2003). As such, increased self-belief and confidence might have appeared to represent a worthwhile impact of CMP. However, examined in isolation from a wider programme logic (which took the problem conception as the beginning pf the programme cycle) meant that is was not possible to establish whether 'increased' confidence was a relevant factor in encouraging return to work.

This study differs in two significant ways. Firstly, it is an evaluation of *provider-led* CMP. The pilot programmes were experimental but they were judged to have been successful enough to justify nationwide implementation through DWP and NHS. Provider-led delivery marked further trust in the programme theory by inviting independent and third-sector organisations to bud for Pathways and CMP delivery. At this stage of delivery, programme and implementation theory was well established. Secondly, this evaluation establishes the merit and worth of the entire programme logic in relation to the problem of increased claimant numbers. As such, it looks beyond clinical outcomes and qualitative evidence of improved functioning and whether, firstly, improvements were attributable to programme theory and, secondly, whether the improvements were relevant to the causes of individuals' ongoing incapacity.

This thesis presents a new way of looking at welfare to work programmes. A seven stage, circular model of programme development is presented in Chapter 2. It describes how strands of logic can be traced from problem conception through to programme concept, design and theory, delivery, outputs and outcomes. This chapter asserts that social programmes must be based on a sound understanding of the problem itself and then follow a logical chain of related objectives (programme concept), activities (interventions), outputs (short term effects) and outcomes (long term effects). Each step must follow logically from the preceding one and be based, as far as possible, on extant evidence. The model forms the basis of this evaluation which traces the consistency of CMP's chain of logic through its development, delivery and results. Evaluation designs relevant and appropriate

to CMP and the rationale for the theory-driven approach which this study adopted are discussed. The chapter outlines the theoretical frameworks relevant to the study of incapacity claimants. It explains the foundations of Interpretative Phenomenological Analysis (IPA) and the rationale for its use with case studies.

Viewed in its entirety, these stages describe an overall *programme logic.* This study tests the programme logic by examining each stage in detail and identifying where certain stages deviated from the overall logic resulting in loss of fidelity and explores the impact of this on the effectiveness of the programme.

Figure (0.1) charts the programme's evolution from understanding the problem of incapacity claiming through programme design and delivery and finishing with evaluation of the programme's impact.
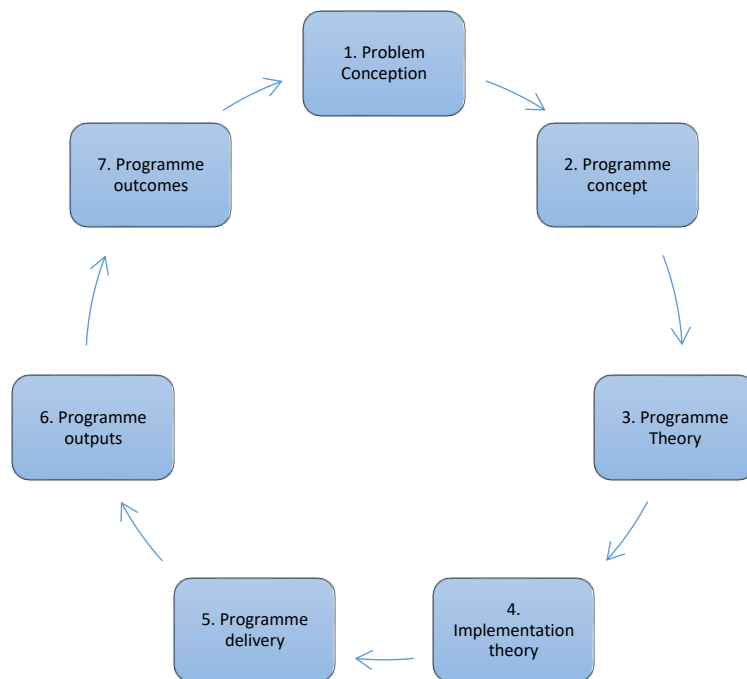
Fig 0.1: Cycle of Programme Logic for Norfolk CMP.

Chapters 3 to 7 follow the evaluation design outlined in Chapter 2 and present analyses of CMP design and delivery in line with the development stages described. Chapter 3 explores the problem concept and the meaning of the term 'problem' to different stakeholders. It examines how the prevailing political agenda shaped policy and summarises the social research drawn on by policy makers. It then summarises New Labour's conception of the problem of 2.79 million incapacity

claimants as outlined in 'Pathways to work: Helping people into employment' (Smith, 2002) which described social, economic and psychological factors influencing claimants' moves from drawing incapacity benefits to job seeking. These are consistent with findings from field research undertaken in this study.

Chapters 4 and 5 analyse in detail the CMP content and other relevant sources to infer the programme's concept and theory (desired change-goals) and implementation theory (realistic means of achieving these goals) and contrasts these with the problem concept described in Chapter 3. The inferred programme concept is a health based intervention aimed at improving participants' ability to manage health and return to work (programme theory) which primarily used the principles of group based cognitive behavioural therapy (implementation theory). The concept and theory of CMP is seen to be inconsistent with the problem concept outlined in Chapter 3 because of an over-emphasis on health management and lack of attention to social, economic and psychological factors influencing claimants' decision making. Chapter 5 describes the replacement of the CMP with the 'CMP Express.' The changes were made in response to lower than expected employment outcomes and to the testimonials of participants. Both may be seen as descriptors of the problem concept. As such the programme development can be seen as a natural realignment of the development stages proposed in Chapter 3 to form a consistent chain of logic.

Chapter 6 presents a detailed account of CMP as implemented in Norfolk. The IPA qualitative method is used to analyse transcripts of interviews with programme practitioners. Findings from this research, alongside the author's own account of CMP delivery are summarised and discussed. An emerging overall theme from this analysis is of practitioners deviating from explicit problem conception and programme theory and developing their own formulations. This occurs via an interactive and responsive approach to programme participants and a realisation of the power of group processes within CMP.

Chapter 7 discusses the immediate effects of CMP in Norfolk. Outputs are described as the immediate impacts of attendance on CMP. The CMP concept anticipated that these would include improvements in health and corresponding increase in confidence so that work would be possible. Clinical outcome data and other 'soft outcomes' are presented and their impact established. Participant feedback data and testimonies taken from recorded programme completion interviews provide further evidence of specific behaviour change following participation. Little evidence is found for anticipated outputs in line with programme theory but unintended effects were noted

including participants re-enforcing their belief that ill health (as well as social, economic and psychological factors) impeded their employment prospects. It was observed that during CMP attendance, participants re-evaluated their situations (as claimants) and made decisions whether or not to use the programme as a springboard for job seeking. This phenomenon is consistent with knowledge from evaluation data discussed in chapter 1.

Chapter 8 presents six participant case studies. The sample represents three people who returned to employment and three who did not. Each group includes one participant who improved clinically, one who did not and another whose clinical outcome measures indicated no mental illness either before or after CMP. Each case study provides a biography of the participant before and after programme attendance and describes the impact of CMP on them. Interviews were conducted up to four years after attendance and allow for CMP to be seen in the wider contexts of participants' lives. IPA methodology was used to analyse the interviews. The resulting themes are explored and described here as the individual's *formulation of incapacity*. This is a description of the many factors that combined to result in the person claiming incapacity benefits. Each formulation of incapacity includes health problems but also reveals social and personal factors influencing the trajectory of initial illness, benefit claim, use of CMP and subsequent employment stories. Conclusions are presented in Chapter 9.

Acknowledgement

List of abbreviations

BACP   British Association for Counselling and Psychotherapy
BMJ   British Medical Journal
CBT   Cognitive Behavioural Therapy
CMP   Condition Management Programme
DLA   Disability Living Allowance
DWA   Disability Working Allowance
DWP   Department for Work and Pensions
ESA   Employment and Support Allowance
HADS   Hospital Anxiety and Depression Score
IB   Incapacity Benefit
IPA   Interpretative Phenomenological Analysis
IS   Income Support
IVB   Invalidity Benefit
IBPA   Incapacity Benefit Personal Advisor
JSA   Jobseeker's Allowance
MHC   Mental health condition
NAU   National Audit Office
OSA   Occupational Self-Assessment
PCA   Personal Capability Assessment
PtW   Pathways to Work
PW   Permitted work (previously 'therapeutic work')
RTWC   Return to Work Credit
WCA   Work Capability Assessment (replaced PCA)
WCQ   Work Confidence Questionnaire
WFI   Work Focused Interview
WP   The Work Programme

The term Incapacity Benefit (IB) refers to the specific health benefit for non-employed persons who were deemed unable to work due to a health condition. This benefit was introduced in 1995 and phased out from 2008 when it was replaced by Employment and Support Allowance (ESA).

The term incapacity benefit(s) refers to all income replacement schemes for persons not employed because of health conditions including IVB, IB and ESA.

Chapter 1 – Incapacity, Welfare to Work and the Condition Management Programme

This chapter examines the emergence of the Condition Management Programme in the context of increasing incapacity claimant numbers and associated policy reform. It charts the growth in claimant numbers throughout the seventies, eighties and nineties and the responses of successive governments to the problem. This culminated in the adoption of *welfare to work* as the primary strategy for the management of sickness-related workless-ness. Before describing the launch of Pathways to Work and CMP, this chapter considers the government's broader welfare strategy in response to globalisation and how it shaped the development of CMP. It moves on to the launch of Pathways to work in 2002 and the Condition Management Programme pilots. This section describes the purpose and function of CMP and early findings from the pilot evaluations. The announcement, in 2006, of the expansion of Pathways to Work alongside the introduction of Employment and Support Allowance (replacing Incapacity Benefit) is discussed. Such expansion enabled *provider-led* delivery. This allowed independent and third sector organisations to deliver the service and sub-contract healthcare organisations to provide CMP. The CMP was delivered in Norfolk using this model. The evolution of the Norfolk CMP, which this study evaluates, is discussed. The chapter closes with a summary of welfare to work evaluation data.

Growth in incapacity benefit claims and government responses

The increase in incapacity claimants between the 1970s and mid 1990s is demonstrated in figure 1.1 below.
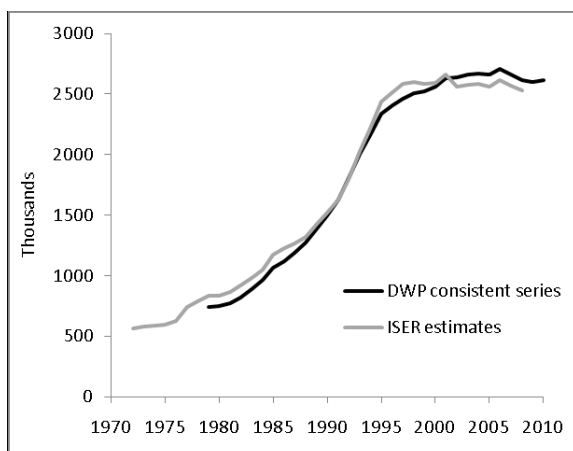
Fig 1.1 Number of working age claimants of benefits on grounds of incapacity for work, 1972-2010 (Source: Institute for Social and Economic Research, 2011)

Invalidity Benefit (IVB) was introduced in 1971. This assisted individuals who had been 'invalided out' of employment and was paid at a higher rate than basic unemployment benefit (Burchardt, 1999). Beforehand, all claimants of out of work benefits were treated the same regardless of health status (ibid). The number of IVB claimants tripled between 1975 and 1992. The main explaination was believed to be maturation of the benefit resulting in increased claims (Acheson, 1998) alongside failure of claimants to move back into work (Lonsdale et al, 1993; Rowlingson and Berthoud, 1996). IVB conditions did not require an objective medical test of incapacity to work (ibid). This, and its relative generous rate compared to unemployment benefit, was regarded as disincentive to leave the benefit. For the over-50s, average IVB payments were twice those of unemployment benefits (Waddell and Aylward, 2005). Incapacity Benefit replaced IVB in 1995. This was accompanied by the *All Work Test* which assessed claimants' ability to undertake any work (as opposed to their previous employment) (Burchardt, 1999).

In addition to the yearly increase in claimant numbers, it was noted that the longer individuals claimed incapacity benefit, the less likely they were to return to work (Bambra et al 2005). In May 2005, 74% of claimants had not worked for more than two years (DWP, 2006). It was noted that the growth in incapacity occurred during a period in which objective measures showed increases in health (Waddell and Aylward, 2010). The implication of this was an ill explored and complex relationship between health and ability to work.

Period of claim	% of claimants (May 2005)
8+ years	35
6-8 years	11
4-6 years	13
2-4 years	15
1-2 years	10
6-12 months	7
3-6 months	4
Under 3 months	5

Table 1.1 Period of incapacity claims (Source: DWP, 2006 p.26)

Discussion around sickness benefits has traditionally centred on the tension between moral hazard and the need for a safety net (Considine and O'Sullivan, 2014; Garthwaite, 2014). It has been argued that persistent lack of work *re-enforces* poverty (Murray, 1996) and that a culture of poverty has led people to cease expectation of work (Mead, 1997). It has been suggested that increased claimant numbers have weakened the social norms against living off benefit payments resulting in benefits being seen as a 'right' (Lindbeck (2004). Some commentators have objected to these arguments

(Handler and Hasenfeld, 2007; Field, 1997) whilst others have acknowledged both the good of providing a safety net and the potential for 'safety' to transform into 'rights' (Lindbeck, 2004; Lechmann and Schnabel, 2013).

Government policy in the 1980s responded to the moral 'deserving versus undeserving' argument by keeping benefit payments modest, tightening rules on eligibility and by use of sanctions (Golsch, 2006; Considine, 2001). However, whilst unemployment fell, incapacity claimant numbers remained static. Conservative 'Next Steps' policy began the process of 'managerialising' the problem through the separation of employment services from the civil service (Considine, 2001). The effect of this will be discussed later in this chapter.

New Labour's response to increasing Incapacity Benefit claiming can be outlined in three phases: from 1997, a continuation of Conservative employment policy; from 1999, the creation of the infrastructure for welfare to work through the New Deals legislation and finally, from 2002, the introduction and subsequent expansion of Pathways to Work. Early New Labour legislation focused on re-skilling through the 'new deals,' (Golsch, 2006). The 'New Contract for Welfare' (DfEE, 1998) reforms marked the creation of the infrastructure necessary for increased engagement with the benefit claimant population in what became increasingly termed 'welfare to work.' Claimant activation was introduced under the banner of 'work for those who can, security for those who cannot' (DSS, 1999). Planned reduction in the scale of incapacity benefit claiming was incorporated within wider policy reform which sought to be proactive in helping people into work, make work pay, ensure people had the skills and education to respond to the modern labour market and support those most vulnerable to discrimination and disadvantage (DSS, 1999).

Incapacity Benefit was the main focus of the 'proactive' welfare system due to a four-fold increase in real term cost since 1974 and growing perception that it was subsidising unemployment and early retirement (Burchardt, 1999). It was addressed by introducing limited means testing and continued testing of ability to work with increased emphasis on what work could be undertaken (Stanley, 2004). The New Deal for Disabled People (1998) also required benefit claimants to commence face to face contact with advisers in the form of 'work focused interviews' (WFI). Increased intervention of this nature required new ways of administering leading to the creation of JobCentre Plus in October 2001 with implementation nationally over the subsequent six years (Riley et al, 2011).

The result was substantial job growth coupled with increased job insecurity and the polarization of work-rich and work-poor households (Golsch, 2006). Golsch argues that flexibility and de-regulation alongside weak employment protection made it became easier both to lose employment and to *gain* it. The effect of this instability on individuals, however, may be shielded by level of educational qualification, career maturity i.e. life and work experience and other 'individual characteristics' (ibid). The segment of the working population known to be least protected, in these terms, were those on incapacity benefit (Lonsdale et al, 1993; Errens and Ghate, 1993; Rowlingson & Berthoud, 1996) who were characterised by poorer qualifications and low employability. Regardless of discourse over entitlement and perverse effects of state paternalism (Considine and O'Sullivan, 2014) and ongoing policy reform, incapacity rates continued to rise between 1990 and 2000.

Welfare to work and the 'responsibilisation' of claimants

Welfare to work has emerged as the foremost strategy for welfare provision since the 1990s. It has been described as the government's reaction to the conflicting demand for a protectionist welfare policy in the context of a globalised economy (Walker and Wiseman, 2005). The central tenet of 'welfare to work' is that governments are no-longer able to sustain the cost of long term workless-ness and that state support must be accompanied with increased individual responsibility. This section describes how globalisation has transformed the experience of work and brought about a culture of 'managerialism' within public service administration. This has made the *deserving versus undeserving* conception of incapacity partly redundant. It is argued that globalisation, and government responses to it, have brought about new pressures on the non-employed which have been expressed in programmes such as CMP.

Rather than being regarded, only as a remedy for incapacity claiming, Pathways to Work may be seen as a manifestation of the government's overarching policy response to the *wider* problem of welfare provision. This response has been described as 'responsibilisation' of the public (Considine, 2001). This strategy was driven by the failure of previous policies to reduce incapacity claimant numbers and the impact of globalisation. The implication of this is that the government's foremost intention was to run a programme aimed at reassigning responsibility for benefit claiming away from central government and into the hands of claimants and employment service providers. This has repercussions for the underpinning concept of CMP as well as the stages of development, delivery and measurement that followed. The effect of these influences on CMP provides insight into the possible reasons for its disappointing impact.

Globalization has been described as a pressure towards homogenization resulting from technological and economic developments of global scope, the information revolution, global economic competition and the tendency to look beyond geographical boundaries for solutions to problems (Stoker, 2000). It has profoundly changed the job prospects for working age people, particularly those previously employed in heavy industry (Fothergill, 1997).

New Labour inherited the problem of increased claimant numbers after previous policy measures had resulted only in a steady increase in benefit recipients. The problem was seen as too large (or politically risky) for the government to solve on its own. This led to an overall policy of *steering* rather than directing change (Stoker, 2000). Globalization affected benefit recipients in three ways. Firstly, it changed the nature of the work to which claimants contemplated returning. Secondly, it influenced how government agencies operated, encouraging new ways of working with the non-employed. Finally, it created economic imperatives on governments to reduce the claimant numbers (Castles, 2004).

Some claimants may have been aware of the changing nature of employers' expectations prior to becoming out of work. Others may have become aware of the need for soft skills whilst searching for work and reading job descriptions. Such skills are described in figure 1.2 below. The changing requirements of employers impacted significantly on the employment prospects of incapacity claimants, particularly those who had been employed for long periods in industries where soft skills were not required. The decline of the 'job for life' has been well documented (Capelli et al, 1997; Ostrey and Spiegel, 2004). In order to find employment, individuals are increasingly required to be enterprising, to market themselves, to organise and funding 'continuing professional development,' and to be team-workers, co-creators and net-workers rather than simply workers. It is likely that radically transformed expectations of employers had a direct impact on the consciousness of IB claimants.

Golsch (2006) writes:

> "The globalization process is likely to affect labour market careers but also people's psychological wellbeing, perceptions and expectations about their labour market career and social life" (p.306).

Globalization impacted on the government's ability to manage the cost of welfare provision which indirectly affected benefit claimants. The costs associated with welfare provision included macro-economic impacts as well as the direct financial outlay of the benefits themselves. International

trade required increasing cost competitiveness which, in turn, demanded lower production costs (the most significant being wages). Wages could be managed down by limiting taxation but this placed pressure on state expenditure including welfare benefits (Castles, 2004). Compounding this problem, more generous welfare payments were seen to cause an upward pressure on wages. In addition, it was feared that international capital flows resulting from globalisation might result in capital flight in economies where welfare payments were regarded as overly generous (ibid).

Employers want the people they employ to:

1. *Have good written and verbal communication skills*
2. *Be honest and have integrity*
3. *Have good team-working skills*
4. *Have good inter-personal skills*
5. *Be highly motivated and show initiative*
6. *Have a strong work ethic*
7. *Have good analytical skills*
8. *Be flexible and adaptable in work*
9. *Have good IT skills*
10. *Have good organisational skills*

Figure 1.2 Example of how employers' expectations of job hunters. Source – Connexions website (accessed 21 January 2014)

Alongside pressures to limit welfare expenditure, the government faced increasing liabilities of an aging population with accompanying pension and healthcare costs. Increasingly, 'out of work' benefits were squeezed by these conflicting demands and became a target for savings.

Since the 1980s, the increasingly globalised economy has stimulated a respective managerial response from government (Considine, 2001; Du Gay, 2007; Le Grand & Bartlett, 1993). Considine (2001) describes how the UK government has transformed from a procedural deliverer of 'benefit services', through stages of target-driven corporate style management and attempts to generate quasi-markets before settling on a blend of corporate-network governance. In this model, the government sets targets for re-employment of claimants, then places the process of delivery out to tender. The capacity of government agencies to affect change is not intrinsic to them but to their ability to activate people and markets (Du Gay, 2007). With network governance, the sum of the parts (government ministries, government agencies, third and private sector service providers and the public) is thought to be greater than the whole.

Considine (2001) outlined four components of enterprising states: increased use of performance monitoring and management science, entrepreneurialism (to generate innovation) and division of policy making and policy delivery through the separation of government *departments*, such as DWP, and *agencies*, such as the Benefits Agency. The final aspect of the 'enterprising state' was increased citizen responsibility. The latter could be seen as benign such as increasing 'consumer' sovereignty by offering choice of different services. However, it could, according to Considine, be more sinister;

> "Self-service is viewed as a means of activating or mobilising clients and thus reducing their dependency on government" (p.13).

Du Gay (2007) goes further to describe how, as a result of globalization, governments have lost the levers of economic management they once held and have been forced to turn to governance in order to 'steer rather than row' (p.165).

> "To govern better the state is to govern less but more 'entrepreneurially.' It is to
> mobilise 'society' so that society can play an enhanced role in solving problems
> that have come to be seen as the sole province of the state to manage. This
> requires the responsibilization and autonomization of a host of actants –
> individual and collective – as conditions of its effectiveness" (p.165).

Without a managerial approach and focus on activating individuals, welfare systems could be seen as potential causes of social and economic problems (Lindbeck, 2004; Lechmann & Schnabel, 2013). CMP could be seen as the inevitable outcome of the transition from ineffective top-down welfare provision to 'network-governed' solutions. The explicit purpose of CMP (described in detail below) was to offer claimants assistance to self-manage their health to enable a return to employment. However, a subtler purpose may have been to shift responsibility for incapacity and unemployment away from central government and into the hands of the state.

The social and political context when CMP was conceived placed pressure on the government to re-envision the nature of welfare provision. Through a mixture of global pressure and the inevitable move toward target-driven 'managerialism,' the government sought new means of managing the incapacity problem. The government, as budget holders for the unemployed, and claimants themselves, were symbiotically forced to modernise. The resulting effect on welfare to work proposals under New Labour is been shown to have had two main impacts. Firstly, it was to be

effective in reducing claimant numbers. Secondly, it needed to fit with the long-term aim of re-defining the nature of welfare by addressing the relationship between recipient/claimant and the state. The key to this, for central government, was to 'responsibilise' the claimants and to 'network-govern' service provision to independent providers. This underlying principle shaped the design of CMP as the programme was required to activate claimants rather than allow them to remain passive recipients of benefits. This was made possible by making them responsible for management of their health and wellbeing. This represented a new approach to the problem of rising incapacity claims which was established in Pathways to Work.

Pathways to Work: Helping people into employment

New Labour's strategy to address long term incapacity was unveiled by Rt Hon Andrew Smith, Secretary of State for Work and Pensions in the green paper *Pathways to Work: Helping People into Employment* (2002). In the initial consultation paper (Nov 2002) and response and action plan (June 2003), Smith outlined the requirement to build on the New Deals with further support for those with the potential to return to work. This entailed financial incentives, better support and ground breaking rehabilitation programmes.

> "Fundamental to our approach is the belief that many people on incapacity benefits
> need not be at the end of their working life but can be at the start of a working future"
> (p.1).

Pathways to Work's objective was to provide comprehensive, focused assistance to help claimants overcome difficulties described as *barriers to employment*. Participation involved six mandatory *work-focused* interviews (WFI) with a personal adviser who provided employment advice and support and an incentive scheme offering £40 per week for the first 12 months of employment (*NAU, 2010).* Finally, Pathways offered work-focused rehabilitation through the Condition Management Programme. Smith's paper, *Pathways to Work: Helping People into Employment* (2002) is important to this study as it presents policy maker's conception of the problem of incapacity claiming. This is discussed in detail in chapter 3. CMP itself was not launched nationwide until 2006 as discussed below.

Implementation of Pathways to Work and the Condition Management Programme

The CMP strand of Pathways to Work was described as a 'non-treatment' to differentiate it from standard, NHS-led, healthcare intervention (Ford and Plowright, 2009). However, it utilised healthcare interventions such as Cognitive Behavioural Therapy (CBT) which is commonly used in

treatment of mental health conditions. The purpose of CMP was to equip people psychologically to manage common health conditions, enabling return to employment.   The programme targeted cardiovascular, musculo-skeletal and, most commonly, mental health conditions. The CBT-driven mental health component was also seen as applicable to those with physical health conditions because psychological wellbeing influenced behavioural responses to physical health problems (Joyce et al, 2009). CMP was initially delivered by NHS practitioners, normally in non-clinical settings such as community centres.

CMP was designed to be a programme of 'innovative, non-treatment interventions' based on cognitive educational programmes and was developed jointly between DWP and NHS (Ford and Plowright, 2009).   DWP funded the pilots and was accountable for implementation whilst the NHS was responsible for delivery interventions and for publicity. Referral by an Incapacity Benefit Personal Advisor (IBPA), was followed by an initial assessment with a CMP practitioner within ten days. Responsibility for specific programme content and delivery was at the discretion of pilot sites recognising local demographics (Ford and Plowright, 2009). Specific content of the seven pilots varied but the key focus areas were:

- Activity and lifestyle: practical demonstration and educational input on exercise and healthy lifestyle.
- Symptom management: focusing heavily on anxiety and depression with further educational input on pain, fatigue and management of angina.
- Coping: Advice on self-care
- Return to work: Advice on management of health specifically in the context of the workplace

The CMP was trialled in Bridgend; Renfrewshire, Inverclyde, Argylle and Bute; Derbyshire from October 2003 and East Lancashire, Essex, Gateshead and Somerset from April 2004.

The pilots were regarded as an opportunity to examine ways in which economically inactive people could re-engage with work and pilot evaluation was led by Lancashire School of Health & Postgraduate Medicine, University of Central Lancashire with significant input from Anglia Ruskin University, Queen Margaret University College, Edinburgh, Centre for Psychosocial & Disability Research, Cardiff University, Northumbria University (Ford and Plowright, 2009).

The pilot programme evaluation adopted Realistic Evaluation Theory approach (Pawson and Tilley, 2007) using mixed methods obtaining data from site visits and interviews with staff and participants.

Qualitative data were collected in the form of the Work Confidence Questionnaire (WCQ) which asked participants to rate their confidence in four areas:

1. Ability to work
2. Ability to find work
3. Ability to manage health condition at work
4. Belief that health would not decline as a result of work

Quantitative data were collected using HAD scores (Hospital Anxiety and Depression Score) (Snaith, 2003) which were taken before and after the programme. Return to work rate was collated via participant self-report. The return to work outcomes were inconclusive, however, the pilots were found to increase confidence and coping skills which were associated with improved job-seeking behaviour (Ford and Plowright, 2009). Evaluation data from the pilot programmes is examined in greater detail in the final section of this chapter.

The pilot programmes were offered to new (rather than long-term) claimants and participation was voluntary. In spite of non-comparability with the pilot scheme's participants (NAO, 2010), CMP was launched nationwide in 2006 enabling on-going, new and repeat claimants to volunteer for the programme.

Following the Welfare Reform Act (2007), participation in Pathways to Work became mandatory for new and existing claimants. 'Customers' were subject to sanctions for failure to participate. These were applied in stages resulting in participants benefit payments eventually being reduced to the equivalent of Jobseekers Allowance. This implied that, if individuals did not take steps to improve their health, they would be regarded as job-seekers. In practice, attendance at an initial work focused interview and the creation of a work focused plan following were compulsory, however failure to follow the plan was *not* subject to sanctions. As such, attending the intervention itself remained essentially voluntary.

Welfare Reform (2007) - Nation-wide implementation of Pathways to Work and CMP

The Rt Hon John Hutton MP, spelled out the government's aim to reduce the number of incapacity benefit claimants by one million within ten years (DWP, 2006). At this point, half of the Incapacity Benefit caseload had claimed the benefit for more than five years (ibid). Hutton reinforced Smith's rationale for reform:

"Almost nothing is expected of claimants – and little support is offered. Those who try

to plan their return to work through volunteering and training perceive that they run

the risk of proving themselves capable of work and therefore losing their entitlement"

(p4).

The implication of this was that claiming incapacity benefit is intrinsically harmful to wellbeing. The green paper heralded expansion of Pathways (including CMP delivery) to independent providers (DWP, 2006) and the introduction of the new Employment and Support Allowance (ESA) (Welfare Reform Act, 2007). This opened the delivery of CMP to independent employment services and for them to sub-contract CMP to healthcare providers. This model was applied in Norfolk.

Employment and Support Allowance (ESA) replaced Incapacity Benefit as the main sickness related benefit. Following an initial 13-week period (during which financial support was paid at the same rate as Jobseeker's allowance), claimants undertook a health assessment to establish which of two groups they would join. The work-related activity group paid ESA at a lower rate and required claimants to undertake work-related activity and attend work-related interviews. The claim could last for up to twelve months. A new claim could be made after a further 12 weeks. The 'support group' recognised those with more disabling conditions and claim time was not limited (subject to periodic re-assessments) and did not require claimants to attend interviews. Underpinning these changes was the new Work Capability Assessment (WCA) which replaced the Personal Capability Assessment. The WCA emphasised work that claimants potentially could do rather than assuming complete incapability to work due to a health condition.

Despite faith in a health management solution to incapacity, it was widely suggested that incapacity benefit claims could represent disguised unemployment (Elhorst, 2003, Beatty et al 2004, Fothergill & Wilson, 2007). Fothergill and Wilson (2007) described the Labour Government's aim of reducing incapacity benefit claimants by one million within ten years as unfeasible given that the geographical distribution of IB claims represented not just sickness but hidden unemployment caused by industrial decline and poor growth in certain parts of the country. In contrast, Hutton claimed that the growth in incapacity benefit claiming was a nation-wide problem:

'Over the last decade the characteristics of claimants have changed. No longer is it just

those from the industrial heartlands. The South East has more claimants than the North

East and there are at least 150,000 claimants in every region, making this a national

problem' (DWP, 2006. P.3)

However, this assertion did not account for claimant numbers *relative* to the size of the working

population in different geographical areas. Fothergill and Wilson (2007) challenged this view citing a

higher proportion of the working population claiming incapacity benefits in the North East compared

to the South East (11% and 4.8% respectively). Furthermore, the rate of IB claims in the North East in

2006 was the highest level nationally and the rate in the South East was the lowest, a trend that was

repeated across de-industrialised geographical areas across the UK.

The notion of hidden employment questions the rationale for a health-related intervention. A

possible explanation is that it would be unwise to cite hidden unemployment as this would imply

previous mismanagement of workless people and could be unpopular with claimants and

representative groups (Bambra et al, 2005; Grover and Piggott, 2010, Wiggan, 2011).   Welfare to

work policy combined not only labour market reform but a coupling of social rights with personal

responsibility (Beatty and Fothergill, 2004). Personal responsibility meant that individuals were

required to undertake appropriate job seeking activity in return for benefit payments giving rise to

the term workfare.

Wiggan (2012) described increasing conditionality in unwelcome terms:

"The consequence is that social security is no longer recognised as a welcome form of

collective protection that ameliorates risks and/or compensates individuals for unequal

distribution of resources and opportunities within society. Rather it is recast as an active

agent in the moulding of individuals to the needs of economic policy" (p.384).

The move was criticised, by some, for creating a two-tier system redolent of the 'deserving versus

undeserving' argument (Grant, 2010; Bambra 2012). However, the homogenization of

unemployment benefits (with the bottom tier of ESA equating broadly to job-seekers) also suggested

tacit acknowledgment from the government that there were some incapacity claimants who were

incapable of work and others who struggled in the employment market regardless of health status.

The service available for the latter group was 'work related activity.'

The consultation drew responses from sources ranging from disability rights organisations, charities,

academics and think-tanks, health professionals and supported employment providers. The Joseph

Rowntree Foundation recognised the potential benefits of assisting those who have been 'relatively

distant from the labour market' (2006, p.3) but expressed concerns over persistent discrimination

from employers towards people with disabilities. Others' concerns related to the need to simplify bureaucracy, raising awareness of disability discrimination in the workplace and concerns about the appropriateness of the Work Capability Assessment for fluctuating or mental health problems. Social and political concerns included fears that outcome based funding would disadvantage the 'hard to reach' groups who were furthest from the workplace and might lead to 'perverse incentives' for service providers and that the two-tiered ESA would create an incentive to demonstrate incapacity (DWP, 2006). None of the responses questioned the core principle of assisting claimants back into employment by helping them to manage health conditions.

Provider-led Pathways to Work in Norfolk

This section examines the final (Provider-led) stage of Pathways to Work which was implemented nationwide including in Norfolk. Pathways providers were allowed considerable autonomy regarding how CMP was sub-contracted and subsequently delivered. The conditions for payment of CMP providers were challenging, placing them under immediate pressure to seek return to work 'outcomes' (NAO, 2010). Providers were paid by result rather than for the service itself. In Norfolk, 30% of the Pathways Provider's fee was paid when an individual reached six weeks in a new job and the remaining 70% was paid after six months of continuous employment. Conversely, the CMP provider received 70% of its fee for meeting the target of assessment within ten days from referral and a further 30% when the client completed their programme. Payment was not conditional on return to work outcomes or clinical outcomes. Considine (2001) argued that, in the tendering process, real markets were not formed and that, while there was a flow of money, the culture of 'contractualism' was not conducive to innovation. This view was affirmed by the National Audit Office (2010) which was critical of Pathways' tendering process for encouraging proposals that might win contracts but subsequently prove to be impossible to deliver.

The specific focus of this evaluation is the CMP in Norfolk. The total numbers of participants for the Norfolk CMP is no longer known but the data set for this research is based on 193 clients. Their ages ranged from 19 to 62 and the mean age was 43. 53% were male and 47% female. The CMP was delivered in three formats. The first, described in this study as the 'original' programme, began in March 2008 offering one compulsory introductory day and further optional modules. These were weekly, two to three hour groups lasting between two and six weeks. (The programmes are examined in detail in Chapter 4). Participants attended an initial assessment in which the purpose and content of CMP were explained, relevant modules selected and pre-intervention outcome

measures (Hospital Anxiety and Depression Score and Occupational Self-Assessment) taken (Snaith, 2003).

Whilst the groups were not delivered as 'group therapy,' they were regarded as being *therapeutic.* Participants were encouraged to use their colleagues as a resource in addition to the manualised programme content. Modules were delivered on a rolling basis with individuals attending no more than two modules concurrently. Depending on how many modules were selected by an individual and their case manager, complete programmes could last up to six months. In light of this and the strict financial terms of the contracts described above, the Pathways provider for Norfolk may have regarded the original CMP as too slow to be effective. It was replaced with the "express" programme which lasted six weeks. This format was initially intended only for participants who were regarded as 'close' to the job market. However, it was adopted as the standard intervention for all customers.

In October 2009, after around six months of delivery of the CMP Express, the Norfolk Pathways provider began a process of re-commissioning its CMP provision and invited suppliers to submit alternative CMP proposals. However, in April 2010, all contracts with CMP providers were cancelled and the Pathways provider took its CMP provision in house. The author was subsequently employed by the Pathways provider on a non-contractual basis to offer CMP under their new format. This final iteration of CMP in Norfolk was on a solely one to one basis providing return to work counselling using resources from previous programmes up to a maximum of sixteen meetings.

The purpose of this format remained unaltered and the same written materials were used where appropriate. The specific aim was to address identified barriers preventing employment. This format provided more scope to acknowledge and address issues such as lack of confidence, self-doubt or wavering motivation. Primary barriers were identified during the initial consultation and monitored as the meetings progressed. Only written resources relevant to the participant's presentation were used meaning that the programme was no-longer standard or manual based. This format was maintained until the Pathways to Work contracts ran out in March 2011.

From its conception through to its completion, CMP remained a health-first intervention (Warren et al, 2013). This focus, and the specific programme theory within each module, are examined critically in later chapters. The final section of this chapter explores welfare to work evaluation data which inform the debate on how effectively incapacity claimants can be *activated* into seeking employment.

Welfare to Work evaluation

This chapter closes with a summary of evaluations of welfare to work programmes. In spite of CMP being described as an innovative programme (Smith, 2002), previous programmes and considerable research had been aimed at solving the problem of static claimant numbers. This section takes a closer look at evaluation data on CMP as well as programmes and policy initiatives that preceded and followed it. Eight themes are presented outlining low employability factors amongst the claimant population, inconsistent results of interventions and common challenges in delivering programmes. The concept of claimants' self-appraisal of sickness and employment prospects impacting on their decision to return to work emerges as a key insight. A related observation from this data is the failure of programmes to treat participants as individual cases with a unique set of circumstances and priorities which influence their decision making.

This section summarises research into nationwide welfare to work policies and programmes that existed before, during and after CMP. The emerging themes assist in the interpretation of the government's welfare strategy and CMP's design and delivery which are addressed in later chapters. It reviews findings from evaluations of policy initiatives and programmes since 1993. This includes the ONE programme which was piloted before Pathways and CMP. ONE brought together the Employment Service, Benefits Agency and Local Authorities at a single point of contact and included a Personal Adviser to work with claimants.

The subject matter and sources are summarised in table 2.1. Key findings are outlined in Appendix 4. The first section introduces the sources and discusses their strengths and weaknesses. Eight key themes are presented and analysed. The chapter ends by discussing the implications of these findings for the concept and theory on which CMP was based.

Subject	DWP/DSS Research reports	Independent academic studies
Impact of policy changes to sickness benefits (IVB, DWA, IB, NDDP)	7	
Studies relating to health, disability and working	4	1
ONE Programme	7	
Pathways to Work (including CMP)	12	
CMP (specifically)	5	1
The Work Programme	2	0
Miscellaneous health based employment interventions		5
Total	**37**	**7**

Table 1.2 Summary of welfare to work evaluation subjects

The majority of these reports were sponsored by the Department for Work and Pensions (previously the Department for Social Security). These are rigorous and systematic reports and some are large scale longitudinal studies. However, most are limited by a narrow scope and inconclusive findings. Some reports focused on different aspects of the same programme for example the impact of compulsory attendance on the ONE programme (Green et al, 2001) and employer's reactions to recruiting ONE participants (Bunt et al, 2001). Others provide data at different stages of the same programme for example reports on the first wave of Pathways to Work pilots (Adam et al, 2006; Corden and Nice, 2006; Corden and Nice, 2006a). Summative conclusions on programme effectiveness are rare. However, the main criticism of the CMP pilot evaluations was that the participants were new (rather than long-term or repeat) claimants (NAU, 2010) unlike this study. This meant that there was no preliminary data supporting the effectiveness of the CMP for long-term claimants attending Provider-led programmes like the one this study evaluates.

DWP-sponsored reports offer broad bodies of data describing participant, practitioner and manager views and experiences (Nice et al, 2009; Tennant et al, 2010). Whilst these studies are valuable for detecting general themes within the data, they are limited by their focus on the specific CMP conception which was to provide health advice and assistance to enable return to employment. For example, they provide evidence of improved psychological functioning but clear links between interventions and return to work outcomes are not established.

In contrast to this, the independent academic studies reviewed here provide summative appraisals of the interventions and concise discussion on reasons for the initiatives' success or failure. Of these, only one is based on CMP whilst the others are smaller scale, overseas studies examining the effects of psychological or behavioural interventions on incapacity claimants. These studies are of robust design with appropriate counterfactuals. Where these reports lack scale (compared to DWP research reports) they offer clear conclusions.

Viewed as a body of evidence, these sources summarise the problem conception, programme concept and programme delivery phases of CMP design and delivery (see chapter 3) which resonate with the corresponding chapters within this study. Eight key findings emerge (summarised in Appendix 1).

1) Long term incapacity claimants are characteristically, detached from the labour market, 2) they possess lower human capital resources and 3) they face barriers to employment which are unresponsive to health-based programmes, in particular lower employability factors. Given that CMP was a primarily health-orientated intervention, these findings suggest that the programme's scope was too limited. 4) Reports frequently found that, though interventions commonly resulted in

improved health for participants, this did not translate into return to work outcomes. 5) Claimants were seen to hold strong views on the extent of their health problems and the likelihood of obtaining work. These findings suggest that claimant's self-appraisal and personal opinions were stronger determinants of returning to work than their functional health impairment. 6) The link between illness and unemployment was frequently described as unclear. This further weakens the rationale for the predominantly health-based focus underpinning CMP. 7) Interventions were beset with difficulties reducing their effectiveness. Linked to this; 8) knowledge of participants' unique situations and circumstances were seen to be necessary requirements to inspire change and to make interventions relevant.

Four reports describe the static population of incapacity claimants (Lonsdale et al, 1993; Errens & Gate, 1993; Loumidis et al, 2001 and Newton et al, 2014). Except for the latter, these are reports on claimant characteristics rather than programme evaluations. It is not mentioned in evaluations of either ONE, Pathways to Work or CMP. This may reflect faith in mental health interventions to cure the problem of long term incapacity claiming.

A widely-reported finding was of lower human capital resources in long-term incapacity claimants and the presence of non-health related barriers to employment (Lonsdale et al, 1993; Errens and Ghate, 1993; Rowlingson & Berthoud, 1996; Dorsett et al, 1998; Green et al, 2000; Bunt et al, 2001; Loumidis, 2001; Davies & Johnson, 2001; Ashworth et al, 2001; Hedges & Sykes, 2001; Davies et al, 2001). However, these observations were omitted in accounts of Pathways and CMP. Again, this may suggest a determined belief that individuals with multiple barriers to employment could be assisted into work by learning to manage health conditions. Alternatively, it may be that evaluations were designed to focus on observable outcomes rather than the problem conception.

The pattern is reversed regarding observation of positive outcomes. Numerous evaluations of Pathways and CMP observed favourable impacts on participant wellbeing including improved confidence, reduced anxiety and depression and ability to manage stress (Pittam et al, 2008; Ford, 2008; Dorsett, 2008; Bewley et al, 2008, Warrener et al, 2009; Ford and Plowright, 2009; Hudson et al, 2009; Nice and Davidson, 2010; Kellet et al, 2010; Hayllar et al, 2010; Hayllar & Wood, 2011). However, these reports also found that return to work outcomes which were unsatisfactory or ambiguous. None are compared to a counterfactual, to performance targets or to existing return to work trends. The pilot programmes were believed to have increased the probability of being in paid work by 7.4% from a baseline of 29.7% (Bewley et al, 2007). However, this was based on any work rather than 16 hours per week or more. Return to work outcomes for different condition

management programmes were reported variously at 16% (Kellet et al, 2010), 25% (Ford, 2008) and 26% (Hayllar et al, 2010). In another programme, 65.5% of participants remained on IB or ESA; 13% went on to a different benefit and 3.5% left IB through retirement or entry into full time education leaving only 18% who obtained employment. (Greater Merseyside NHS, 2011). There is no unequivocal evidence of improved health functioning leading to return to work outcomes within this body of evidence.

Conversely, there is robust evidence that claimant's views on their own health and employment prospects impacted strongly on return to work activity. This theme is ubiquitous in studies on claimant characteristics, the impact of policy measures and evaluations of the ONE programme (Lonsdale et al, 1993; Dorsett et al, 1998; Green et al, 2000; Davies and Johnson, 2001; Corden and Sainsbury, 2001; Hedges and Sykes, 2001; Davies et al, 2001; Kelleher et al, 2002; Brouwers et al, 2006). This observation was also noted (though less frequently) in CMP and Pathways evaluations (Corden and Nice, 2006; Barnes and Hudson, 2006; Ford, 2008; Dorsett, 2008; Warrener et al, 2009; Hudson et al, 2009; Hayllar et al, 2010).

The notion of participant's personal beliefs impacting on employment outcomes runs counter to the programme concept underpinning CMP. This has implications for understanding the programme's problem concept and programme theory: what prevents incapacity claimants from seeking work and what interventions could influence this? Belief in the assumption that health status was the key determinant influencing job-seeking behaviour may have led evaluators to seek evidence of improved health and health management in favour of other determinants.

The theory and underlying problem concept of CMP are questioned by the frequent acknowledgment of lack of clarity in the link between incapacity and employment (Adam et al, 2006; Corden and Nice, 2006; Bewley et al, 2007; Ford, 2008) in CMP pilot evaluations. Ford and Plowright (2009) recognised that programme content related to employment had a negative impact on some participants, a factor that clouds the link between employment and incapacity. Ashworth et al (2001) described a large group of people whose health prevented them from competing in the labour market rather than functionally preventing work itself. It was noted that long term or older incapacity claimants were more likely to have moved into incapacity claiming from unemployment rather than health (Loumidis et al 2001). Other reports couched reservations on the employment and incapacity link in terms of a need for a longer-term evidence base (Ford, 2008; Ford and Plowright, 2009). In an independent review of factors predicting return to work, Blank et al (2008) challenged inconsistent use of terms related to mental health asserting that papers based on the

medical model of mental health were overly focussed on specific conditions and were therefore biased against social determinants of incapacity. This observation may have relevance for CMP evaluations which sought and found evidence for improved functioning in isolation of other factors (as described above).

It was not until 2012 that a DWP sponsored paper clearly acknowledged the paucity of evidence linking clinical interventions and employment outcomes (Dibben et al, 2012). This meta-analysis reached unfavourable conclusions about the relationship between return to work and health interventions:

> "In general, there is a lack of studies which provide evidence of employment outcomes for MHC" (p.18).
> "There seems to be little evidence on clinical/medical interventions resulting in employment outcomes" (p.19).
> "The evidence base for interventions for those with MHCs was very weak." (p.20).

Dibben et al's report was written after CMP had been replaced by the Work Programme which had a strong 'work-first' rather than health priority and may reflect the policy movement away from health-related interventions.

Prior to the launch of CMP, it was known that delivering health-based, return to work initiatives were prone to difficulties. Further problems were noted during and after CMP. The 'sudden death' decision following transition from IB to Jobseeker's Allowance resulted in participants' programmes ending without warning (Hedges and Sykes, 2001). Lack of knowledge or understanding of programmes led employment advisers to provide inadequate advice (Green at al, 2001; Corden and Nice, 2006; Dorsett, 2008). Rigid systems, new ways of working and the pressure of throughput targets meant that advisers had inadequate time to offer tailored services in both ONE and Pathways (Kelleher et al, 2002; Cordon et al, 2005; Brouwers et al, 2006; Nice and Davidson, 2010). Overly systematic procedures or a 'one size fits all' approach was not welcomed by some Pathways customers (Hudson et al, 2009) and led to claimants being invited to participate in ONE even whilst receiving treatment in hospital (Cotton et al, 2001). Poor attendance and attrition negatively affected the impact of ONE (Davies et al, 2001) and Pathways (Barnes and Hudson, 2006).

These findings suggest that employment programmes struggled to engage customers in terms of both concept and organisation; generic designs treated claimants as a homogenous group and inflexible procedures re-enforced the mismatch between participants' unique needs and programme's interventions. Before Pathways and CMP were launched, it was widely observed that close relationships between practitioners and customers and detailed knowledge of claimant's unique situations brought positive results (Davis and Johnson, 2001; Corden and Sainsbury, 2001; Hedges and Sykes, 2001; Davies et al, 2001; Green et al, 2001). Some studies noted failure of staff to break through avoidant tendencies (Brouwers et al, 2006; Cordon and Nice, 2006). Others reported a willingness amongst staff to accept claimant's negative self-prognosis without challenge and to subsequently 'give up' on them (Davies and Johnson, 2001; Hedges and Sykes, 2001; Davies et al, 2001). Also noted was a failure to work with participants to set meaningful, relevant goals (Corden and Sainsbury, 2001; Corden et al, 2005; Thorslund, 2007). These findings tie in with the recurrent observation that claimants based work related decisions on a *self-appraisal* of their health and employment prospects. A strong focus on health conditions may have led to inadequate notice being taken of participant's unique histories and their specific barriers and concerns.

This section has summarised the findings from evaluations into health-based policy interventions and programmes for incapacity claimants before, during and after CMP. There is abundant evidence that a significant cause of long-term incapacity is lack of competitiveness in the labour market due to lower human capital resources (lesser qualifications and non-current skills) and lower employability (age and poor sickness record). Many such claimants would be unlikely to achieve employment in a competitive job market regardless of their health or ability to manage it. There is evidence that younger claimants with higher employability factors found work after attending programmes (Lonsdale et al, 2003). However, it was thought they could have made the transition into employment without any intervention (Rowlingson and Berthoud, 1996; Davies et al, 2001). Alongside this, it is widely acknowledged that the link between improved health and returning to work is weak. Therefore, CMP may be seen as inappropriate for some participants whose principle barrier to employment was low employability whilst irrelevant to some others whose main barrier to employment was health.

Claimants are known to self-assess the extent and impact of their health condition and their likelihood of obtaining employment. This suggests that the key leverage in influencing job-seeking activity is in helping individuals make accurate assessments of their ability to work and to determine their best decision based on this. Instead, CMP appears to have helped claimant's wellbeing to

improve but *not* help them make a decision about work. This explains the common observation that participant's health improved but expected return to work outcomes did not follow. Generic, 'one size fits all' programmes alongside failure to engage with participants and their unique circumstances offer valid reasons for the failure of participants to re-appraise their beliefs about work.

These findings indicate a research methodology that examines the unique situations of participants and clarifies how, and the extent to which, the programme impacted on them. This study identifies the concept and theory underpinning CMP and assesses its soundness in relation to course participants. The following chapter outlines the evaluation approach and qualitative methods used to gather data for this purpose.

Chapter 2 - Evaluation and research methods

Introduction

The first section of this chapter sets out the method of evaluation proposed for this study. The second section describes specific research methods.

Hansen (2005) defines evaluation relevant to CMP:

> "A careful retrospective assessment of the merit, worth and value of administration, output and outcome of government interventions which is intended to play a role in future, practical action situations" (p.448)

The Norfolk CMP is a small example of a large scale, national social programme (Pathways to Work). However, careful analysis of a singular case can lead to broader generalizations (Cronbach, 1980; Simons, 2015). The purpose of this evaluation is not to establish whether or not the Norfolk CMP was successful but to identify both helpful and unhelpful aspects of the programme. The findings should enable the design of more effective and targeted programmes.

In judging the value of a programme, the underlying purpose is not only to prove but to *improve* (Clarke, 1999). Pawson and Tilley (1997) assert that all programmes work some of the time and no programmes work all of the time. Furthermore, they state that programme leaders rarely believe that programmes result in large scale social change, that policy makers do not read research reports and that decisions are based on trial and error and gradual sensitization to social research. Some programmes fail to meet expectations but may do if delivered differently. Alternatively, some programmes work but might not be replicated in different contexts.

The CMP pilots of 2002-3, were judged as successful enough to justify national rollout (Ford and Plowright, 2009). However, the provider-led CMP model delivered in Norfolk differed markedly. It varied in geographical location and economy, population and job opportunities. It took place in a radically different stage of the economic cycle (beginning of the last recession). Programme delivery was different in terms of both personnel and methods. Given these variations, a formative evaluation of the Norfolk CMP seeking to establish what worked, for whom and under what circumstances (Pawson and Tilley, 1997) may be more useful than a summative evaluation. The

hope is that this study will add to the 'ecology of evaluation' (Sridharan and Nakaima, 2012) on welfare to work programmes specifically and to social programmes generally.

This chapter outlines the broad steps undertaken in delivering social programmes (figure 3.1). It is argued that the effectiveness of a programme is measured not only in its outputs but in the accuracy of the problems identified in the needs analysis and the fidelity of each stage of programme delivery to these initial analyses. The rest of this chapter defines each stage and presents evaluation activity appropriate to them. The first section ends with a discussion on specific evaluation methods which are appropriate for a study of this nature.

Part 1 – Evaluation methods

Stages of programme development and corresponding evaluation

Stages of programme design and delivery	Evaluation data
Identified social problem	Identification of problem and needs analysis
Programme concept (What is the programme? What will it do?)	Strategies identified to 'solve' the problem
Programme design (programme theory and implementation theory)	Identification of programme theory
Programme implementation and delivery	Observation and data collection
Programme outputs	Observations of programme mechanisms
Programme outcomes	Observations related to intended mechanisms, contexts and outcomes and unintended outcomes and mechanisms and previously unidentified contexts
Application of evaluation in respect of related social 'problems'	

Figure 2.1 Norfolk CMP – stages of evaluation

Figure 2.1 describes the broad stages of the design and delivery of the CMP and, alongside it, a hypothetical model for a retrospective evaluation using sources of naturally occurring data generated at the time of the programme and supplemented with later participant and practitioner testimonies. The first stage of programme development is to identify a social problem and its key features. Policy makers identify outcomes which, they hope, will ameliorate the problem. The goals are described as programme concept and logic (the programme seeks outcome Y in response to problem X) and implementation theory (we will achieve outcome Y using method Z) (Rossi et al,

2004). The programme concept, logic and implementation theory should be relevant to the problem as previously identified (ibid).

Having set logical programme goals based on accurate conception of the problem, a programme is commissioned. The programme is then designed, assembled and aggregated through a mixture of innovation and existing practice. The programme is based on a theory or theories which are consistent with the goals described in the programme concept and follow the premise that certain actions will result in particular outcomes (i.e. input A from programme practitioners should result in output B from programme participants). The theory behind the specific actions within the intervention may be drawn from the current evidence base or, if there is no such evidence, could be described as anticipatory theory. Clarke (1999) describes how 'theory' at this stage may, in reality, be no more than a hunch or intuition. This stage of programme development is essentially a hypothesis based on which inputs and actions 'should' work for which recipients under certain circumstances (Pawson and Tilley, 1997). As with the previous stage in the development process, the theoretical mechanisms and anticipated outcomes must be faithful to the goals identified in the programme logic.

For the programme to be effective it must then be delivered using methods that maintain fidelity with the theory, programme concept and problem conception. This represents a significant challenge due to potential variation in individuals delivering programmes and the participants attending them. Delivering programmes of this kind requires a significant transfer of knowledge from programme designers to facilitators and development of facilitator skills and practise (Cronbach 1980). Furthermore, there may be variation in the delivery of programme materials and the provision of appropriate accommodation. Even simple programmes are liable to be flawed in some way (Ibid).

Adequate delivery of the programme results, firstly, in outputs and, later, in outcomes. For example, a programme designed to reduce waiting times in hospital casualty departments may generate an output of people having the knowledge, skill and confidence to dress a wound. The desired outcome for this intervention would be more superficial wounds being dressed at home leading to fewer emergency admissions. However, programmes also have unintended outputs and outcomes. These may be both foreseeable and unforeseeable (Morell, 2005). Programmes with evaluation included in their design enable programme implementers to adjust inputs accordingly to restore programme outcomes and improve the effectiveness of the programme (Battye, 2015). Unintended

consequences of programmes may also provide a rich resource for evaluators wishing to link outcomes to programme theory (Greenberg & Morris, 2005; Simons, 2015 and Morrell, 2005). For example, the focus on (health) condition management in the programme concept for the Norfolk CMP was seen to encourage some participants to delay job-seeking activity until their health improved further. This explored in greater detail in the case studies in Chapter 8.

A successful programme requires integrity of design from problem analysis to delivery of the intervention (Rossi et al, 2004). Programmes may fail to meet expectations if the method of delivery is inconsistent with the programme theory or if the programme theory is inconsistent with the social problem it is designed to solve. Even a well delivered programme that fails to maintain this integrity is likely to fail or fall short of intended benefits (ibid).

An effective programme evaluation requires an audit of the design integrity through each stage of delivery. It seeks to identify breaks and weaknesses in the logic, clarifies the impacts and effects on participants and asks whether these were the result of the programme itself or of extraneous factors. This process applies equally to both unintended and unforeseen impacts. The rest of this chapter charts in detail the course of evaluation as described above.

Problem analysis

A detailed explication of the problem of large scale incapacity benefit claiming is found in Chapter 3. Here, the purpose is to outline the relevance of problem analysis to the evaluator and its implications for this study. However, it is important to note that the 'problem' of large scale incapacity benefit claiming is subject to considerable debate. This has implications for the programme concept, logic and theory of delivery from the outset. Layard (2006) set out anxiety and depression as direct and specific causes of inability to work and cites CBT as the most effective response. If this were the case, the chain of programme logic might look like the example in figure 2.2 (below).

Other commentators suggest that the problem is more complex in both nature and context. Beatty et al (2013) propose that anxiety and depression may not inevitably lead directly to non-employment. Rather than inherently preventing work, they assert that illnesses make individuals less employable in a competitive employment market. Fothergill and Wilson (2007) describe how health-related employability varies geographically according to economic and labour-market conditions.

Problem:
Inability of incapacity benefit claimants to self-manage anxiety and depression effectively is a 'barrier to employment.'

Programme concept:
The barrier to employment can be removed if individuals are able to self-manage anxiety and depression. This will enable to return to work. The logic can be expressed as a concept: the *Condition Management Programme*.

Programme design (programme theory and implementation theory):
The programme can be implemented via psycho-education delivered by health care professionals. Evidence base for CBT indicates it as the therapy of choice for treatment of anxiety and depression. It is psycho-educational and encourages client-led application of mood improving techniques. Teaching intervention A (e.g. cognitive restructuring) will lead to output B (e.g. client learns ability to re-appraise negative thoughts rationally and thereby regulate mood more effectively).

Programme implementation and delivery:
Relevant practitioners (e.g. CBT therapists) are trained in the purpose, logic and design of the programme and then deliver/teach the specific interventions to course participants

Programme outputs:
Course participants demonstrate the knowledge, skills and confidence to manage their mood effectively.

Programme outcomes:
Course participants no longer believe that their health condition constitutes a barrier to employment, they are able to manage mood effectively and consequently intensify job-seeking behaviour accordingly.

Figure 2.2: Example of a programme logic chain relevant to CMP

Rossi et al (2004) propose:

> "Needs assessment is fundamental because a programme cannot be effective at
> ameliorating a social problem if there is no problem to begin with or if the programme
> services do not actually relate to any problem" (p.102)

Rossi et al stress the importance of accurate analysis of the initial problem, including knowledge of the individuals associated with it, and the necessity for a logical progression of design according to the originally identified needs.

A difficulty for the evaluator in assessing the needs analysis is that they may not be party to it. However, Reiss (1971) cited in Clarke (1999) proposes that needs analysis can be conducted retrospectively and inferred through examination of related documents such as policy papers, by interviewing relevant people, through the needs assessments stated in previous research and through logical reasoning (working back from the programme itself).

Problem analysis might be described as the 'why?' of social programmes. The example given in figure 2.2 is a singular strand of logic from the CMP. However, social problems are rarely unitary issues and may have different characteristics in different contexts.

The second main difficulty is that the problem is likely to be complex and multi-faceted. A social problem may be understood in various ways from different viewpoints. To a policy maker, the cost of providing incapacity benefit at £12 billion per year (DWP, 2006) might be the heart of the problem. However, such a programme rationale might not be readily translated through programme logic. For example, a claimant may or may not be concerned about national debt and may be conceptualise the problem out of more personal concerns.

The significance of needs analysis for the evaluator is in assessing how effectively the original needs analysis was conducted and in assessing the application of subsequent stages of programme delivery in light of it.

Programme Concept

A programme's *concept* is the statement of a solution to the problem or to an aspect of it. In the case of CMP, the key aspect of the problem of incapacity benefit is that claimants experience their health condition as a barrier to employment. The logic of CMP is that this barrier to employment may be removed or lessened by giving participants knowledge and skills to manage their condition better. The logic of managing a health condition gives birth to the programme *concept*: a condition management programme.

The condition management programme, as a concept, differed to standard healthcare. CMP incorporated psycho-educational training rather than treatment. The focus for the participant was self-management rather than passive receipt of the healthcare. Improvement, rather than cure was expected. Healthcare relates to all known health conditions. However, CMP would focus only on the three main health condition groups associated with long term incapacity: mild to moderate mental health, cardio-vascular and muscular-skeletal conditions (Ford and Plowright, 2008).

Implementation theory, which should not be confused with *programme* theory, is a series of statements describing how the concept can be applied. It is guided by the programme concept. The original implementation theory for CMP was a jointly run pilot programme delivered by the NHS and the DWP via Job-centre plus. It was run in non-standard healthcare locations. Here, the

implementation theory is that a programme delivered by NHS would have credibility amongst claimants but delivery away from familiar healthcare locations such as local health would reinforce that CMP was different to healthcare.

The concept constitutes the foundation of the intervention and set the tone for delivery and should give due consideration to the programme's context (Pawson and Tilley, 1997; Astbury, 2010). Rossi et al (2004) set out the importance of the fundamental concepts within programmes:

> "The social problems that programs address are often so complex and difficult that bringing about even small improvements may pose formidable challenges. A program's theory is the concept of what must be done to bring about the intended social benefits. As such, it is the foundation on which every program rests" (p.134).

When assessing the foundations of a programme, the evaluator identifies and tests the logic and plausibility for the concept. Rossi et al (ibid) suggest the following questions:

1. Are the goals and objectives well defined?
2. Are the goals and objectives feasible? Are the expectations realistic?
3. Is the change process presumed in the concept plausible?

The goals and objectives may be located through analysis of contemporary policy documents, early evaluations and through the verbal testimony of individuals involved at the concept stages of programme design.

The feasibility of the goals and realism of expectations are harder to evaluate but can be tested in two ways. A goal could be said to be realistic if it is based on experience from past programmes delivered in similar contexts or if it is based on reasonable expectations drawn from relevant social science research. For example, Layard (2006) claimed that individuals could return to employment if cured of their anxiety using CBT at a cost of £850 per head. A test of whether this was realistic would be whether a previous programme had succeeded in similar ways or whether CBT had been found to be effective in the context of incapacity claiming.

The second method of testing plausibility is through retrospective analysis. The testimony of CMP practitioners and participants during and after the intervention can allow the evaluator to

reconstruct the logic. In other words, the end results of the programme are the test of a programme's integrity of design. Clarke (1999) emphasises the value of seeing the logic of a programme throughout its application as well as at its inception:

> "At the outset, it is essential that the evaluator clarifies the aims, content and structure of the programme. This entails not only identifying the different components of the programme but also developing an understanding of how the various elements are expected to produce the desired effects" (p.9).

Programme theory and implementation theory

In broad terms, programme theory is the detailed explanation of *how* the programme concept will lead to desired outputs. Programme theory has been described as the 'black box' of programme design (Astbury, 2010). It should include detail of interventions within the programme and explanation of how the specific inputs lead to corresponding outputs. Astbury (ibid) describes these as unobservable, causal entities that exist between delivery of the intervention and its outcome. These causal levers explain how programmes bring about changes in participants' reasoning and behaviour (Ibid).

Programme Theory describes the mechanisms by which the purpose (programme concept) may be achieved. In relation to CMP, programme theory could be summarised as: Cognitive Behavioural Therapy (and other interventions) equips participants with knowledge and skills which, if used appropriately, will enable them to maintain a better standard of health enabling them to work. *Implementation Theory,* explains how the theory will be implemented using methods which are realistic and workable. This includes consideration of factors such as who should deliver the intervention (type of clinician and level of experience or qualification), where events are to be held, how many participants take part in each session, whether parts of the programme are best delivered as a group or individual intervention, how the participants are selected, how frequently sessions are held, what additional resources are required (books, IT, audio-visual), the overall length of the programme (for each participant), the processes of referral between Pathways Employment Advisors and health professionals delivering CMP.

Pawson and Tilley (1997) describe causal entities as mechanisms adding that they are usually hidden and are sensitive to variations in context. Pawson and Tilley (1997) define programme theory as a triad of mechanism, context and outcome. Adedokun et al, (2011) alternatively describes causation

in terms of *processes* by which programme components affect outcomes and *conditions* which are factors that moderate direction or magnitude of the effect.

Programme Goal	Programme Objective	Specific activities	Programme theory	Outcome
Lessen barrier to employment (feelings of anxiety) experienced by incapacity benefit claimant.	Participant to learn skills to lessen impacts of and distress caused by anxiety	Cognitive restructuring Relaxation: Progressive muscle tensing, regulated breathing, mental distraction, positive imagery, affirmations	Participant increases confidence in ability to regulate anxiety through instruction and practise, encouragement from practitioners/fellow participants and from familiarity with evidence based techniques	Participant believes that anxiety is no longer a significant barrier to employment

Figure 2.3. Programme logic applied to CMP

Programme logic requires a link between goals and objectives which are sub-divided into functions, components and activities (Rossi, 2004). The components and activities must be linked to expected outcomes (Adedokun, 2011). An example of this, as applied to CMP, is provided in figure 2.3. Good theory, according to Astbury (2010) contains both a conceptual component (driven by policy makers) and an empirical component (driven by observation and experimentation with individuals in the relevant setting).

Rossi et al (2004) describe a continuum between programme conception in the eyes of the official and in the eyes of those closest to the programme. A policy maker may seek to reduce intergenerational workless-ness and its impacts on society. However, this reasoning may not resonate strongly with participants or with practitioners.

Astbury (2010) illustrates this point forcefully:

> "Whether the causal 'tendencies' of a particular mechanism is activated, is largely dependent then on human reasoning and volition. This is because mechanisms work *through* human agents who have the (cognitive) capacity to think and act in terms of causalities and who also possess other capacities that make things happen. In practical terms, people do not react to programmes like billiard balls that are hit; rather programmes only 'work' if people choose to make them work and are placed in the right conditions to enable them to do so" (p.370).

In other words, even a good theory will only work *theoretically* on the grounds that it depends ultimately on the will of the participant.

According to Clark (1999):

> "[A] theory based approach is essential if the objective of the exercise is to establish
> how and why a social programme succeeds or fails" (p.134).

When assessing the theoretical foundation of a programme the evaluator is required to establish and test the validity of the causal influences espoused in the programme design.

Adedokun et al (2011) suggests four methods for eliciting programme theory:

1. Prior theory and research in the relevant domain.

2. Implicit theory described by individuals who are or were close to the programme.

3. Observation of the programme in action.

4. Exploratory research to test critical assumptions.

Prior and implicit theory may be derived from historical sources such as policy documents, promotional literature and from verbal testimony of individuals involved with programme delivery.

Sridharan and Nakaima (2012) describe the relationships between programme activities and outputs in terms of theory of change and suggest 'contribution-analysis' as a means of testing it. They ask:

1. Did the intended results occur?

2. If not, why not?

3. If yes, is it reasonable to conclude that the programme was the contributing factor to bring about the intended results?

These questions require either observation of programme delivery or retrospective evaluation. Appropriate sources include participant testimonies and participant surveys (Clark, 1999) as well as naturally occurring evidence such as clinical outcome measures and exit interview data generated at the conclusion of each participant's programme.

Sridharan and Nakaima's (2012) third question (above) poses a particular challenge to the evaluator. They point out:

> "Initial theories of change are rarely ever precise enough to define the contingencies
> that are needed for complex interventions to impact long term outcomes like health
> behaviour change or improvement in health" (p.383).

Clarke (1999) adds that, in practise, programme theory that drives the design and delivery of social programmes is generally derived from intuitive assumptions rather than empirical evidence.

Programme implementation and delivery

The terms implementation and delivery describe the transfer of the concept and theory of the programme to the participant. The two terms are used to differentiate between customer facing and non-customer facing delivery. For example, provision of training to practitioners and production of programme manuals would be described as implementation. Presenting specific interventions to participants would be described as delivery. Implementation and delivery may be defined as the provision of interventions that are faithful to the programme logic, concept, implementation theory and programme theory. There are potential difficulties with this.

Course participants can influence the content and style of delivery by their reaction (positive or negative) which practitioners may be aware of and responsive to. Practitioners' comprehension of the programme's logic can vary. Limitations of time may influence the relative weight and emphasis given to certain interventions. Logistical considerations such as venue location and appropriateness and course timings influence the delivery of interventions. Content may be added or removed by practitioners responding to immediate challenges. Both content and style of delivery may be subject to pressures from commissioners and other stakeholders who seek rapid results. This may be prevalent where programme providers are 'paid by results' (Battye, 2015).

The role of the evaluator here is not to discard 'impurities' in the delivery of the programme concept but to work with them. Cronbach (1980) points out that even in extremely well controlled programmes and evaluations, amongst other flaws, practitioners are not briefed properly and materials are delivered late or not at all amongst. Good evaluations welcome the imperfections into the study.

Implementation could be described as *programme theory* in *practice*. An evaluation should describe the extent of, and the ways in which, the practical programme delivery deviates from the programme theory. The study should then describe the *results* of these deviations in terms of programme outputs. These might be positive, negative or make no apparent difference. As indicated by Cronbach (1980) above, each of these findings leads to valid assessment of a programmes worth.

Questions the evaluator may wish to ask include:

What are practitioners' understanding of the programme logic, concept and theory?

Are the procedures for programme delivery well defined and sufficient?

Was sufficient training given to course practitioners? What was included in the training?

Were there facilitation guides explaining how and why interventions were delivered?

Was there supervision of programme practitioners evidencing fidelity of practise?

Are programme resources such as workbooks consistent with theory?

What deviations between programme design and delivery were observed?

What impact did these deviations have? Was the impact sufficient to corrupt the programme theory?

The evaluator may refer to course materials, workbooks and facilitator guides and locate records of programme progress reviews. They may also interview programme practitioners focusing on their interpretation and practical implementation of the programme and speak with programme participants on their experiences of how the programme was delivered.

Programme Outputs

Programme outputs are observable changes in participant behaviour and outlook which can be attributed to the intervention rather than extraneous influences. Hansen (2005) describes this process as change reasoning; the extent to which the object of evaluation changed in terms of behaviour.

Outputs are not unitary facts. Rossi et al (2004) describe them in temporal terms of initial, intermediate and longer term. Pawson and Tilley (1997) define outcomes as observations of mechanisms and contexts alongside outcomes. Morell (2005) discusses 'consequences' and asserts that there are frequently unintended and may be both foreseeable and unforeseeable. Cronbach (1980) proposes that the results of an evaluation are so dependent on the setting that the evaluator is essentially an historian of the programme.

A desired outcome of CMP would be for a participant to believe that his or her health no longer poses a significant barrier to gaining employment. Others include use of mood-management strategies, ability to relax, effective communication and increasing activity. At the point of programme completion, outcomes may take the form of changes in outlook rather than in substantive behaviour change.

Evaluators may identify outcomes by interviewing participants though this may pose some difficulties. Behaviour change may be adequately described in an interview but it cannot be observed in practice. Some participants may provide pleasing feedback without foundation for their optimism (Grimm, 2010). The interviewer should seek specific examples rather than general tendencies by looking for evidence of changes in behaviour due to increased confidence. Evaluators should ask open questions and wherever possible, seek specific examples.

A method of evaluating outputs could be to explicitly test participants by asking them to describe strategies for improving sleep and relaxation skills or asking them to positively re-frame a negative assumption about ability their health or the workplace. An alternative might be to ask participants which strategies they intend to use and the reasons why. Interviews held at the end of a programme are likely to indicate a high point in motivation which may reduce the reliability of the impact evaluation. There is also limited time for the individual to make significant behavioural changes at this point.

The evaluator may identify outcomes through use of formal measures such as the Work Confidence Questionnaire used in CMP which asked the following questions:

1 – I am able to manage my health at work

2 – Working will not adversely affect my health

3 – I am able to find work

4 – My health does not affect my ability to work

using a Likert Scale with the following responses:

1 – Much less confident

2 – Less confident

3 – No change in confidence

4 – More confident

5 – Much more confident

Clinical outcome measures give a snapshot view of their mood at the time it is administered. Significant improvements suggest that participants currently feel 'better.' The CMP in Norfolk featured pre and post course Hospital Anxiety and Depression Scores (HADS). However, improvements may be attributable to increased social contact during course attendance which might return to its previous state after the programme or to other factors unrelated to the programme. Most importantly when considering outputs is that an instrument such as HADS measures mood itself rather than the *ability to manage* mood which is the expressed intention of the programme.

Programme outcomes

Outcomes may be described as the programme outcomes put into action. For example, a desired CMP output would be for participants to have greater control over the symptoms of their condition.

This could be translated into the outcome of greater work-seeking activity. Under provider-led Pathways to Work, providers were paid by results. Each participant returning to work was described as an 'outcome.' Other outcomes may have included greater use of social resources, increased contribution to community activities, seeking and obtaining opportunities for voluntary work and continued use of skills learned on CMP to manage health conditions. Evaluation of pilot CMP programmes indicated behaviours which were described as demonstrating movement towards work (Kellet et al, 2011).

As with outputs, outcomes may be identified through analysis of policy documents and promotional materials or they may be inferred from internal reviews and management documents associated with programme delivery.

However, not all programme outputs are desirable and the challenge to the evaluator is to identify any outcomes which are attributable to the programme input (Morell, 2005). Pawson (2005) alerts the evaluation community to the possibility that programmes may, for some participants in some contexts, lead to negative results.

> "Programmes work for some and to the detriment of others, they create benefits for
> him and poverty traps for her, what seems sound in Yorkshire may not apply in New
> York" (p. 582).

Pawson (ibid) describes 'scavenging' for data on processes and outcomes associated with programmes in order to establish desired outcomes. Emergent outcomes may be established by seeking the testimony of course participants. An evaluation may throw light on each step of programme delivery, and give evidence of weaknesses, strengths and suggestions for improvement.

A social policy initiative has a wide range of stakeholders: policy makers, policy implementers, evaluation commissioners, practitioners, participants and evaluators. These roles have implications for the type of evaluation undertaken and for evaluators themselves.

Government departments normally want to assess the results of their policies within timescales dictated by elections and parliaments (Sridharan and Nakaima, 2012). Summative evaluations may be favourable to policy makers who seek to question whether (or prove that) an initiative has worked. When Pathways to Work was launched, the last Labour government set a target of reducing the number of incapacity benefit claimants by one million within ten years (DWP, 2006). The wording of the goal lends itself to a summative evaluation. The CMP element of 'Pathways' was commended by some for positive impacts (Ford, 2008; Corden and Nice, 2006; Barnes and Hudson, 2006) however it was criticised for falling short of targets (NAU, 2010). The National Audit Office, in

particular, pointed out that the positive outcomes of claimants coming off incapacity benefits and finding employment were mainly due to stricter work capability assessments and not due to Pathways to Work or CMP. Consequently, the 'go/no go' decision as described by Cronbach (1980) swung decisively in favour of 'no go' and health related programmes were abandoned in favour of a 'work-first' approach as soon as contracts had run their course (Warren et al, 2013).

However, the re-emergence of health-related inputs in a pilot scheme begun in 2013 (Warren et al, 2013) calls for greater insight into the effectiveness or otherwise of the 'health-first' approach. A rigorous experimental design calls for a comparison of those who received the intervention with a control group (Cook and Campbell, 1979). This requires random allocation of participants bringing outcomes that are unbiased, internally valid and free from selection bias (Greenberg and Morris, 2005). However, an experimental design to welfare to work evaluation brings several challenges. Participants may differ in drive and motivation even when they are not selected; the 'Hawthorne effect' (Astbury, 2010). Experimental designs may struggle with complexity in the social problems (Sridharan and Nakaima, 2012). An intervention versus no-intervention analysis may deliver a valid 'worked' or 'did not work' evaluation but the result may lack transferability to different geographical locations of economic circumstances (Pawson and Tilley, 1997). Overtly 'results focused' evaluations have been criticised for generating less impactful and less innovative programmes (Lehman, 2015).

Greenberg and Morris (2005) describe difficulty in generalizing evaluation results:

> "This is a serious, if obvious problem. Social attitudes, government institutions, the business cycle, the relative demand for unskilled and skilled labour and other relevant factors may change in the years following an evaluation. Likewise, different locations may have dissimilar social attitudes, local government institutions, labour market conditions and so forth. Moreover, the characteristics of programme participants could differ as well" (p.234).

These observations are pertinent to CMP which was delivered both before and after the global financial crisis of 2008 and across geographically and economically diverse conditions.

Criticisms of theory driven evaluation

This evaluation has been undertaken using a theory-driven approach. However, this approach is subject to criticisms. This section examines the relevance of these criticisms to this study and identifies potential alternative methods. Shadish et al (1991) present a history of evaluation in three stages: i) establishment of truth, ii) use and pragmatism and iii) integration, and implore us to build on past achievement rather than assert a hierarchy.

Weiss (1997) summarises some of the hazards of theory based evaluation:

> "The idea of theory based evaluation is plausible and cogent, and it promises to bring greater explanatory powers to evaluation. However, problems beset its use, including inadequate theories about pathways to desired outcomes in many program areas, confusion between theories of implementation and theories of programmatic action, difficulties in eliciting or reconstructing usable theories, measurement error, complexities in analysis and others" (p.501)

Scriven (1994) picks up on both the advantages and disadvantages as described by Weiss. He questions the value of focusing on explanation:

> "In programme evaluation, we are concerned to establish the merit, worth, quality or value of programs, in whole or in part, at the request of some client or clients, and for the benefit of some audience. To do this, we do not need to know how programs work or why they fail to work or even what its components are" (p.75)

For Scriven, *how* a program works is secondary to whether it works and though it may be useful to have greater understanding of the mechanism of success (or otherwise), it is not a necessity.

Scriven (1998) describes a 'minimalist theory of evaluation' by which the worth and significance of the subject being evaluated (evaluand) are established through a trans-disciplinary process comprised of statistics, measurement, decision theory and experimental design and is finally expressed as conclusions which describe ranks, scores and grades. This process is preceded by a scoping exercise to establish the purpose of the evaluation, the nature of the evaluand, the criteria for establishing merit, validation of sources by which these criteria are established and the weight or relative importance of these criteria. Scriven (1998) describes programme logic as

> "…a kind of organization chart of the links between inputs, components and outputs and outcomes" (p.61)

However, this logic is not to be used as an evaluation finding but as *part* of the scoping process described above. Scriven (ibid) questions the use of the term *theory*.

> "One often finds students thinking that identifying the components of an evaluand…is a sign one is doing theory-driven evaluation. On the contrary, it is merely a sign that one is doing one species of analytic evaluation – something which had been identified and done long before theory-driven emerged – involving no theory in anything like the proper use of that term" (p.59).

Whilst pointing out that understanding something's components (such as the parts of a vehicle) does not equate to a theory (for example, of mechanical locomotion), he accepts that understanding the 'instructions for assembly' (1998) can be helpful for pinpointing a failure or inefficiency in a process. In the main, however, theory or, as Scriven describes it 'deep explanation,' is the domain of subject experts *not* evaluators and attempts to establish theory may jeopardise the core purpose and requisite skills of evaluation. The trans-disciplinary skills of evaluation include planning, designing, needs assessment, goal-clarifying, diagnosing, recommending, auditing, decision-making, selecting, trouble shooting and the formulation of regulations and legislation (Scriven, 1998) and may be applied to everyday life, managerial life, professional life and governance as well as to programmes. In such terms, it is hard to conceive of a theory driven evaluation of organisational values or the extent of team-working since the measures of success are hard to operationalise. Where it is hard to elucidate meaningful theory, there is a risk that that theory-driven evaluation may end up evaluating the theory rather than the practice (Coryn et al, 2011).

However, Donaldson (2007) differentiates between *theory driven* in the scientific sense described by Scriven and *program theory-driven.* This study does not seek to establish a *theory of reemployment for long term incapacity claimants* but to understand the *theory of the programme* and analyse its actual effects relative to its intended effects.

Weiss (1997) (above) points to measurement error and complexities in analysis. At the heart of these lie validity, generalisation and transferability. The pilot studies of CMP were evaluated using a *realistic evaluation* approach (Pawson and Tilley, 1997) and were judged as promising enough to justify further commissioning (Ford, 2008). CMP was subsequently judged to have failed (NAU, 2010) on the basis of a hard-headed analysis of its unimpressive return to work outcomes. An experimental approach might have offered an alternative method of assessing the pilot programmes. Campbell (1969) alluded to pitfalls in interpretations of data that may be relevant to CMP:

> "…political jeopardies…are often sufficient to explain the lack of hard-headed evaluation of effects…It is one of the most characteristic aspects of the present situation that *specific reforms are advocated as though they were certain to be successful*" (p.172).

Measurement of CMP was subject to several threats to internal validity outlined by Campbell (1969). It commenced shortly before the 2008 banking crisis and subsequent recession making it susceptible to the threat of history. The use of testing instruments may have influenced participants scoring behaviour either positively or negatively. The first collection of clinical outcomes data was taken when participants were likely to experience heightened anxiety leading to false positive clinical

outcomes at the second stage of collection. Participation based on high clinical outcome measure scores was likely to lead to regression artifacts. The programme was subject to selection bias. Being voluntary, it potentially recruited individuals who were more motivated to achieve employment. It was subject to experimental mortality because outcome clinical data were not collected for those who did not complete their programme.

CMP evaluation was also subject to threats to external validity defined by Campbell (ibid). Altered job seeking behaviour may have been attributed simply to attendance rather than the effects of the programme (interaction of selection and experimental treatment), participants may have been subject to multiple influences and pressures regarding employment (multiple treatment interference), the clinical outcome measures (related to health) may not measure factors closely related to job-seeking behaviour in long-term claimants (irrelevant responsiveness of measures) and the programme itself may not have been delivered consistently (irrelevant replicability of the treatment).

Whilst there are ethical considerations to operating a non-treatment control group, Daponte (2008) offers quasi-experimental designs that allow for some of these threats. The timing of evaluation is significant. Observations undertaken too soon after the treatment may offer a false positive whilst those undertaken after a long delay may offer a false negative. CMP was designed to improve health management and confidence. Knowledge may take longer both to gain and to lose whilst confidence, especially in the context of a motivational or inspiring group, may rise swiftly but fall equally quickly once the support of the group is lost. A time series design where observations were taken at specified intervals based on a sound scoping exercise between evaluators and programme providers (Scriven, 1998) both before and after an intervention may have offered a pre-test – post-test data set capable of locating an effect caused by CMP. A control group undertaking the programme after an earlier cohort completed the treatment would offer a valid comparison whilst negating ethical concerns around denying treatment.

The purpose of the designs suggested above is to assess whether there was a change, establish if the programme caused the change and assess whether the change might have been observed without the programme. Further manipulations of the programme assessed in the same way could further illuminate the intensity of the intervention required to bring about change (dose-response). Whilst there are problems with control groups in the case of CMP (individuals differ in motivation and the control group may be subject to diffuse interference through health services or other employment assistance), Campbell (1969) asserts that it is only *plausible* rival hypotheses that can invalidate findings:

"It is not failure-to-control in general that bothers us, but only those failures of control which permit truly plausible rival hypotheses, laws with a degree of scientific establishment comparable to or exceeding that of the law our experiment is designed to test" (p.356).

Even if it were possible to apply standardised treatment (subject to the procedures applied in laboratory experiments), Cronbach (1980) questions whether this would offer greater utility to the policy shaping community. It is likely that further treatments offered after the 'experiment' would differ. As such, variation in treatment (described by Cronbach as a 'certain' to occur) should be seen as acceptable *as long as it is observed* (p.276). Cronbach offers number of measures to promote generalisability in both experimental and non-experimental designs. Observations from sub-populations may be separated and measured using a matrix format. In terms of CMP, this might include 'soft' variables such as length of claim, self-rated distance from the workplace and levels of qualification and experience. 'Hard' variables would include demographic data such as age, sex, ethnic background and geographical location. Cronbach also advocates the use of two or more instrumental or other indicators as a means of challenging threats to internal and external validity.

The theory driven approach seeks to explain outcomes enabling greater formative evaluation (Pawson and Tilley, 1997; Weiss, 1997). However, the measures outlined above by Cronbach (1980) suggest that such utility may be achieved from non-theory driven approaches, a view shared by Scriven (1994):

"Formative evaluation is not only possible without explanations and recommendations, it is essentially distinct from providing them and it can have great utility without them" (p.77)

However, Cronbach and Scriven differ considerably in their view of the role of explanation. Cronbach (1980) writes:

"The only way that the PSC [policy shaping community] can exercise judgment about future programs bearing the same label as the *T* studied is to understand the process by which the treatment works. Understanding is required to make use of even a well-grounded formal conclusion" (p.274).

Cronbach's (ibid) view is that the evaluation should not provide the reader with the ultimate judgment of the value of a programme (as propounded by Scriven) but to 'illuminate the decision' (p.155) with relevant and robust information leaving the literal evaluation of the programme to the reader.

A quasi-experimental design for the evaluation of the Norfolk CMP could have been implemented by comparison with a counterfactual made up from individuals who were referred and assessed for CMP but did not undertake the intervention itself. Return to work outcomes could be compared between the two groups. Alternatively, the counterfactual could be taken from a random selection of claimants who were never referred for CMP and therefore were untouched by Pathways to Work. This design would have the benefit of establishing whether there was a statistically significant difference in return to work outcomes.

There are problems with this approach. An individual who was assessed for CMP but did not then participate could not be said to have had no intervention. The assessment required attendees to give focused consideration to their health and employment for one hour in addition to anticipatory thoughts and subsequent reflection. Some individuals reported increasing job-seeking activity to avoid participation in CMP (Mitchell and Woodfield, 2008). Individuals who declined to participate may represent a self-selecting group of resistant individuals whilst those who elected to participate could be seen as intrinsically motivated.

A control group having no contact with Pathways or CMP may have experienced no influence at all giving a 'pure' comparison. However, chronic benefit claiming is thought to be self-perpetuating in its very nature (Freud, 2007) so it is questionable whether 'no programme' really means no influence. Conversely, behaviour change following intervention could be attributed to the fact that a programme existed rather than to an active component *within* the programme. Welfare to Work has been described as a 'blend of help and hassle' (Peck and Theodore, 2000) implying that selection for a programme is, itself, a causal factor in the generation of outcomes.

A critical drawback of the experimental approach, pertinent to CMP, is its propensity to draw binary conclusions (Pawson and Tilley, 1997). In other words, knowing what works does not necessarily help us to understand what *specifically* worked and why. Greenberg and Morris (2005) assert:

> "Policy makers often want to know which elements of the package were most effective. Addressing this question rigorously with a social experiment requires a somewhat more complex design" (p.232).

CMP participants were subject to a selection of different interventions within Pathways to Work. To realise an experimental design along the lines of those discussed above, would require multiple experiments across multiple sites which is beyond the resources available for this evaluation.

The interests of stake-holders may influence evaluation design and also evaluators. Early CMP evaluations were commissioned by the Department for Work and Pensions which was also

responsible, alongside the NHS, for delivery of the programme. Cronbach (1980) points out some difficulties such arrangements may pose to evaluators:

> "The problems of probity in evaluation lie in the behaviour of sponsors and evaluators. The solutions lie in the development of effective critical review to foster proper relations between them. At present, not many evaluation researchers have the freedom of the free-lance critic…Intimacy is no deterrent to frankness, nor is the formal status of contractor (as opposed to employee) a guarantee of frankness" (pp.18-19).

Cronbach (1980) expresses a pragmatic acceptance for the evaluator who has to reconcile aspirations to benefit society with commitments to their sponsor and a desire stay in business. Pawson and Tilley (1997) take this point further asserting that "he who pays the researcher, calls the methodological tune" (p.14) and that policy makers may demand that "evaluation results show us that the [intervention] works" (p.17).

Rather than assess the outcome of CMP, this evaluation examines the *efficiency* of the programme. If a programme were thought of as a journey, its efficiency could be described as the directness of the route taken. The efficiency can be established by examining the strength or integrity of the programme design by asking whether each stage of the programmes development consistent with the needs and designs of the stages that precede it. Measuring outcomes is a part, rather than the purpose, of this process. As such, this evaluation is driven by identification of programme theory and its translation into practise.

However, the focus on *all* stages of the programme's development calls for mixed methods. At the inception of the programme is government policy. At the end point are participants with their unique histories, personalities and needs. Simons (2015) calls for a constructivist approach to case studies arguing that the 'reality' of a programme can be co-constructed through the process of the evaluator working alongside participants making sense of what happened. This evaluation seeks to build a map of concept, input and output for the Norfolk CMP using of historical sources that indicate programme concept, analysis of naturally occurring data generated at the time of the programme and in depth interviews with programme participants and practitioners.

Part 2 – Qualitative evaluation methods

Details of all research methods used in this study are summarised in Table 2.1 below.

Aspect of programme being evaluated	Method	Date	People involved	Additional comments
Context and implementation	Literature review	2013 - 2017	Author	
Problem conception	Literature review	2014 - 2017	Author	
Programme design (concept, programme theory and implementation theory)	Written requests for individual recollections of key stakeholders.	Sept 2015 Oct 2015	Andrew Smith MP CMP implementation manager (anon)	
	Review of promotional materials	Aug 2014	Author	
	Review of programme manual and facilitator guides	Aug 2014	Author	
Programme delivery	Auto-ethnographic account	March 2011	Author	
	Practitioner interviews: Interpretative phenomenological analysis	Nov 2015	3 x practitioner (anon)	Ethical approval granted: Nov 2015
Programme outputs	Hospital Anxiety and Depression Score (HADS) Occupational Self-Assessment (OSA) Work Confidence Questionnaire (WCQ) Return to work timescale	March 2008 to March 2011	Naturally occurring data collected as standard CMP procedure	
	CMP 'express' customer feedback sheets	May 2010	7 participants	Voluntary participation
	CMP 'one to one' format feedback sheets	April 2010 to March 2011	12 participants	Voluntary participation
	Return to work outcomes	Nov 2011 to March 2012	101 x CMP participants	Former participants were contacted by phone to establish benefit or return to work status
	Recorded 'exit interviews'	Dec 2010 to April 2011	9 x participants from 'express' and 'one to one' programme formats	Ethical approval granted: Nov 2010
Programme outcomes	Recorded Case Study interviews: Interpretative phenomenological analysis	Dec 2013 to July 2014	6 x participants from all CMP formats	Ethical approval granted: Nov 2013

Table 2.1: Summary of data collected

Case studies and Interpretative Phenomenological Analysis

The second section of this chapter sets out the theoretical framework and associated methodology for the use of case studies. Case studies provide rich, qualitative data from participants' perspectives. They focus primarily on problem conception and outcomes and, to a lesser extent, on programme delivery.

The method chosen for the case studies was Interpretative Phenomenological Analysis. The intention was to portray the person in their transition from health and work to decline in health and loss of employment, the progression of their claim for benefits through to participation in CMP and beyond. CMP was intended to be 'holistic,' (Ford and Plowright, 2008) considering psychological and social features as well as biological factors relating to incapacity. These case studies seek to describe the 'whole' person in the context of their employment and subsequent benefit claim.

The case studies have advantages over the previous recorded exit interview data. The passage of time allowed for the emergence of biographical information *after* CMP. The likelihood of participants providing 'socially desirable' responses is lessened in the light of subsequent employment progress and the passage of time. Reflection on CMP may be more objective for several reasons. Since exit interview data was shared with Shaw Trust (who were acting on behalf of the DWP) participants may have self-censored their responses out of anxiety related to their benefit security. Such fears would have lessened with the passage of time and, in the context of case-study interviews, they maintained anonymity.

The scope of the interview (leaving school until present day) gave the opportunity to see the CMP in a broader context. An observer of programmes in real time may be tempted to inflate its significance in for participants. A programme might be described at the time as 'life changing' but reflection after significant passage of time allows impact of this life change to be assessed realistically. It is hoped that building a picture of the person's situation leading up to participation in CMP and beyond provides the opportunity to observe outcomes in the context of wider influences that were beyond the scope of CMP.

The purpose of the case studies is to gather evidence of how some participants reacted to CMP in both the short and long term taking into account their histories before participation. This evidence can help test the validity programme development in terms of fidelity as discussed in the first section of this chapter. The stories should reveal where participants' fit with the explicit problem conception and programme theory, where they did not fit and offer potential explanations for both.

An incapacity benefit claimant may need compelling reasons to change. Aside from their health condition, they might ask: Am I likely to find the kind of work I would like to do? Am I likely to pass an interview? Are employers likely to want me to work for them? Do I have relevant skills, experience and qualifications? Am I likely to keep my job if I get one? Will I cope with the requirements of the job? Would I 'fit in' at work? Does work fit with my new lifestyle and commitments? Do I feel able to 'compete' for work and retain a new job amongst people who have not been benefit claimants? They might also ask whether they would be better off financially.

Insight into a person's sense of their own best interests in light of these considerations could be gained by detailed history-taking and candid discussion about their life, health and employment. The immediate results of these case studies are stories which present distinct problem conceptions. The interventions within CMP and the programme theory behind them can be assessed considering the outputs and outcomes distinct to these cases.

At the heart of CMP lies the question of why many IB claimants did not seek work and what could be done to address this. It is established that depression and anxiety are causes of incapacity. Conversely, receipt of incapacity benefits *causes* anxiety and depression (Artazcoz et al, 2004; Bambra and Eikemo, 2009; Price et al, 2002). This evaluation seeks to identify what works, for whom and under what circumstances (Pawson and Tilley, 1997) and is therefore concerned with the element of incapacity which could be described as 'being on benefits.'

CMP participants described loss of status, reduction in self-esteem and confidence, stigmatisation, loss of 'currency' in the workplace and a sense of social marginalisation. These factors require individuals to revise their views of themselves in light of changes in relationships and interactions with family, community and wider society (McFadyen, 1995; Jakobsen, 2001). Society includes not just other people but organisations such as the NHS, Benefits Agency, Job Centre and welfare to work providers such as Shaw Trust.

Life on incapacity benefits infers not just loss of employment but threat to identity in terms of 'self' (role identity) and in society (social identity). Changes in health and employment status bring about new relationships with the state and, with them, a different quality of interaction; a transactional relationship in which the state provides benefits in return for proof of illness and evidence of attempts to recover (Burke and Stets, 2009). This quality of relating influences the individual's personal and social identity. Health conditions drive changes in individuals' identities and new forms of social interaction. Individuals who claim health benefits may also begin to develop a new relationship with their *health* (Charmaz, 1997). The meaning of health or illness may move beyond the experience of symptoms and personal impacts and become a feature of identity and focus of

interactions with the state. For the claimant, an ongoing incapacity benefit claim may involve a complex relationship between their health, their identity and with society.

In light of this, case studies investigate the lived experience of individuals who have experienced these transitions and explores how evolving relationships with self, society and illness impact on job seeking behaviour.

Theoretical Frameworks

In this section, the three components identified above (claimants' relationships with self, with society and with their health) are examined within the theoretical frameworks of identity theory, symbolic interactionism and social constructionism respectively.

Identity theory benefit claimants' relationship with self

Identity regularly emerges as a superordinate theme in the wider body of IPA studies Smith (2004). Identity theory seeks to explain the meanings that people hold for themselves within the various roles that they hold (Burke and Stets, 2009). These roles include membership of particular groups, social and work contexts and meanings associated with the 'type of person' an individual sees themselves as being. For example, a person might see themselves as hard-working and capable. They may also find meaning in a vocational role such as 'I am a tree surgeon' or 'I am a teacher.' Identity has been described in terms of capital (Cote and Schwartz, 2002) meaning that individuals may obtain 'ego strength' that leads to future personal and economic benefits for example 'I am an Oxbridge graduate.' Identity theory posits that the meanings associated with such roles are not simply the sum of the experiences of the person within the role but are the product of a historical and ongoing, reflexive discourse (Riach and Loretto, 2009). A work identity is commonly used to establish 'how we are' and 'how we are doing,' (Jakobsen, 2001).

In the terms described above, it is unsurprising that some CMP participants found loss of employment to be harmful to their sense of worth. Case studies analysis (Chapter 8) demonstrates how some participants experienced feelings of shame upon losing employment. Charmaz (1991) describes how illness impacts on self-concept leading, eventually, to loss of agency and inertia:

> 'Loss of self means being involuntarily dispossessed of former attributes and sentiments that comprise one's self-concept, as well as the actions and experiences upon which they are based. It also means losing the self-definitions with which one had most identified. With loss of self, earlier boundaries of the self-concept shrink and become permeable. The self grows vulnerable to demeaning images reflected by

others. The attrition of former attributes and sentiments results in changed feelings about self. Resignation follows. Hence, loss of self, results in passivity' (p.258).

Following a crisis in identity, a need to re-establish identity in new terms emerges. Conrad and Barker (2010) describe how individuals make sense of their situation and reclaim a sense of self in the case of a health condition:

'People endeavour to endow their illness with meaning within the context of their personal and social relationships, employment status, health insurance coverage, religious and cultural beliefs, and the like. Individuals may abate an erosion of self by engaging in identity reconstruction' (p.72).

Conrad and Barker establish a link between identity of self, personal meaning of illness and interaction with social institutions and culture. In any context (including amongst people who have jobs), failure or disappointment may be understood as the impact of illness rather than of personal choice or competence. This is especially the case where there is a concurrent health condition or a social environment which is sympathetic to health concerns. These factors may interact to form a personal construction of a situation such as the background to an incapacity claim. This construction may not be objectively accurate but may be held as true by the individual. In such cases, this belief forms an element of the 'problem' of incapacity claiming.

Symbolic interactionism and benefit claimants' relationship with society

Symbolic interactionism contends that individuals act on the basis of the *meanings* that things have for them and that meaning is created first by perception and then interpretation of events or situations in the world in light of this perception (Benzies and Allen, 2001). The relationship between the individual and their environment may be seen as reciprocal. For some CMP participants, being 'on benefits' was commonly described as demeaning and resulted in resentment or passive compliance. Symbolic interactionism asserts that the 'meaning' of benefit receipt is not based on objective reality but the *interaction* between the individual and their environment. In the context of this study, *environment* refers to both government agencies and other individuals or organisations who express opinions about welfare and benefits.   Being 'on benefits' is, therefore, a constantly changing, reflexive relationship which impacts both individual and environment.

Stryker (2002) describes how interactionism allows for both agency and 'stuck-ness':

'The structural symbolic interactionist frame incorporates…ideas that on the one hand stress the possibility for openness and fluidity of social interaction, self-direction and

human agency and on the other hand stress constraints on that openness, fluidity, self-direction and agency inherent in the fact that persons are members of society' (p.211)

This provides a potential basis for understanding the conflict between action and stasis in terms of job seeking. Benzies and Allen (2001), using similar terms, describe how individuals may retain agency yet still be constrained by society:

> 'Ideas and behaviours are distinctive processes that are constantly changing depending on how the individual interprets the world. However, these changes occur within the constraints established by the characteristics of the individual and the environment and as such humans are nondeterministic, yet predictable in some ways' (p.542)

This offers an explanation as to why some CMP participants appeared to clearly retain agency in some aspects of their life whilst simultaneously appearing to be helpless in others as was apparent from case studies (Chapter 8).

Social constructionism and benefit claimants' relationship with health

Social constructionism requires the researcher to adopt a critical stance towards 'taken-for-granted' ways of understanding the world potentially resulting in radically different explanations for social phenomena (Burr, 2003). Applying this to incapacity claiming necessitates looking beyond appraisal of health purely in terms of symptomology or diagnoses indicated by psychological instruments (Snaith, 2003; Keilhofner and Burke, 1980). Incapacity may be seen to exist as how an individual makes personal sense of it. It has been argued that incapacity does not exist in ontological terms; that it is, instead, a construct created out of language, discourse and culture (Elder-Vass, 2010). Social phenomena such as incapacity may be seen as the result of historical events, social forces and ideologies (Hacking, 1999).

A social constructionist view of illness suggests that health conditions are embedded with cultural meaning (Conrad and Barker, 2010). *Meanings* are reflected back to the 'patient' influencing their experience of being ill. Knowledge of illness may be constructed by interested parties (with medical and political implications) (ibid). In the case of this evaluation, the 'medical' implication is the diagnosis which gives the patient's complaint a diagnosis and the 'political' consequence may be the emergence of health-based welfare to work initiatives.

The *combined effect* of constructs of identity, society and illness form the individual's conception of the problem of being an incapacity benefit recipient. The combination of personal distress, the need

to maintain self-esteem by attending to self-identity and the increasing trend for medicalization of distress may lead to a justification for the 'incapacity' label (Millward, Lutte & Purvis, 2005).

Theoretical underpinnings of Interpretative Phenomenological Analysis

IPA brings together hermeneutics and phenomenology (Pringle et al, 2011). Phenomenology uncovers meanings whilst hermeneutics interprets them. At all points in the analysis of data, what the participant actually says remains fundamental. Implications arising from an IPA study are rooted in participants' statements and are usually supported by direct quotations (Pringle et al, 2010). Shinebourne (2011) adds ideography as a third strand of IPA's epistemological framework. Whilst IPA cannot test hypotheses or provide broad generalised conclusions, single case-studies offer the opportunity to achieve a narrow but deep appraisal of a unique and specific situation (ibid).

Brocki and Wearden (2006) emphasise how symbolic interactionism (and phenomenology) informs the application of IPA describing how the fundamentals of symbolic interactionism:

> '…human beings are not passive perceivers of an objective reality, but rather that they come to interpret and understand the world by formulating their own biographical stories into a form that makes sense to them' (p.88).

Therefore, the work of IPA is to learn something about a person by making sense of this individual making their own sense of their experience, a process Smith calls *double hermeneutics* (2004). Making sense of the individual in this way enables the interviewer to construct a *formulation of incapacity*. This is a summary of the themes generated in the interview which relate to the individuals experiences, beliefs and behaviours related to employment and receipt of benefits.

IPA and Hermeneutics

Smith (2007) describes bracketing off or at least acknowledging his preconceptions about a subject before meeting with a research participant. His description of an encounter with a research participant chimes with person centred theory of psychotherapy (Rogers, 1951).

> 'Whatever my previous concerns or positions, I have moved from a point where I am the focus to one where the participant is the focus as I attend closely to the participant's story, facilitate the participant uncovering his/her experience. This requires an intense attentiveness to and engagement with the participant as he/she speaks' (p.6).

Here, Smith describes the hermeneutic circle in terms of the dynamic between the researcher and the participant. The beginning point is the researcher with his concerns and preconceptions. Having encountered the participant in the manner described above, he returns to his starting position but is

changed by the encounter and so the process continues from the researcher's new starting point. The outcome is a revelation of the participant's experiencing. In person centred therapy, this process of intense consideration of an individual's experience, combined with deliberate positive regard for the participant results in a different kind of 'research' in which the researcher is the client who learns something new about themselves or how they experience themselves.

The primary hermeneutic circle, according to Smith (ibid) is the relationship between the part and the whole. In the same way in which a word cannot be fully understood without the context of a sentence, a sentence cannot be fully appreciated outside the context of the specific passage and that within the complete text. Understanding develops in a circular rather than linear manner as each word informs the sentence and the sentence informs the word. Allowing the completion of each 'circle' at each level of analysis (word, sentence, passage, text, oeuvre and ultimately a person's whole lived experience) enables a picture to emerge. In the context of CMP, appraising participants' experiences through a hermeneutic lens helps the researcher to imagine what might lie beyond the 'face-value' statements that are represented in much qualitative research conducted with early CMP participants. For example, it is interesting to note a comment such as:

> 'We have got goals, not just ploughing through life aimlessly, that's what I feel.' (Pittam et al, 2008 p.42).

It is interesting that this person has goals as a result of their CMP but the significance of 'ploughing' and 'aimlessly' requires a context which, explored delicately, may reveal more than just the need for goals and direction.

Smith also explores the role of presupposition within interpretation. It is suggested that to understand another person's experiencing, it is necessary to bracket off personal presuppositions (Brocki and Wearden 2007) but Smith draws on Heideggar (1962) to illustrate the importance of having a 'fore-conception' in order to apprehend a phenomenon as well as to shape understanding through the hermeneutic circle as described above.

> 'Whenever something is interpreted as something, the interpretation will be founded essentially upon the fore-having, fore-sight and fore-conception. An interaction is never a presupposition-less apprehending of something presented to us (Heideggar, 1962 pp. 191-192 quoted in Smith, 2007 p.6).

Moran (2000) describes this process:

> 'When we see something, we always see it *as* something and project a certain set of expectations upon it, expectations which are then fulfilled or exploded in subsequent perceptions' (p.234)

Research necessitates focusing of attention on new learning rather than on preconceptions. However, avoidance of preconceptions is only possible when they are known. It is through encounter with research participants that new objects of interest and awareness bring to light 'fore-conceptions' that were beyond the researcher's immediate awareness (Shinebourne, 2011) and shape them into new understanding.

It is in this way that IPA is an idiographic or 'bottom up' approach. Hypotheses cannot be tested using IPA. Instead, the analysis *generates* hypotheses; the meaning and understanding of an individual's experience emerges. The overarching purpose, like some psychotherapeutic approaches, is to reveal the previously unseen. In a further link to psychotherapy, Smith (2007) describes the application of phenomenology and hermeneutics as requiring an agility or light-footedness to jump between the grammatical and the psychological or, in other words, from words to meanings to implications and back to language. As Smith (ibid) puts it:

> 'When analysing the language, I am also analysing the person. My analysis of the person helps make sense of my analysis of the language' (p.9).

The concept of 'part and whole' described above, can be extended to other sources connected to the research participant (Smith, 2007). As both researcher and practitioner within the CMP, the author is able to analyse interview transcripts in light of other data including written notes from initial 'assessment' meetings and later 'exit' interview comments. Smith (2007) contends that each piece of data may be interpreted in terms of the hermeneutic circle and then in relation to a series of 'concentric circles.'

Principles of IPA

IPA delivers a narrow but deep investigation of a phenomenon which aims to give a whole and complete picture of a person focusing on their uniqueness rather than seeking generalisations. Such studies could be seen as subjective, intuitive and impressionistic (Malim et al 1992). Smith et al (2009) advise IPA researchers to think in terms of 'theoretical transferability rather than empirical generalizability.' As such, a case-study interview that reveals a problem conception that differs from explicit programme theory cannot be said to certainly apply in other cases; only that it could.

IPA's rigour lies in the fact that findings are rooted strongly in what participants actually say and are supported with direct quotations (Pringle et al, 2010). Smith et al (2009) state that an IPA study's findings must provide a credible account for a phenomenon but not necessarily the only one. However, there is no reason why IPA findings cannot be triangulated with other methods of data collection (Casey and Murphy, 2009). This study presents case-study analysis alongside other data in order to critique the programme theory for CMP. This particular component of the study seeks rich, personal data on benefit claiming and CMP from the perspective of claimants themselves. IPA places the individual at the centre of the enquiry. The overall subject may be a social phenomenon such as problematic IB claimant numbers it is *people* who are implicated in such phenomena. In placing the participants' understanding and meaning-making at the heart of the research task, IPA acknowledges the 'constructed' nature of illness (Brocki and Wearden, 2006).

Application of IPA

Smith and Osborn (2004) describe the purpose and fit of IPA:

> 'It attempts to explore/understand/make sense of the subjective meanings of events/experiences/states of the individual participants themselves. This is in contrast with most psychology which is concerned with: (1) trying to test re-existing hypotheses on the part of the researcher, (2) finding average results for a group of participants as a whole or (3) attempting to produce a quantitative measure of an objective reality.' (p.230)

The participants in the case studies from this study are drawn from a variety of socio-economic backgrounds. IPA has been criticised for being reliant on participants' abilities to articulate their thoughts and experiences adequately (Brocki and Wearden (2007). However, Smith (2004) asserts that there is no correlation between socio-economic status and the richness of the data obtained and that the value of the account is more likely to be associated with the importance the participant places on the particular subject. It is should be recognised that IPA does not simply elucidate facts, rather that is understanding individual's perceptions and responses, the hermeneutic circle (Smith, 2007) where IPA imparts its value. Therefore, intelligent, perceptive or 'accurate' comments from participants on specific phenomena are of no more value to this enquiry than less coherent ones.

The starting point of this study is to evaluate the appropriateness of the broad application of psychological therapy (CBT) in relation to static incapacity claims. It is the *interaction* between person and state (as well as other personal and cultural influences) that must be investigated. The focal point is the individual rather than the condition hence the appropriateness of the

phenomenological drive of IPA. Smith and Osborn (2004) give an example of how IPA might be used to find out how a hospital patient is responding to a particular condition they are suffering from and, in doing so, describe some of the questions the case-studies seek answers to in regard to a person's response to living on incapacity benefit:

> 'What are the particular ways this condition is affecting this person? What influences in the person's biography affect their response? How does the condition affect the person's sense of identity? How does the person interpret the diagnostic label they have been given for their condition?' (p.230)

Sampling and data collection

IPA makes no pretence of obtaining a random sample Smith and Osborn (2004). The sample of individuals recruited for case studies is homogenous in that all attended the CMP and claimed IB on the basis of mental health. However, variety within this group has been achieved in order to give balance. Sub groups within the sample are divided firstly into those who attained or failed to attain re-employment with 12 months of completing CMP and those who did or did not improve clinically.

Semi-structured interview with questions applied flexibly are used to bring out expansive responses from participants. The interviewer should be free to probe interesting areas that arise and be responsive rather than directive. How questions are posed will be sensitive to how the interviewer feels that the participant is responding (Smith and Osborn, 2004).

Formulating questions in advance is not meant to bring rigidity, control or to enhance reliability but to increase the likelihood of achieving a useful set of data and make maximum use of the interview. For example, thinking through subject areas that require sensitivity *before* the interview reduces the likelihood of causing distress or unwittingly influencing participants' responses. It also focuses the interviewer on what he seeks to investigate.

When designing the interview and collating questions, the interviewer should firstly identify the broad areas of enquiry. These may be based on relevant research literature or on programme theory generated from preliminary research. Specific questions should then draw responses in these areas. Finally, the interviewer should decide on a general order leaving more sensitive questions until later when the participant is likely to feel more relaxed. The questions should be open and non-value laden. (Smith and Osborn, 2004). Interviews should be flexible and take the form of a discussion (Reid et al, 2005):

> 'They are easily managed; allow rapport to be developed; allow participants to think, speak and be heard; and are well suited to in-depth and personal discussion' (p.22)

Case-study outputs

Brocki and Wearden (2007) suggest that IPA has grown in popularity partly due to the move away from the biomedical model of disease and illness and towards understanding patients' perceptions. This explanation characterises the deviation between the explicit programme theory (primarily biomedical) and the implied theory espoused by CMP practitioners (Chapter 6) which was primarily social in its grounding. The purpose is to generate portrayals of people that are accurate and distinctive and pick up on more than just 'facts.' Claimants may be linked by shared diagnoses but differ greatly in how their workless status was arrived at and maintained. Smith (2004) laments how psychology had lost its drive towards meaning in favour of being the science of 'information processing.' Only rich, personal detail of a person's life allows the researcher to investigate why some participants seized the opportunity whilst others held back in terms of making best use of CMP?

This is not to suggest that participants' stated views were necessarily accurate in explaining the problem behind incapacity claiming. Larkin et al (2006) present the dual, complimentary commitments of IPA as 'giving voice' to the concerns of participants and making sense of them from a psychological perspective. Interpretation is key in this instance. Smith (2004) aligns IPA with cognitive psychology in terms of it being the science of meaning making. The political context of incapacity claiming was not lost on benefit recipients (described in Chapters 7 and 8). The inductive nature of IPA allows a setting aside of political and societal issues and their consequent distortions and instead allows a fresh, bottom up view on what happens in the lives of benefit recipients.

Smith (2004), drawing on Ricoeur (1970), indicates that 'hermeneutics of suspicion' allows for questioning and critical engagement on the part of the researcher allowing them to posit interpretations which the participants themselves might be unlikely, unwilling or unable to see or acknowledge themselves. This is particularly relevant to this study where the controversial nature of the subject of welfare benefits might result in conscious or unconscious distortion within the participant's account. The desired outputs of the case-studies should be formulations of each individual that, supported by direct quotations, outline their unique response to being out of work and claiming incapacity benefits. Each should indicate the composite factors that constitute their situation as a benefit claimant.

Case studies are used in this study to assess the relevance and appropriateness of the programme concept and theory to individual claimants. However, they also generate further understanding of unintended programme outcomes (Greenberg and Morris, 2005; Morell, 2005; Simons, 2015) as discussed earlier in this chapter. This adds to the body of knowledge on incapacity claiming; the

problem conception. The next chapter explores the problem conception as it was understood by the social research and policy making communities prior to the inception of CMP.

Chapter 3 - Incapacity Benefit: Problem conception

This chapter builds on the model of evaluation described in Chapter 2 which proposes that the effectiveness of a programme can be evaluated by examining the continuity of design throughout each stage of its development.

This chapter is concerned with the first stage; understanding the problem of incapacity claiming. Problem conceptions can be analysed retrospectively (Reiss, 1971). They may be inferred through examination of related documents, by interviewing relevant people, through the needs assessments stated in previous research and through logical reasoning. This chapter reconstructs the conception of the problem of increased numbers of IB claimants as understood by policy makers.

The government's conception of static incapacity claims provides the basis for CMP. Subsequent stages must relate to the problem conception if the programme is to be successful (Rossi, 2004). This chapter also discusses alternative problem conceptions as expressed by social scientists and other interested parties. This enables discussion on the appropriateness of the government's problem conception in the context of contemporary thinking. The chapter begins with a discussion on the meaning of the term 'problem conception' then examines three sources of influence for government policy at the time of Pathways to Work's inception. These were the prevailing political agenda, contemporary social research and recent policy interventions. It concludes by drawing together the strands described above into a problem conception statement.

What is meant by a 'social problem?'

The term 'problem conception' suggests that the 'conception' can be distinguished from problem itself. A fundamental problem may be described as an influence or as an outcome. A problem as an influence might be described as *factor(s) that cause effects with harmful consequences*. In relation to IB claimants, these might include health, physical or mental impairments, skills deficits, discrimination, lack of appropriate job opportunities and stigma. These could be described as problem units contributing to the overall problem of being out of work due to incapacity.

An example of a problem as an outcome might be that IB claimants are less likely than non-health related claimants to obtain employment, leading to lower benefit outflow. As a result of the problem units described above, people claiming incapacity benefit are more likely to cease efforts to regain employment compared to JSA claimants.

The conception of a problem may differ amongst different people or groups. Some may conceive the problem in terms of their *reaction* to the fundamental problem. For example, a politician may note that there are *too many* claimants or that claims are *too costly* to sustain. Claimants' problem conceptions may differ significantly from politicians'. They might recognise their challenging financial situation or they might view the problem as one of unfairness or injustice. These are *reactions* to how the problem presents itself to them rather than fundamental, causative factors.

The problem conception could also be described in terms of *why* it is a problem. This differs from the fundamental problem which is characterised by *what is causing* it. The distinction is important for two reasons. Conceptions of problems are belief based reactions which vary amongst different people or groups. There may be resistance to social programmes where the designers conceive of the problem very differently to the individuals who are the subjects of it. However, if the purpose of a programme is to ameliorate a problem then it must address the causative factors (fundamental problem) rather than individuals' reactions.

However, the notion of a problem conception should not be dismissed as redundant. Comprehensive understanding of a problem enables the conceptualisation of a solution. This forms the basis of programme concept, logic, theory and design. It is not easy to communicate a social problem and its resulting programme *only* in terms of fundamental causative factors especially if they are formed of complex inter-related problem units. Problem conception can therefore be regarded as a summative formulation bringing together both *what* is generating a problem and *why* it is a problem.

Political Agenda

Political agenda may be seen as the lens through which the problem is viewed and the solution inferred. Political agenda may be divided into *primary* and *applied* ideology. The former was characterised by Tony Blair's 'third way' concept of welfare provision (Blair, 1998a). Applied ideology is identifiable in policy documents which were driven by and allude to the *primary* ideology.

This section draws on primary sources to describe how political ideology influenced contemporary thinking on incapacity. It outlines the primary political ideology propounded by Blair and demonstrates how this set the guiding principles for subsequent measures. The transmission of guiding principles into specific policies demonstrates fidelity between policy shaping and policy making.

The white paper *New Ambitions for our Country: A new contract for welfare,* introduced by Blair in March 1998, described two options for continued provision of the Welfare State: a *reduction* or an

increase in spending. He describes a 'third way' which would re-envision the relationship between the citizen and the state. This entailed provision of cash benefits but also *services* which would assist citizens out of poverty by helping them gain employment. Absence of paid work was described as a guarantee of life on low income and provision of assistance to enable people to obtain employment was central to the 'new contract' (Blair, 1998a)

> "The government's aim is to rebuild the welfare state around work. The skills and energies
> of the workforce are the UK's biggest economic asset. And for both individuals and
> families, paid work is the most secure way of averting poverty and dependence" (p.23).

Blair called for a change in culture for all concerned parties:

> "The government's biggest investment since taking office has been a large-scale welfare to
> work programme. Our ambition is nothing less than a change of culture among benefit
> claimants, employers and public servants – with rights and responsibilities on both sides"
> (p.24).

At the heart of this change in culture was the concept of a balance of rights and responsibilities which Blair characterised in the phrase "work for those who can – security for those who cannot" (1998a). This is consistent with the primary desire to 'responsibilise' (Considine, 2002) claimants, as discussed in Chapter 1.

The 'new contract for welfare' continued:

> "Of course, many people with disability or long term illness are simply not in a position to
> undertake work. Our commitment to them is unwavering. But there are others who may
> be able to work and who should get more help to do so" (p.27).

This statement implies a deserving versus undeserving dichotomy. The deserving would receive unwavering support but others were to be offered support with the imperative "should," reinforcing the notion of responsibility. Linked to this dichotomy is the understanding that incapacity is not a fixed phenomenon; that there are different levels of incapacity of which some need not prevent paid work.

The new ideology asserted need for change in culture on both sides of the welfare transaction:

> "The responsibilities of individuals who can provide for themselves and their families to do
> so must always be matched by a responsibility on the part of the government to provide
> opportunities for self-advancement. The government's aim is to provide services of such

high quality that there would simply be no reason why people should not take them up"

(p.31).

The problem was seen as both the failure of some claimants to attempt to gain employment and failure of government to provide adequate help in terms of civil rights, recognition of additional costs faced by disabled people and absence work promotion within IB provision.

Blair (2010) later reflected on his thinking regarding the role of the state:

"Suddenly, alongside the vested interests of capital could be seen very clearly the vested interests of the state. Bureaucracies are run by people. People have interests. And whereas the market compels change, there is no similar compulsion in the public sector. Left to its own devices it grows" (p.202).

Blair's statement implies that the state of welfare administration suited both the providers and the provided for and that its structures and processes needed overhauling. The relationship between state and claimant is seen as *interdependent* as well as paternalistic.

The barriers to employment described by Blair, included the 'unemployment trap' (where individuals were financially worse off at work compared to benefits), misunderstandings on the amount of work disabled people could do without losing their benefits and fear of loss of employment after ending their claim. These factors are relevant to both IB and JSA and are not linked directly to poor health.

Blair (1998a) asserted:

"In the area of welfare to work, we have the New Deal, the largest assault on structural unemployment ever undertaken in this country, benefitting the young and long term unemployed and, potentially, many lone parents, disabled people and those with long term illness" (p.iii).

However, in his memoirs, Blair (2010) later revealed much less certainty regarding the direction and extent of reform:

"In welfare and law and order, I similarly worried that we had a good mantra – 'rights and responsibilities together' – but no comprehensive policy thrust to underpin it…The extraordinary thing was that there was no outside body, or institute or centre of learning that provided the dimension…I used to pore over the latest offerings from various reputable academic or scholarly quarters and find nothing of real help…while we were trying to come up with solutions – 'what counts is what works' – the sobering truth was that the system of welfare and public services was vastly complex and 'what

does work?' was the question I kept referring to, without a great amount of external intellectual sustenance being provided" (p.201).

This passage reveals a drive for results to keep in line with rhetoric. The *desire for reform* was the lens through which the problem of 2.5 million IB claimants was examined, though there appeared to be a paucity of research evidence for an obvious response. Blair believed that poor policy and inadequate administration had caused increased claimants and that improvements in these areas would resolve the problem.

A new contract for welfare: Support for disabled people (DSS, October 1998) followed Blair's 'New contract' and built on the same principles. It restated Blair's assertion that the best route out of poverty for disabled people was work and that the primary aim was, for those who had been in work, to keep them in contact with the labour market and help them back into work. Failure to offer help was described as writing people off and consigning them to a lifetime on benefits (DSS, 1998b).

> "The present system effectively writes off people with a long-term illness or disability to a lifetime of dependency. It implies that they are incapable of any work and, as a result, they receive no job-related assistance" (p.4).

The document offers little explanation of the root causes of the problem but describes two related issues; ease of benefit access leading to increasing in-flow and failure to leave the benefit resulting in reduced out-flow. It noted that IB claims increased with unemployment in the 1980s and 1990s but failed to decrease as unemployment fell. This suggests that key to the problem of IB claims was the tendency for individuals to remain on benefits.

The report highlighted that disabled people were twice as likely to be unemployed than non-disabled people (DSS, 1998b) but attributed this to failures in the administration of IB, stating that 'incapacity benefit discourages work' (p.16). IB was said to supplement income for some claimants, effectively providing early retirement, especially in homes with a second income or when claimants received other income such as ill health retirement pension.

> "IB was designed to help people who became too ill or disabled to work while in work, rather than as a form of support for those who had been out of work for some time" (p.19).

The 'All work test' was judged to test only on what claimants could *not* do "implying that those who pass the test are incapable of all, or any, work" (p.16). This resulted in increased claims from individuals who might have been capable of a different kind of work. The all work test was said to present a gateway to enhanced income.

Broad solutions were proposed:

> "Capacity and incapacity form a continuum and a modern benefits system needs to take
> more account of people's individual needs and abilities" (DSS, 1998b, p.16).

It proposed a shift in the meaning of assistance from "what money we can pay you to how can we
help you become more independent" (p.18). This meant that:

> "Those on benefit who may be able to work should be offered assistance with training
> and job search, help to overcome barriers and encouragement to get back to work and
> achieve greater independence and inclusion" (p.17).

It added that support must be offered earlier in a claim, emphasising that leaving IB behind was
harder than obtaining it. The need for help in 'overcoming barriers' alluded to the discouraging
effects of being in receipt of IB. The requirement for assistance with training lacks detail but
suggests acknowledgment that those with disabilities were more likely than the non-disabled to lack
marketable skills. Assistance with job search suggested a belief that some IB claimants lacked
motivation or ability to do so themselves.

Assistance managing health conditions was not mentioned at this stage. The focus was the failure of
previous policy to help claimants *leave* IB. Causes of minimal out-flow were not related to health
itself. The report stated that the government would *test* the most cost-effective ways of keeping in
contact. This implies that government strategy, due to the absence of previous interventions of this
nature, was experimental (Stafford, 2002).

Pathways to Work: Helping people into employment

In contrast, *Pathways to Work: Helping people into employment*, introduced by Rt Hon Andrew
Smith in November 2002, offered clear insights into the government's conception of the incapacity
problem and an appreciation of its underlying causes. This was followed by *Pathways to work:
Helping people into employment - The Government's response and action plan* in June 2003. In both
documents, Smith described stagnant outflows, observations on claimant characteristics, non-health
related obstacles facing claimants and the personal impacts of claiming IB including how welfare
administration could cause incapacity to become entrenched.

The documents questioned how IB claimant numbers had trebled in a period during which
unemployment fell and general health increased. Increased sickness reporting due to greater social
acceptability was regarded only as a partial explanation. Instead, the increase was attributed to a
balance of complex factors which varied geographically. These included: loss of contact with the

labour market, age and the effects of benefit administration itself. The latter was explained in some detail: IB claims required no activity on the part of the claimant and very little contact. No formal support of any kind was offered by the state. The fact that unemployed jobseekers faced the opposite of this (active and high levels of contact with the state) may have further encouraged some claimants to see IB as less arduous.

Smith asserted that IB had, for some, become a form of subsidised early retirement costing the economy £16 billion per annum (75% of IB claimants were over the age of fifty). Deindustrialisation was said to cause some communities to rely heavily on benefits of all kinds. In such areas, claimants had drifted onto IB during economic downturns but failed to return when the economy improved. However, it noted that the top ten highest concentrations of IB claimants (where on average 15% of the working age population were in receipt of sickness benefits) still amounted, in total, to only 9% of the total number of claimants nationwide.

It observed that most IB claimants did not have the most severe of illnesses or disabilities and that receipt of IB did not preclude all work possibilities. Since job demands varied, incapacity was described as a continuum rather than a fixed concept. It noted that three million people, who were in work, would also qualify for IB under existing qualification rules. Smith summarised his conception of static incapacity claims:

> 'Most people moving onto IB do not report severe health conditions. A return to some form of employment is likely to improve health. Onset of a period of poor health may bring people onto IB but other obstacles keep them there as well – particularly low confidence, a belief that work will be harmful and poor financial incentives to return to work; and the longer a person remains on benefits the less likely they are to ever get back to any job, irrespective of their original condition and its severity.' Smith, 2003 (p.4)

Smith listed causal factors related to detachment from the labour market rather than exclusively to health. These were acceptance of being permanently unemployed, lack of confidence about employability, lower levels of qualifications, deterioration in skills and the long term effects of non-employment. The latter included isolation, stigma, social exclusion, changes in health-related behaviour and becoming trapped on low income (Smith, 2002).

The report noted that some causes of entrenchment were attributable to welfare provision itself. NHS care had failed to promote activity over rest causing deterioration in health conditions. The

Work Capability Assessment had focused on what individuals could *not* do rather than on what they *could* leading claimants to emphasise illness to ensure benefit continuity. Finally, claimants were said to misunderstand the idea that receipt of IB did not preclude attempts to find work and that the reverse of this took hold in the minds of some claimants.

> "People who qualify for incapacity benefits do not have to look actively for work in return for these benefits. But many clients misunderstand this point believing that they must therefore do nothing to suggest they might be able to work" (p.17)

These observations indicate that whilst the incapacity problem could be summarised as a single numerical fact (claimant count), it was formed of several smaller related and unrelated problems.

Social research

Social research into the causes of entrenched incapacity claiming can be divided into *commissioned* studies which were commissioned by the government and *independent* research which was not. The former includes specific research commissioned by the Department for Work and Pensions. It is reasonable to assume that these sources of primary research influenced policy makers' problem conception because they are referred to in the policy document *Pathways to Work* which introduced CMP. This section also includes research which was available at the time of CMP's inception and which may have influenced policy maker's problem conception. Central to this is Beatty and Fothergill's conception of increased incapacity claims as *hidden unemployment* (1997, 2001). Whilst their research is not cited in policy documents, their arguments are referred to.

This section draws upon the research cited in the policy document *Pathways to Work* and summarises the findings under the headings: benefit recipients' claim trajectory, perception of situation and future goals, generic claimant characteristics, health status and finally, socio-economic barriers and social exclusion.

Claim trajectory, perception of self and personal goals

C*laim trajectory* describes how claimants arrived at their situation and regarded their likely prospects. Hills et al (2001) use the term 'pathway into work' (p.194) which describes a transition through stages towards a return to employment. Such movements included vocational training or becoming positive about employment or permitted work. The concept is one of claimants taking steps towards self-sufficiency. However, it does not question the likelihood of *all* the necessary stages being completed or whether there was an appropriate job opportunity awaiting them.

Davis and Johnson (2001) identified four groups or *types* of claimants forming a transition model:

1 – Already working

2 – Want to work as a priority

3 – Considering work in the future

4 – Do not consider work is an option

This model could be likened to the Transtheoretical Model (Prochaska and DiClemente, 1983) which identified five stages on a movement towards the goal of abstinence from substance misuse. These were pre-contemplation (not considering change in the next six months), contemplation (considering change within the next six months), change preparation (getting ready to take action within 30 days), action (having made overt lifestyle changes in the last six months) and maintenance (having adopted a new behavior for more than six months).

This similarity is suggestive of a psychological component to long term IB claims. The implication is that individual claimants possess a cognitive picture of paid employment in contrast to a corresponding set of beliefs regarding continued benefit claiming.

Prochaska & DiClemente (1983)		Davis & Johnson (2001)	
1	Pre-contemplation	4	Do not consider work as an option
2	Contemplation	3	Considering work in the future
3	Change preparation	2	Want to work as a priority
4	Action		
5	Maintenance	1	Already working

Table 3.1 Comparison of Prochaska and DiClemente (1983) Trans-theoretical Model with Davis and Johnson (2001) claimant types.

Davis and Johnson (ibid) recognised two dominant trends in their evaluation of the One Programme: people moving from stage 2 in to stage 1 (those wanting to work as a priority going on to find employment) and from stage 4 into stage 3 (those believing work is not an option beginning to consider work as an option in the future). However, there was not a reported trend of movement from stages 4 or 3 right through to employment. This suggests that claimants could be helped to find employment if they already wanted to work 'as a priority' but those who were initially pre-contemplating work or contemplating work in the future were not able to be supported beyond desiring work.

They described:

"In some cases, the movement was in attitude rather than behaviour: some individuals who had previously discussed work as an option felt that this was something they would like to do" (pp.68-69)

As such, the attitude of the claimant was seen as an indicator of change. Those who changed (moved up the transition stages) exhibited a strong, consistent work history and work ethic, clarity on the work they sought and motivation to find work. The least successful focused discussions with advisors on benefits rather than work and received little advice on barriers to employment. Some claimants reportedly feared being forced into work before they felt ready (Legard et al, 2002) which supports the idea of movement towards or readiness for work.

Ashworth et al (2001) noted that those who left IB voluntarily were more likely to believe that their health had improved and that those whose IB claims ended and then subsequently claimed Jobseeker's Allowance were *less* likely to believe that their health had improved. Self-perception was seen as a significant factor in determining employment. Compared to stable JSA claimants, individuals who moved either direction between JSA and IB reported negative perceptions.

"This lowered perception of job chances might be related either to their understanding of the barriers to work caused by their health or other problems, or it might be learned through disillusionment through low success in the job-search process" (p.104).

As such, Ashworth et al allude to a distinction between health and health-perception. Claimants whose IB claims were disallowed reported less job-seeking activity and continued to classify themselves as sick rather than unemployed. However, those who were actively seeking work after ending an IB claim were those who were least likely to have appealed the decision (Dorsett et al, 1998). This indicates the impact of individuals' beliefs about their own prospects and health on job seeking behaviour.

Dorsett et al's (ibid) investigation into job-seeking activity following departure from IB presents a stark picture of two clear trajectories with one aimed towards regaining employment and the other moving clearly towards "early retirement" (p.8). The first trajectory demonstrated a strong bias towards work or independent income (voluntary leavers and disallowed non-appellants, recent work experience, reporting recovered health, a stronger attachment to the labour market and greater human capital resources). In contrast, the second trajectory demonstrated a bias away from work and towards benefits (disallowed claimants and appellants, little recent work experience, reporting continued disability, decayed attachment to the labour-market and little to offer employers (lower human capital resources).

These contrasting directions resonate with Davis and Johnson's (2001) claimant 'types.' The first group could be seen to be either considering work in the future or wanting to work as a priority whilst the second group did not consider work as an option. Whereas Davis and Johnson considered this a matter of transition, Dorsett et al (1998) regard movement away from work as an outcome.

A prominent feature of addiction recovery in the 'pre-contemplation' stage, is fear of change. This is an understandable phenomenon (Carr, 2008). The long-term impact of substance misuse is increasing disruption in social, financial, psychological, emotional, physical and spiritual functioning (Alcoholics Anonymous, 2001). Use of a substance provides *temporary* relief from the harm caused by long term use of that same substance. Relief is experienced at the point of substance use and suffering (withdrawal and craving) is experienced when *not* using. Through this process of conditioning, the addicted person concludes that not using the substance would be distressing. They may fear 'sobriety' on the assumption that they would continue to experience their current distress but fail to recognize that the substance was the cause of the distress. Because the decline in functioning develops slowly, this seemingly obvious fact it is rarely obvious to the person trapped in addiction (Carr, 2008).

Applied to IB, these principles suggest that *long term* receipt of ill health benefits causes disruption in claimants functioning. Unhappiness intrinsic to benefit receipt may be *temporarily* relieved by the receipt of the cash benefit which solves *part* of the problem of incapacity (low income). The claimant may conclude that distress normally experienced might continue into life after benefits, resulting in fear. As with substance addiction, the harm associated with long term claims is not attributed accurately. Because it develops slowly over time, the causes of harm and distress are difficult to discern.

This is consistent with the view that long term incapacity claims had a strong psychological component (Dorsett et al, 1998; Franche and Krause, 2002). It supports policy makers' assertions that claimants might be functionally capable of work (Smith, 2002). A claimant might have a genuine, long term condition but refrain from seeking employment because of fear rather than functional impairment related to the condition. If the claimant receives benefits on the basis of their condition, this may re-inforce their belief that their health prevents employment. This process may be explained by the theories of symbolic interactionism and social constructionism as discussed in Chapter 2.

Claimant characteristics

Claimant characteristics described by Smith (2002), allude to attitudinal factors and personal biography including previous work experience and family situations. Job seeking increased if claimants had an employed partner and dependent children but reduced in if the claimant's partner was also unemployed (Dorsett et al, 1998). Return to employment was seen as more likely if claimants had a strong employment history and work ethic, if they knew the work they sought and had significant motives for this action (Davis and Johnson, 2001). Individuals who voluntarily ended their IB claim, were significantly more likely to find employment. Two-thirds of claimants in such circumstances, gained work almost immediately (Ashworth et al, 2001). However, those least likely to actively seek employment, typically believed that work was not possible for them (ibid).

Claimants were likely to have had a long working history with 57% of claimants having worked for more than twenty years prior to their claim (Grewal et al, 2002). However, growing numbers of IB claimants were previously Jobseekers (claiming JSA) of whom 31% had not reported a work limiting health problem at the outset of their JSA claim (Ashworth et al 2001). This suggests the development of pathology during or as a result of the claim.

Human capital resources such as recent, relevant work experience and sought after skills or qualifications were seen as a significant determinant for return to employment (Acheson, 1998; Dorsett et al, 1998)

Younger claimants (under 25) were known to be considerably advantaged over older claimants (55 or over) (Dorsett et al, 1998; Ashworth et al, 2001) suggesting an issue of employability as well as functionality (degree of impairment). While Pathways to Work (Smith, 2003) does not directly allude to the concept of employability (desirability of a job applicant to potential employers), it does correspond with policy makers' view that impairment alone did not necessarily prevent employment.

Possession of qualifications up to A-Level standard was associated with greater job seeking behaviour though possession of a degree or higher qualification was associated with a particularly *low* likelihood of active job search (Dorsett et al, 1998). Again, this suggests that factors distinct from functional impairment resulted in ongoing claims.

Health status

Health status included claimant's *perception* of their health as well as diagnosis and assessment of functional impairment. Health was not seen as a static factor. The key messages within Pathways to Work (2002) were that 'most people moving onto incapacity benefits do not report severe health

conditions,' (p.12) 'for most the outlook for a return to work should be good' (p.13) and 'most people moving onto these benefits face a range of obstacles to getting back to work' (p.13).

That health could worsen during the period of claiming was highlighted by Acheson (1998):

"Ill health puts them at greater risk of unemployment and the experience of unemployment in turn may damage their health still further" (p.46).

The mechanism for this was seen as increased poverty and hardship, social exclusion (isolation and stigma) and changes in health-related behaviour (ibid). As noted above, some benefit claimants were known to develop or worsen previously unreported health conditions during the period of their claim (Ashworth et al, 2001). That claimants' conditions could change or worsen over time is suggestive that long term benefit claiming could lead to a new condition in its own right; a condition that could be composed of both biological and social features.

Claimants frequently reported a desire to return to employment (Acheson, 1998; Grewal et al 2002). Up to 65% of claimants stated that they could definitely work if specific adjustments were made to the workplace. 35% said they needed no adjustment other than a reduction in working hours or flexible working patterns. 24% of claimants stated that work was not possible for them under any circumstances (Grewal et al, 2002).

The functional impacts of work limiting conditions compared to *perception* of health condition were explored by Dorsett et al (1998). Of those who ended an IB claim and found employment, only 18% denied *any* health effect on their ability to work, however;

"Their reports of barriers placed in the way of work did not emphasise their disability, or even an employer's likely view, as much as problems associated with their age, qualifications and local competition for jobs. Even the unemployed felt that other barriers to work were more significant than their disability; only those among the large numbers still classifying themselves as being sick and disabled placed their disability to the fore among reasons for finding work more difficult than it might be" (p.5).

Where claimants were positive about employability and job availability, they were less concerned by their illness. This suggests that the relationship between health conditions and employment had both biological *and* psychological components (Dorsett et al, 1998). However, Dorsett et al (ibid) warn against discounting health in terms of its influence on people's thinking and behaviour:

"It would be wrong to ignore the strength of respondents' own reports which suggested that continuing disability is an important factor in some cases" (p.154)

Just as those advantaged in the job market may be less troubled by health conditions, those who *were* disadvantaged were more likely to emphasise the effect of their health condition on their employment prospects. Alluding to the strength of respondents' accounts, Dorsett et al (1998) suggest that responses revealed psychological as well as functional barriers to employment. Some individuals may have preferred a validated impairment than to see themselves as unemployable. This resonates with identity theory and people's relationships with health as described in Chapter 2.

There was evidence that some claimants used knowledge of capability scoring in medical assessments as a lever to maximise their incapacity (Legard et al, 2002). This implies that claimants could be influenced by social and economic factors in responding to their biological condition. Put together, these factors might influence decisions regarding job seeking behaviour. Franche and Krause (2002) wrote:

> "Disability and return to work following an injury or illness has been recognised as a process influenced by a variety of social, psychological and economic factors…The employee's psychological processes initiating and sustaining return to work cannot be considered in isolation of these factors. Nevertheless, the employee remains the ultimate agent of change in the return-to-work process in that only he or she takes the final decision of going in for a day's work' (p.234).

The biopsychosocial model describes incapacity not seen as a fixed state but as a continuum influenced by a balance of factors (Waddell and Aylward, 2010). The concept of a decisions and choice chimed with Blair's mantra of rights and responsibilities.

Socio-economic barriers and social exclusion

Grewal et al (2002) described how disabled people defined their identity, personal worth and worth to society, principally on ability to work. Inability to work was described as the defining feature of disability and being prevented from working was regarded as traumatic. This might generate strong motivation to work. However, entering work was also seen as a risk if it was not sustainable (ibid):

> "Disabled people on benefits felt that at least this provided them with a stable and predictable income which they could ill afford to lose. These fears were most acutely felt by those who had been forced to stop work through disability, having already experienced one traumatic event in the world of work, there was heightened concern about making the transition back into the workplace" (p.150).

As well as the health condition itself, adverse effects on claimant's confidence in their ability to return to work included lack of support and workplace adaptations and a belief that they would be

discriminated against. Legard et al (2002) reported that claimants found it hard to think of work in the abstract when their own (often negative) experiences predominated. High levels of anxiety at the thought of losing Incapacity Benefit or of being forced into employment before they felt ready could re-enforce this fear. This is consistent with the psychology of dependency described by Carr (2008).

Grewal et al (2002) also described multiple effects of having to stop working. These included reduced income and the challenge to self-concept through the experience of receiving un-earned income and impacts on social lives when friendship circles shrank. These factors accord with Acheson (1998) who described increased poverty and social exclusion resulting from incapacity claims. In spite of anxiety brought about by benefit-insecurity, many claimants described awareness of the danger of becoming excluded from the labour market and slipping into a 'rut' (Osgood et al, 2002). The greater the period of the IB claim, the more these effects were seen to become embedded and, as discouragement set in, so job-seeking was reported to fall away (Dorsett, 2002). These observations point to lengthy benefit claims as having social as well as psychological and biological features.

Independent (non-commissioned) social science research

This section summarises contemporary viewpoints on IB claims that were not referenced directly in policy documents. In accordance with Blair and Smith, some sources allude to a failing benefits system including the lack of systematic assistance and the belief that IB had become a form of long term enhanced unemployment or a route into early retirement (Stafford, 2003). Part of this failure was seen to be intrinsic to its design. Berthoud (1998a)

> "It is not so much that claimants are unable to work; more that disability prevents them getting a job…A welfare to work policy that concentrated on increasing financial incentives would not be effective if the real problem lay either in employers' refusal to hire disabled people or in the genuine incapacity of individuals to undertake paid employment" (p.127)

In keeping with the view that IB was a route into early retirement, it was noted that these same concerns were apparent when IB replaced its predecessor Invalidity Benefit (IVB) in 1992 (McKeever, 2000). It had also been thought at that time that the system for granting invalidity benefit was flawed because it failed to test ability as opposed to disability (ibid). Smith's assertion that most disabled people desired employment and that loss of employment led to stigma and isolation was supported (McKeever, 2000; Turton, 2001; Walker, 1998). In keeping with Smith's appraisal of

incapacity, it was widely noted that disability could be viewed as a continuum rather than a binary position (McKeever, 2000; Berthoud, 1998; Franche and Krause, 2002; Turton 2001).

Turton (2001) argued that there were few circumstances at the time which would make a move into paid work financially viable for the IB claimant. The decision to make or to continue an IB claim rather than find employment was seen as likely to increase claimants' sense of social exclusion leading to entrenchment in their circumstances (Walker, 1998; Drake, 2000). Once individuals found themselves in this trap, the benefit system itself contributed to a fear of losing benefits and of a job opportunity not working out (Walker, 1998; McKeever, 2000). As a result of perverse incentives and reduced incentives (and fear) associated with employment, a ratchet effect of increasing claimant numbers was seen to be inevitable.

Alternative views

Berthoud (1998) disagreed with Smith's assertion that IB was necessarily a route into early retirement stating that decrease in outflows from IB occurred in all age groups not only in those over the age of 50. Stafford (2003) argued that the increase of claimants could be explained as the natural maturation of the benefit; that people with sickness and incapacity and had hitherto failed to make their claim. However, it has also been claimed that increased incapacity claiming represented hidden unemployment in de-industrialised locations as discussed in Chapter 1 (Beatty and Fothergill, 2000, 2001, 2002) or other economic shocks (Berthoud, 1998).

Smith acknowledged that de-industrialisation had contributed to low outflows from IB leading to concentrations of benefit reliance in some communities but noted that this represented a small proportion of claimants overall. However, the frequent cause of long term incapacity following industrial closures was seen to include loss of currency in skills, a drop in confidence and unattractiveness to employers due to a health condition or poor sickness record. Fothergill and Beatty (1996) refer to labour market adjustment in UK coalfields where individuals who were capable of working despite a health condition found themselves competing in new areas of employment where the same condition made them less attractive to employers. The reason for their inability to regain employment was not their condition directly but the implication of this condition on their employability. The same factors might also apply to claimants *outside* of the highest IB claimant concentrations (in non-de-industrialised areas).

Franche and Krause (2002) stated that people might lose their employment through health but re-employment was dependent on the factor they described as readiness to return to work. Therefore, examining the problem only in terms of increased inflow rather than impediments to outflow might

result in skewed understanding of the problem and, consequently, identification of an inappropriate solution.

Evaluation of contemporary work-focused interventions

The nature of social problems may be partly inferred by the impact interventions have on them (Reiss, 1971). Prior to Pathways to Work, New Labour had introduced the *New Deal for Disabled People* (Blair, 1998) and piloted innovative schemes such as the ONE Programme (Davies and Johnson, 2001) which brought together the DWP and Benefits Agency to provide assistance for disabled people seeking a return to work.

As with the lens of political agenda, evaluation of existing practice attempts to understand the nature problem by examining the effect of programmes on it. The problem concept is described in terms of how an intervention impacts on it. That interventions for job seekers and incapacity claimants at the time contained generic features suggests that policy makers were seeing the two groups as homogenous in ways that had not previously been considered.

Research detailing existing and pilot interventions revealed what was seen as helpful and unhelpful in assisting claimants or reducing claimant numbers. Establishing 'what works' gives clues to policy makers' conception of the incapacity problem. Some of the factors discussed in the literature could be considered as tendencies whilst others are more obviously measurable. An example of the former is the Capability Report which was described as overly focussed on a medical rather than work focussed assessment and consequently encouraged clients to focus on their medical complaint rather than on their potential for work (Osgood et al, 2002). Another was the appeals process following medical assessments which was thought to promote health status as the primary focus for claimants leading some to regard it as the gateway to benefits (Dorsett et al, 1998).

An example of a measurable relationship between intervention and outcome was the level of experience of the organisation delivering it. A small number of schemes produced higher than expected employment outcomes including with client groups who were described as far from 'job ready' when they joined (Osgood et al, 2002; Hills et al, 2001). These schemes were noted for having a comprehensive pathway from entry to the programme through to employment. They also incorporated intensive one to one support and guidance throughout. Integral to such programmes was the prospect of a specific employment opportunity. In other words, there was a job or predictable opportunity for the client to work towards from the outset of their programme. Organisations which delivered better than average results paid careful attention to the targeting of opportunities in the local labour market.

Organisations with poorer outcomes typically had less experience in the field, weaker relationships with the labour market and were both less selective with regard to the client group they worked with and less capable in dealing with complex cases (Hills et al, 2001).

Intensity and appropriateness of job searching was significant (Osgood et al, 2002). Some clients commented on appropriate and relevant searches whilst others described feeling disregarded. It was noted that in some meetings with personal advisers, job searches might not be undertaken (ibid). Failure to make progress was associated with difficulty in dealing with clients' expectations. Expectations might be unrealistically high or not sufficiently ambitious (Davies and Johnson, 2001). Poorer outcomes followed when the agenda of meetings was driven by either health or employment status rather than by probing more deeply to help clients to gain an understanding of their specific, personal barriers to employment (ibid).

Level of contact was significant. Claimants who moved from JSA to IB were least likely to have had a meeting with a Disability Employment Adviser (Ashworth et al, 2001). Fewer IB leavers reported assistance from the Employment Service (Dorsett et al, 1998). Individuals who thought of themselves as unlikely to swiftly return to work were allowed to withdraw from regular contact. (Osgood et al, 2002) reported:

> "A number of clients felt that if they were likely to be unfit for work for the foreseeable future, then attending work focussed meetings with advisers, whose remit is to re-engage clients in the labour market, would prove irrelevant. These clients believed it was best to postpone a meeting until such a time that a client was fully recovered and in a position to benefit fully from a work focussed discussion" (p.91).

Promoting sustained contact was therefore seen as desirable to prevent participants from falling out of job contention.

The relationship between adviser and client was seen as important in terms of marrying of goals and claimants feeling understood and listened to (Osgood et al, 2002). Advice was regarded as helpful only when it resonated with the clients' own views of their needs (Davies and Johnson, 2001). Tension was frequently noted between the desires of the client (to achieve security of their claim) and the adviser who was targeted with guiding their client back into employment (ibid).

These findings, related to successful and unsuccessful strategies on contemporary welfare to work initiatives, might have been of particular interest to designers of CMP. The actual programme is examined in detail in Chapter 4.

Summary of New Labour's conception of the problem of 2.9 million IB claimants

Tony Blair's primary ideological stance as espoused in *New Ambitions for our Country: A new contract for welfare* (1998) is summarised below:

- A life with a low income is guaranteed by the absence of paid work.
- The current culture of welfare has an incorrect balance between rights and responsibilities (for protection against loss of work and for making effort to regain it)
- IB claimants can, in some circumstances, work but are not doing so.
- The current solution (in terms of the benefits system) has not provided adequate assistance.

Table 3.2 outlines Smith's (2002) detailed exposition of the overall New Labour stance on welfare.

Economic/financial	Socio-cultural	Health	Impact of benefits and welfare systems
1.IB is attractive as a route into early retirement 2. IB is attractive as it pays a higher rate than JSA	1.Loss of contact with the labour market habituates claimants into non-employment. 2.Detachment from the labour market leads to assumed acceptance of permanent un-employability. 3.Loss of employment leads to ongoing erosion of self-confidence. 4.On-going non-employment impacts including social isolation and exclusion and stigma.	1.Illness can cause incapacity but it has been wrongly assumed that illness or incapacity necessarily prevents all work and/or prevents it permanently. 2.An impact of non-employment is a worsening of health related behaviours.	1.Little or no expectation to work discourages attempts to gain employment. 2.Medical (NHS) treatment tends to promote rest rather than activity in response to illness. 3.The Work Capability Assessment tests for disability rather than establishing capability. 4.Claimants not being required to look for work leads some to assume that they *must* not do so.

Table 3.2: Summary of Pathways to Work (Smith, 2002) factors leading to increase in IB claimant numbers.

Drawing on a wide variety of sources, Smith demonstrated that increased claimant numbers could be explained by a multitude of factors. The factors listed above could also fit into the categories of biological, psychological and social as espoused in the bio-psycho-social model of illness. Health related factors made up a relatively small proportion of all factors noted though it is not possible to say which factors were most influential. It is, however, possible to divide the factors into two broad categories: reasons for new claims (causes of inflow) and reasons for maintaining the claim rather than returning to work (causes of reduced outflow). The financial concerns are both related to inflow rather than outflow. The same is the case for health factor no.1. The focus of the work capability assessment (impact of benefits and welfare systems no. 3) could be seen as causes of both

inflow and reduced outflow since it occurred after an individual commenced their claim but before the claim was ratified to warrant ongoing payment. Aside from these factors, the other eight causes of increased numbers of IB claimants cited by Smith were related to reduction in outflow.

The factors explored above may be a pattern or combination of influences which, together, form the basis of a claimant's own appraisal of their chances of finding employment. Dorsett et al (1998) described a twin track response to attempts to assist claimants back into employment. They described how some claimants actively sought work believing that their health was recoverable. These people had a stronger attachment to work and a shorter period of disability. Conversely, they described other claimants as having a "strikingly lower attachment to work...whose destination is still more clearly marked by the goal of early retirement" (p.8). They concluded that:

> "Continued disability alone does not place people on this track. But a combination of what they themselves are able to describe as continuing *lowered* capacity to work, together with poor education, increasing years and only distant experience of work, stacks up decisively against their prospects in the labour market" (p.8)

Acknowledging the twin problem of increased in-flow and decreased out-flow, Smith demonstrated that the *causes* of increased IB claimant numbers were different from the reasons why people remained claimants. As with addiction or dependency, the reasons a why a person is unable to escape from their situation may differ from the reasons why they initially became addicted (Carr, 2008).

Having drawn attention to the wide variety of social, cultural and economic effects which discourage leaving IB, Smith referenced the need for innovative rehabilitation programmes. This informed the inception of the Condition Management Programme. The next chapter examines the programmes concept and theory in order to assess the mechanisms through which it was hoped that CMP would address the problem conception.

Chapter 4 - CMP design: concept, programme theory and implementation theory

Introduction – Identifying a programme

Viewed together, programme concept, programme theory and implementation theory can be described as the programme *design.* They describe what CMP was designed to do and how it would achieve it or, alternatively, an interpretation of the needs described in the problem analysis expressed in the form of an intervention. This chapter demonstrates how CMP design was pivotal in the evolution of the Norfolk CMP. Whilst the programme is referred to as CMP throughout this chapter, at the design stage, it may not have been called (or even conceptualised as) a *condition management programme*.

The first section of this chapter explores the purpose and function of CMP considering the problem conception described in the previous chapter. This is described as the *explicit* concept and design. The second section provides a detailed analysis of the CMP programme content in Norfolk enabling the programme concept and theory for the Norfolk CMP to be inferred retrospectively. This is described as the *actual* concept and design. The explicit and actual designs are compared and discussed.

Table 3.2 in the previous chapter summarised the factors that led to increased IB claims as described in *Pathways to Work* (Smith, 2002). These were: economic and financial, socio-cultural, health and the impact of benefits and welfare systems. A programme designed to 'responsibilise' claimants (Considine, 2001) could only address some of these factors such as health and socio-cultural influences. Economic and financial factors were addressed primarily with legislation (Welfare Reform Act, 2007) which replaced Incapacity Benefit with Employment and Support Allowance. Pathways also provided claimants with a return to work allowance of £40 per week. Claimants might have considered remaining on IB until they retired or have sought IB rather than JSA. Beyond encouraging them to reconsider their financial circumstances, a programme could do little to address the financial and economic components of incapacity claiming. Whilst this might be the case however, it may have been necessary for the programme to acknowledge and act in concert with them.

Regarding social and cultural factors, CMP designers may have asked what a programme could do to help people who had become detached from the labour market and become habituated to non-

employment. Movement into a new job role for most people (including those already employed or seeking their first job) involves some trepidation. It requires self-confidence and willingness to accept rejection. It also involves a weighing up of benefits (increased income) and risks (possibility of new job not working out). Severe financial consequences might follow if a 'probationary period' is not passed. Similar considerations faced IB claimants. Seeking employment meant risking incapacity claimant status and income which, though modest, were still favourable compared to JSA. Incapacity benefits did not require claimants to 'sign on' or attend fortnightly meetings which meant they were less onerous. IB claimants were more likely to lack confidence, to be socially isolated and to feel stigmatised. Some may have become resigned to permanent non-employability. Designers of CMP may have asked if it was plausible for a social programme to both re-acquaint people with employment and positively address the social impacts of long term non-employment.

The negative impacts of existing welfare and benefit systems and processes could be addressed, to some extent, by social programmes. Loss of expectation of work and the negative assumption that work must *not* be sought when making an incapacity claim could be addressed by Pathways advisers and supported by CMP. The tendency for NHS treatment to promote rest over activity could certainly be addressed in the CMP.

The last problem area highlighted by Smith (2002) was health. It was noted that an impact of non-employment was a deterioration in health-related behaviours such as disengagement from exercise and social activity. This, too, could be addressed by CMP.

It was also noted that, whilst illness led to incapacity claims, it had been wrongly assumed that incapacity was permanent or that it prevented all types of work. This factor seems to support the concept of a *condition management* programme. However, this assumption deserves further scrutiny. A pertinent question is whether it was *assumed* incapability of work or the underlying condition itself (impairment) that led to disengagement from work. Across a population of 2.7 million claimants, it is reasonable to suppose that some people stopped seeking work due to the former, some to the latter and that some presented a mixture of both. Therefore, CMP would be required to assist with both management of the condition itself *and* assumptions associated with it.

Table 4.1 summarises these problems and offers potential solutions described from the perspectives of claimants. Socio-cultural factors are prominent in the overall problem conception.

	Problem	Type/ category	Impact viewed from claimant's perspective	Solution (programme output) from claimant's perspective
1	Loss of contact with labour market habituates claimant to non-employment.	Socio-cultural	I no longer see myself as economically active	I see myself as economically active.
2	Detachment from labour market leads to acceptance of permanent non-employability.	Socio-cultural	I accept that I will not work again.	I believe I able to work
3	Loss of employment leads to erosion of confidence.	Socio-cultural	I lack confidence and self-belief.	I believe that I have worth and capability making me employable
4	Long-term impacts of on-going non-employment including social isolation and stigma.	Socio-cultural	I feel bad about myself. Society stigmatises me and I feel ashamed.	I do not allow stigma to hold me back
5	NHS treatment promoted rest over activity.	Impact of welfare and benefit systems	Previous treatment has been passive and discouraged activity and participation	I am active and take responsibility for my health
6	Not being required to work led claimants to assume that they *must not* seek it.	Impact of welfare and benefit systems	I have assumed that I must not seek work.	I am taking steps to make employment viable for me including voluntary work, training and looking after my mental and physical health.
7	Incorrect assumption that incapacity prevents all work permanently.	Health	I believe that my condition prevents all work permanently.	I believe that my condition does not prevent all work. I am considering alternative employment.
8	Worsening health related behaviour amongst the non-employed	Health	I have stopped looking after myself.	I am looking after my mental and physical health.

Table 4.1: Summary of factors leading to increase in incapacity claimants as described in Pathways to Work (2002) *viewed from claimants' perspective.*

The 'solutions' column (table 4.1) describes the outputs directly related to Smith's (2002) problem conception. In the design stage, CMP designers may have asked which aspects of the problems discussed above could reasonably be addressed with a programme. They would also need to consider *how* the appropriate interventions should be delivered. Two of these factors (5 and 8) are directly linked to physical or mental health and could be addressed with the single solution of improving health management practices. However, the other factors rely primarily on addressing *beliefs*.

Cognitive behavioural therapy works on the basis that beliefs are theories rather than facts and that it is what people *believe* that influences their emotions and behaviours (Greenberger and Padesky, 2005). CBT identifies beliefs, questions their validity and formulates alternative theories based on a

rational appraisal of the evidence available. This process is called *cognitive restructuring.* The alternative theory can then be tested in reality by trialling it through *behavioural experimentation.* The rationale for behavioural experiments is that alternative theories will not be fully *believed* until there is evidence to justify them.

CMP was available to incapacity claimants with a view to preparing them for a move into employment. This meant that that the decisive behavioural experiment (testing whether work was possible) could not be undertaken without first relinquishing benefits. The summary of problems experienced by incapacity claimants may appear sterile in tabular form but the effects of social isolation, loss of confidence, stigma and habituation to permanent non-employment should not be underestimated. The case studies in Chapter 8 describe in intimate detail the experiences of some claimants. In light of this, for many people, the decision to move from long-term incapacity claiming into employment seeking may be viewed as a considerable leap of faith. From the perspective of CBT, this makes the behavioural experiment exceptionally challenging and has implications for implementation theory. The joint delivery responsibility shared between NHS and DWP suggests that co-ordination between the health and job-seeking components was seen as important. CMP was designed as a classroom based intervention. This would suggest that coherent partnership work with the employment side would be required in order to prevent it being separated from the *health side.* An alternative implementation approach could have been concurrent placement in work experience alongside health management education.

Findings from social research generally (Chapter 3) and from welfare to work evaluations specifically (Chapter 1) imply that social aspects of incapacity claiming were influential in preventing exit from incapacity claiming. There is no evidence amongst this literature that measures the *relative* impact of functional health impairment compared to social factors. It is reasonable to suggest that the programme would need to address *both* health and social components of incapacity requiring not only improvement in health but also revision of beliefs about ability to work. The latter could include the financial implications of changing. Alongside the explicit purpose for CMP (to assist incapacity claimants off benefits and into work), the implicit rationale was to 'responsibilise' or activate the claimant population (as discussed in Chapter 1).

Viewed in these terms, the problems and their potential solutions described in table 4.1 appear highly challenging. However, there are social interventions that address both chronic physical and mental health problems *and* require behaviour change without certainty of success. The 12-step

programme of Alcoholics Anonymous helps individuals to change their behaviour (stop drinking) by addressing beliefs. The second step: "We came to *believe* that a power greater than ourselves could restore us to sanity" (p.60) [emphasis added] encourages participants to address the maladaptive belief that *they* can control alcohol and, instead, to believe that a greater power could help them. The words alone may not help but the alcoholic can be greatly encouraged by the testament of experienced AA attendees who share their stories of recovery in meetings. Through the process of *identification*, new members recognise the similarities in their situations. They begin to see that these people have achieved, with the help of the group, what they have struggled to do alone. After a period of attendance, they begin to imagine living without alcohol. A similarity between this process and moving off incapacity benefits is the need for a leap of faith without a guarantee that they will be better off.

The 12-step programme also places a heavy emphasis on personal responsibility. It requires members to admit to their 'innermost selves' (p.60) that they have a problem with alcohol. Further along the programme, participants must explore their personal 'defects of character' (p.64) and cease blaming others for their problems. As such, alcoholics in recovery are 'responsibilized' by the programme.

However, there are differences between the 12-step and the CMP. AA members frequently describe having hit 'rock bottom.' The element of risk associated with behaviour change is lessened if a person has little to lose. Incapacity claimants, by comparison, stood to lose preferential benefit status (compared to those claiming JSA). Attendance at AA meetings in entirely voluntary and undertaken out of self-interest. The person who stands to gain from attendance is the alcoholic himself. Incapacity claimants might feel that others, notably the government, had the greatest interest in them ceasing to claim benefits. A programme delivered by agencies of the state (DWP and NHS) might be seen as a 'top down' model of service provision (by the time of the Norfolk CMP, attendance was mandatory). By contrast, the assistance offered by AA is essentially self-help and is voluntary. The AA programme addresses addiction in its entirety. The first step: "We admitted that we were powerless over alcohol, that our lives were unmanageable" (p.55) acknowledges that drinking alcohol is fundamental to the alcoholic's difficulties but not the full extent of them. 'Unmanageability' is seen to accompany drinking. The greater part of the programme (steps four to twelve) provides the basis for a different way of living addressing unmanageability in life. As such, AA works (holistically) with every aspect of the person's life. By contrast, the CMP focused on the health component in isolation from the other factors that restricted movement off benefits.

The designers of CMP might regard AA as an unrealistic model for delivery. However, accepting the existence of a problem, taking personal responsibility and identifying with other group members are aspects programme and implementation theory that *are* relevant to incapacity claimants as will be demonstrated in practitioner accounts (Chapter 6) and participants' comments (Chapters 7 and 8). The key conceptual similarity is that both AA members and incapacity claimants faced multiple, chronic 'barriers' to wellbeing through social alienation, strongly negative beliefs and compromised mental and physical health.

The next section of this chapter describes the explicit programme concept, programme theory and implementation theory. Whilst there is no extant blue-print for the CMP, the broad concept and theory can be inferred from contemporary documents including policy reviews, CMP evaluations and promotional literature. Rt Hon Andrew Smith MP and the Department for Work and Pensions were approached, seeking assistance in identifying processes associated with the design of CMP (Appendices 18 and 19). In addition, this chapter draws on the testimony of a manager involved in the implementation of CMP for the Norfolk Pathways to Work provider.

Explicit programme concept and programme theory

Randall (2012) describes the CMPs first steps into being.

> "CMP was developed by a Joint Ministerial Group that included DWP, DH and Welsh and Scottish health representatives. The clear steer from the JMG was that CMP would be a partnership between DWP, DH, NHS and JCP. CMP would be developed and delivered to meet the needs of local populations whilst satisfying the agreed core principles. DH [would] lead the development of CMP in partnership with JCP and NHS" (p.4)

The 'clear steer' regarding the departments charged with production of CMP is redolent of the broad move within public administration to transform how welfare services were delivered as described in Chapter 1 (Du Gay, 2007). The directive for CMP to be delivered according to the needs of local populations meant that the designers of the pilot CMPs had autonomy over content. This may explain the absence of a detailed blueprint explaining the programmes concept and theories. The policy of encouraging local autonomy supports the conception that regional economic variations influenced employability factors within local incapacity claimant populations (Beatty and Fothergill, 2004). However, local autonomy in programme design may have also encouraged a loss of design integrity between the stages of problem identification and solution design.

Barnes and Hudson (2006) go further in describing the 'agreed core principles' alluded to by Randall.

> "The Condition Management Programme (CMP) provision was drawn up jointly between
> the Department of Health (DH) and Department for Work and Pensions (DWP) as part of
> the Pathways to Work pilot. It is work-focused and has been designed in response to the
> three main conditions reported by those claiming Incapacity Benefit (IB) – mental health
> issues, and cardio-vascular and musculoskeletal problems…Some areas have delivered
> generic provision, while others have created specific modules for certain conditions, but
> there has been a movement towards more generic provision over time. Based on a bio-
> psychosocial model of health and illness, the aim of CMP is to go beyond simple medical
> interventions and tackle more deep-seated issues such as anxiety, pain management and
> lack of confidence. It is intended to be empowering, and is explicitly not about providing
> 'treatment'. Plans for service delivery were drawn up in each district according to the
> area's needs profile, and commissioned by Primary Care Trusts" (p.13).

Acknowledgment of the need for empowerment (rather than treatment) on issues such as lack of
confidence and deep-seated anxiety, illustrates that the social character of incapacity claiming was
recognised. However, this offered no guarantee, in itself, that Primary Care Trusts would not
continue to provide 'healthcare' as they were used to doing. Examination of literature related to
early CMP provision (Barnes and Hudson, 2006; Ford, 2008) and subsequent programme materials,
reveals a shift from a blend of social and health input to greater focus on health conditions.

Despite the absence of an original 'blueprint' for CMP design, glimpses of programme concept and
theory can be gleaned from an evaluation of the pilot programmes (Ford and Plowright, 2009):

> "Programmes were designed to encourage activity and build confidence, and these two
> factors were frequently linked together in a dynamic relationship, with either
> participation in activity or exercise described as increasing confidence or vice versa. This
> may explain why increased confidence was reported to be associated with participation
> in programmes designed to improve coping skills, and also in activity/lifestyle
> programmes which involved elements of exercise and socialisation. This suggests that
> increased confidence may be the most important outcome of CMP, and can be achieved
> through a variety of programme configurations. It may be that the single most important
> outcome measure for CMP in future might be a measure of confidence or self-efficacy"
> (p.98)

The assertion that confidence may be the most important outcome suggests that, at the stage of pilot evaluation, the outcomes were *emerging* or becoming apparent rather than being directly pursued as key outcomes. Ford and Plowright's observation of the dynamic relationship between activity and exercise on the one hand and increased confidence on the other, also supports the proposition that both health status *and* related beliefs influenced whether claimants would pursue changes in their lives. Ford and Plowright asserted that the pilots varied in composition and all underwent changes over time. However, the statement above indicates an overarching purpose for CMP of building confidence and increasing activity. As such, the problem conception could be described as:

IB claimants have lost confidence in themselves, lack self-efficacy and have ceased acting in a way which suggests belief that their situation will improve.

The programme theory might be described as:

Increasing activity and improving coping skills will bring about an experience of increased wellbeing and consequently build confidence and optimism for the future.

The corresponding implementation theory would be:

Participation and experience (behavioural experimentation in CBT terms) leads to the generation of evidence proving that change is possible and achievable by one's own efforts.

The National Audit Office (2010) later offered an overarching programme theory.

> "Condition Management Programme – Designed to help individuals manage their
> disability or health condition to permit a return to work" (p.19)

This description demonstrates how a programme's philosophy may evolve or be misunderstood over time. The term 'permit' (a return to work) suggests that inability to manage a condition *necessarily* prevented a return to work. The emphasis is on 'disability' and 'health' management.

The programme concept for CMP appears implicit in its title: it is a programme to help manage health conditions. By definition, incapacity claimants had health conditions and, since the health condition resulted in incapacity, unsatisfactory management of health could be seen as the principle barrier to employment. Help in learning how to manage conditions might remove this barrier enabling return to employment. This assumes that the term 'condition' relates to a clinical state of health such as depression or anxiety. If the 'condition' was regarded as composing of social factors then learning skills to manage depression could be seen as *symptom* management (depression being

a symptom of the social problem) rather than condition management. It may be noted that Smith (2002) described a host of social factors associated with poor outflows from Incapacity Benefit.

The generic description described by NAU is similar to many available in the CMP literature which describe CMPs overall philosophy (Lindsay and Dutton, 2010; Clayton et al, 2011; Demou, Gibson and Macdonald, 2012; Kellet et al, 2011) as follows:

Problem conception:

People claiming IB face a barrier to employment through the existence of a health condition which limits capacity for work and reduces employability.

Programme theory:

Provision of health education, advice and teaching of specific skills will enable participants to gain greater control of their health condition making work a realistic prospect.

Implementation theory:

Use of evidence based interventions (commonly CBT or 5-areas approach) that encourage and empower rather than provision of traditional treatment.

An NHS North West Good Practice Case Study (undated) stated that the programme was available to health-related benefit claimants:

> "…with the aim of helping them to gain the skills to enable them to better understand and manage their health condition, alongside support, that allowed them to explore the range of lifestyle and work opportunities available" (p.1)

Like the NAO definition, this description is broad and unspecific. However, the 'Key Aims' listed below offer more specific goals that hint at observable outputs:

- To help participants better understand their condition in a work environment
- To help participants feel more confident about what they could do and therefore about returning to work
- To enable participants who returned to work to feel more expert about negotiating with their employer
- To enable participants to improve their quality of life, regain control and realise their aspirations

- Connect people back into their communities where they can be part of support systems which will help them manage their conditions and maintain better health outside of the NHS (p.3)

The intention was for participants to feel more confident about managing their conditions at work including being more self-assured when discussing the subject with employers and it was hoped that this would result in better quality of life. The programme reveals an overarching implementation theory: participation should be entirely voluntary and is based on available clinical evidence. It is tailored to meet individual needs by employing a case management approach. Specific interventions are listed in figure 4.1 and were described as

"Programmes of cognitive-educational interventions which supported the individual's goals and were tailored to meet their needs" (p.4)

- Beating the Blues (computerised CBT)
- Exercise on prescription/physical activity
- Pain management
- Stress and anxiety management
- Relaxation techniques
- Managing emotions
- Dealing with low moods
- Confidence building

- Health and lifestyle advice
- Making life changes
- Coping with pain and fatigue
- Benefits of exercise
- Positive thinking and changing negative thoughts
- Sleep management
- Returning to work
- Managing your health condition

Figure 4.2 interventions offered within NHS Condition Management Programme

The list is comprehensive (though it is not known what all the modules entailed). They are mainly based on clinical conditions except for returning to work, confidence building and making life changes. These are suggestive of social, characterological or attitudinal factors. The list refers to specific symptoms and solutions. Some (or all) of these may have been relevant to individual claimants. However, they may not necessarily address the problem conception of incapacity as outlined by Smith (2002).

The problems of alcoholism, as described above, might also be helped by most of these interventions but they might not help the alcoholic to address the core beliefs that underpin their

conviction that they would be better off drinking and worse off sober. The same question of whether the person would be better off leaving or remaining on benefits might apply to incapacity claimants. These interventions could be described as helpful symptom relief. However, they do not target the core components of claimants' incapacity.

Smith (2002) noted that people *commenced* incapacity claims based on health conditions but the reasons why they did not *end* their claims differed. People not ending claims was brought about by the social, economic and cultural impacts of benefit claiming as well as by functional health impairments. As noted by Ford and Plowright (2008), the social and health components of incapacity could to some extent merge, leaving CMP participants feeling more confident if they engaged in activity. However, it was also noted that the reliability of return to work impacts of such improvements remained uncertain (Bewley et al, 2007; Kellet et al, 2010; Ford, 2008; Hayllar et al, 2010).

Table 4.1 presented Smith's (2002) conception of incapacity in terms of beliefs that claimants themselves might describe. Viewed in these terms, the cognitive-educational interventions from the NHS-led CMP (listed above) might be viewed as generally helpful but not sufficiently specific for changing beliefs related to work.

It is also significant to note the inclusion of 'Beating the Blues' which was a computerised CBT intervention for depression and is now recommended by NICE guidelines. Whilst it is supported by an evidence base for recovery from depression, it was an 'off the shelf' intervention aimed at a specific condition. This chapter has suggested that it was possible, in the absence of a clear blueprint for CMP, for local providers to revert to provision of healthcare. This could lead to a loss of integrity in the design process between the stages of problem conception and solution design. Whilst the causes of this cannot be proven, it *can* be said that 'Beating the Blues' (and potentially some of the others on the list above) were generic interventions based on mood improvement rather than *specific* efforts to address the core components of static incapacity outlined by Smith (2002).

It is also hard to prove whether the words in the term *Condition Management Programme* caused a gradual re-interpretation (or misinterpretation) of the key concept of the programme. However, it can be said that the concept and theories inferred from the Norfolk CMP were biased towards a healthcare model (as discussed below).

Nice and Davidson (2010) describe the purpose and design of CMP in 'provider-led' areas as espoused by managers and clinicians in these areas (including Norfolk). The term 'provider-led' describes areas where Pathways to Work and CMP were delivered by non-NHS organisations that won contracts with the DWP. In Nice and Davidson's report, the term 'purpose' could be taken as problem conception and 'design' as programme theory. Managers were asked to describe the programme to somebody who had no prior knowledge of it.

> "Some responses to this question articulated the kinds of people who the programme was aimed at, such as people who have health problems and who are not working as a result, or people whose quality of life is poor due to ill health and who have subsequently 'lost their way.' Most people talked about what the programme aims to do and those most commonly cited can be grouped under three interlinked aims:

> - Helping people to understand their health condition(s), prognosis and treatment options and explore barriers to improved well-being;
> - Helping people manage their condition(s) to improve quality of life and ultimately take steps towards or into paid work;
> - Empowering people to manage their health condition(s) by raising awareness of coping strategies, such as enabling people to think differently, adjust to changing circumstances and focus on what they can do, and providing structure to daily living" (p.15)

Like the NHS-led CMP described above. The design expressed by CMP managers and practitioners focused on *what* the programme would do rather than *why* it did it. The latter consideration (why) relates to the problem conception. The first and third components, described above, might have been more focused on the problem conception if they were followed by the words *for the purpose of addressing negative assumptions about employability.* The second component mentioned returning into or towards paid work but does not describe the mechanism by which this would be achieved.

Ford (2008), however, offered pointers for programme theory, highlighting mechanisms by which CMP *could* lead towards work:

> "Participation in CMP was shown to be associated with changes in coping styles consistent with activation and empowerment:

- Active coping, acceptance and reframing which are known to be associated with return to work following mental health problems, were all significantly increased following participation in CMP" (p.4)

Whilst increase in coping, acceptance and reframing may be associated with return to work, it does not follow that achievement of them would necessarily result in that outcome. Viewed as a whole, the programme theory espoused by CMP staff and the NHS-led programme above works on the assumption that understanding health conditions, helping people to manage them, raising awareness of coping strategies and encouraging empowerment would result automatically in departure from incapacity claiming.

A pilot evaluation noted that *explicit* focus on re-employment was not welcomed by participants and resulted in lower outcome scores (Ford, 2008). This would indicate *not* including the concept of addressing negative assumptions about employability to the programme goals, as suggested above. This leaves a potential problem at the heart of the CMP concept. The integrity of design may be compromised if the concept is focused too heavily on health management. However, focusing on social and cultural factors, such as *assumed* permanent inability to work, might put participants off. As suggested above (and expressed clearly by Smith, 2002), the problem of static incapacity may be characterised by a *blend* of both social and health related factors. This problem conception is examined in detail in the case studies in Chapter 8.

Where the conceptual focus of the programme lay on the continuum of health and social assistance may have rested on whether each participant was consciously seeking employment. This is encapsulated within the first two *solutions* outlined in table 4.1: whether the participant sees themselves as economically active and whether they believe they are able to work. If a claimant remained certain that they could not work, then the CMP concept might have represented a mismatch of intentions between them and the government.

Pittam et al (2008) noted programme theory related to this view of incapacity (as expressed by a CMP practitioner):

"It's actually getting people to understand that actually you're only as incapacitated as you decide to be really" (p.23).

This suggests that participants' attitudinal stance towards their health and its impacts on their lives influenced their ongoing incapacity and that these attitudes could be adapted through the CMP intervention (though the method of implementation is not clear from this example).

Explicit Implementation theory

The government's assertion that incapacity could be reduced by focusing on health-related interventions was supported by Lord Layard who presented evidence based psychotherapy, in particular, CBT, as the key solution to increasingly poor mental health nationwide:

> "Crippling depression and chronic anxiety are the biggest causes of misery in Britain today…Only one in four of those who suffer from depression or chronic anxiety is receiving any kind of treatment. The rest continue to suffer, even though at least half of them could be cured at a cost of no more than £750. This is a waste of people's lives. It is also costing a lot of money. For depression and anxiety make it difficult or impossible to work, and drive people onto Incapacity Benefits. We now have a million people on Incapacity Benefits because of mental illness – more than the total number of unemployed people receiving unemployment benefits. At one time unemployment was our biggest social problem, but we have done a lot to reduce it. So mental illness is now the biggest problem, and we know what to do about it. It is time to use that knowledge. The good news is that we now have evidence-based psychological therapies that can lift at least a half of those affected out of their depression or their chronic fear. These new therapies are not endless or backward looking treatments. They are short, forward-looking treatments that enable people to challenge their negative thinking and build on the positive side of their personalities and situations. The most developed of these therapies is cognitive behaviour therapy" (p.1).

Layard's assertions suggested a firm and genuinely held belief that provision of evidence based therapies could reverse anxiety and depression in half of all cases. The approach proposed treating incapacity in a generic fashion. The specific needs and unique circumstances of individuals are not seen as relevant in the application of treatment. However, research into the effectiveness of psychological therapy indicates that outcomes are influenced by a variety of circumstances and that the best way of identifying 'effective' talking therapy is to establish: what works, for whom and under what circumstances (Cooper, 2008). A recognised component of effective therapy is a clear match of goals and expectations between client and therapy provider (ibid). As discussed above, claimants and programme providers may not agree common goals. The provision of psychological interventions to help manage anxiety with the goal of returning to work, might, for a variety of reasons, cause discomfort to some claimants.

Cognitive Behavioural Therapy (CBT) addresses circumstances (environment), beliefs (thoughts), physical factors, mood (emotional states) and behaviour. As such, it is a suitable psychotherapeutic match with the biopsychosocial model of illness. Having a strong evidence base, it may have been seen as the approach of choice for CMP. It was a requirement within programme proposals from organisations who bid to deliver (provider-led) CMP though, as a Pathways-provider manager described, cost was also a consideration:

> "The DWP…did build into the specification the requirement for certain health professionals to be part of the delivery teams and a model of how this CBT based service should be run. There was a clear pressure on cost and this gave rise to organisations building in IT based /distance learning approaches to some of the models…and reduce face to face contact between high cost health professionals and participants. As a result there was also a need to try and maximise group as opposed to individual work."

This chapter has explored the key outputs required of the CMP if it was to successfully address the problem conception of static incapacity claiming as outlined by Smith (2002). It has identified that the explicit programme design focused heavily on management of health conditions and that this may have been influenced by the predominance of CBT which was based on the biopsychosocial model of illness. It has noted that explicit CMP design separated health and socio-cultural factors from financial and economic influences and that this division may be unrealistic. This section has also proposed that the concept of CMP may have changed over time due to misinterpretation of the problem conception, because of ambiguity in the meaning of the words *condition management,* and through practical and financial pressures involved in the production of a programme.

The rest of this chapter clarifies the specific problem conception, programme theory and implementation theory for the CMP in Norfolk. For this purpose, the next section relies heavily on inferring the specific design from the programme itself (Adedokun et al, 2012)

Actual programme concept and programme theory: the Norfolk CMP

By the time CMP practitioners had been recruited, a programme was in place in the form of participants' course manuals. Training was provided on the use of outcome measures (HADS and OSA) but none was given for the programme itself. As such, no explanation was given on the rationale for CMP (problem conception). Neither guidance on the purpose of the interventions contained within it (programme theory) nor training on best practice for delivery (implementation theory) were provided. Furthermore, there were no accompanying facilitator guides explaining the

timings and methodology for delivery of the 'workshops.' Prior to commencement of CMP, the programme materials had to be interpreted (by the author) and formulated into coherent events.

Clarke and Dawson (1999) explained how programme logic could be derived through observation of delivery as well as in the programme's original design. The purpose of this is to reveal the 'black box' (Astbury, 2010) within each module and to question whether they related to the problem concept as outlined by policy makers, whether the proposed inputs and outputs were defined and realistic and whether the suggested change processes were plausible (Rossi et al, 2004). The following section examines the content of each CMP module in detail. A summary of the programme's content can be found in table 4.2.

Module	Learning outcomes (programme outputs)	Course outline	Content/topics	Exercises
Introduction to healthy Living 1 x 3 hours	To understand more about condition management and make informed choices about the condition management programme.	Understanding illness, impairment and disability Stress and stress management How exercise and keeping active can impact on condition management An introduction to relaxation	Understanding incapacity and health (incapacity, illness, symptoms, impairment, disability, condition, sickness) Stress profile Diet Fitness and exercise	Housekeeping Icebreaker exercise Discussion – definitions of incapacity Discussion – stressors and stress moderators Physical stretching exercises Relaxation exercises Diet quiz
Managing depression in the workplace 6 x 2 hours	Identifying depressive thoughts Learning behavioural strategies for overcoming depression	To develop effective strategies for managing depression in the workplace	Tackling negative thinking: thinking errors, negative voices in thoughts and auto pilot thinking Behavioural activation: pleasant and unpleasant events Assertiveness: personal rights and guidelines for assertive behaviour and communication.	Understanding signs and symptoms of depression Understand the voices in our thoughts (transactional analysis) Strategies for increasing and maintaining activity levels
Anxiety management 6 x 2 hours	Understanding the nature of anxiety: what causes it and what keeps it going Recognising anxiety in yourself Learning ways of managing and overcoming anxiety	To develop an understanding of anxiety and skills to manage it.	Symptomology Mechanisms of anxiety Role of helpful and unhelpful voices in thinking Recognising executive and automatic thinking Challenging logical thinking errors Dysfunctional attitudes Managing panic	'Good breathing' Recognising voices in our thoughts. Mindfulness-based body scan Gestalt awareness (meditation exercise) Thought disputing (CBT) Worry buster (CBT) Thought-stopping

Table 4.3 Summary of Norfolk CMP programme content

Module	Learning outcomes (programme outputs)	Course outline	Content/topics	Exercises
Communication and assertiveness 2 x 2 hours	Defining assertiveness Recognising personal rights Understanding how others can undermine Developing communication confidence	To develop an understanding of and practice skills in assertive communication.	Defining assertiveness (meanings and impacts) Communication styles and skills Personal rights Listening skills and techniques Dealing with difficult people	Assertive beliefs questionnaire 'When am I non-assertive?' questionnaire "LADDER" (mnemonic for making requests assertively) Assertiveness skills e.g. 'broken record'
Stress Management and relaxation 2 x 3 hours	Identifying stressors, strains and moderators Developing and practicing appropriate techniques for relaxation	To develop effective strategies for managing stress in the workplace	Causes and symptoms of stress Balancing demands and resources Relaxation skills Improving sleep Attitudes to stress Goal setting Finding meaning in life	Chevreul's pendulum ('mind over body' exercise) Sleep monitoring Stress Drivers Questionnaire Quality of life survey Sleep modification Mindfulness meditations Relaxation skills based on breathing, visualisation, imaginal and autogenic techniques

Table 4.3 Summary of Norfolk CMP programme content

Introduction to Healthy Living

The introduction module was compulsory. Its specific purpose was to introduce participants to core principles of health management (diet, exercise, stress management and sleep). It also served to orientate participants to the whole programme. After housekeeping instructions, an ice-breaker exercise was added. This was usually 'Two truths and a lie,' a game in which participants and facilitators shared three 'facts' about themselves and the group had to guess which were true and which were false. This mini intervention was designed to set the tone of fun and engagement and was usually well received as evidenced in the testimonies of some former participants (Chapter 7).

The first section on understanding illness and impairment touched on the social component of claiming incapacity benefit. It described the different terms used to describe illness (incapacity, illness, symptoms, impairment, disability, condition and sickness) to explain that illness was not a fixed concept. However, the written input on this section was abstract and did not, in itself, address specific issues in participants' lives.

The psycho-education content, insights and health hints and tips, if applied properly, could help individuals to improve their fitness which could inspire further activity and positive behaviour change. They could potentially help participants to become more resilient in the workplace. However, this input could be beneficial to all people (including those already in work) who might benefit from a healthier lifestyle. In contrast, CMP participants were asked to consider healthy living for the purpose of removing a barrier to employment. This could have suggested to them that returning to work was fully dependent on *improvement* in health.

Smith (2002) pointed out that IB claimants already tended to think that *any* illness made work impossible. Some participants in the Norfolk CMP revealed how they had attended previous similar courses (discussed in Chapter 7) which suggests that attendance on CMP might lead to strengthened cognition that health had not improved enough to 'permit' employment. Similarly, some CMP participants described a focus on their health including assertions that their health had improved but was not yet adequate to meet the demands of work (Chapter 6).

The programme theory is straightforward: *skills of effective health management are required in order to obtain and maintain employment*. This is consistent with the explicit theory described above. Absent from the module, however, are specific efforts inviting participants to consider the value of applying these skills for the purpose of moving into paid work.

Managing Depression in the Workplace

The principle subject areas for this module were tackling negative thinking, inactivity, loss of confidence and assertiveness. Whilst the module was described as 'managing depression in the workplace,' there was no mention of the workplace in the module handbook. The interventions and insights could be effective in preventing relapse into depression once back in employment. However, Smith (2002) points out that failing to leave benefits (static claiming) was a fundamental cause of high claimant numbers. It is helpful to re-examine the course outputs proposed in table 4.1

1. I see myself as economically active
2. I believe I able to work
3. I believe that I have worth and capability making me employable
4. I do not allow stigma to hold me back
5. I am active and take responsibility for my health
6. I am taking steps to make employment viable for me including voluntary work, training and looking after my mental and physical health.
7. I believe that my condition does not stop me from working. I am considering new types of employment
8. I am looking after my mental and physical health.

In this context, depression relates to maladaptive beliefs about the claimant's sense of self-worth, pessimism about work prospects and negative assumptions about the extent of their illness. An alternative conception of depression that reflected these outputs (and claimant descriptions examined in Chapter 8) might be described as 'not at work and feeling depressed' as opposed to 'depressed and therefore out of work.' The module itself was comprehensive. Its range of interventions and exercises, combined with the group dynamic, made it a potentially effective intervention for learning to overcome depression and increase self-efficacy. However, it did not link depression to a specific context (e.g. workless-ness). It is possible that effective use of this resource could help an individual to manage depression leading to improved clinical outcomes (discussed in Chapter 6) yet fail address claimants' decision-making regarding work.

Anxiety Management

Principle input areas were symptomology, the mechanisms of anxiety, role of helpful and unhelpful voices in thinking, recognising executive and automatic thinking, challenging logical thinking errors, dysfunctional attitudes and skills to manage panic. The programme input drew mainly from CBT

and, to a lesser extent, Transactional Analysis (TA). In order to gain personal insights into anxiety, participants undertook a symptom checklist, a weekly 'ego-gram' (using TA principles) and the Dysfunctional Attitude Scale (a self-efficacy scale). Seven discreet skills were taught which could be repeated outside of the programme.

These inputs, insights and skills were potentially effective in reducing anxiety across a variety of settings including the workplace though the workbook made no mention of this. The omission could indicate an assumption that the individual suffered with generalised anxiety disorder (GAD) and that this reduced their ability to function across a variety of settings including the workplace. This may have been the case for a proportion of benefit claimants. Some claimants, though, may have been anxious specifically (and potentially *only)* about the idea of returning to work or of relinquishing the security of IB (explored in detail in Chapters 7 and 8). If this were the case then improved management of generalised anxiety could, for some participants, mean an increased likelihood of returning to work. This could generate an internal conflict of interests between the benefit of improving health and the cost of increasing a sense of insecurity. A potential unintended consequence of managing *generalised* anxiety may have been to increase *specific* anxiety related to returning to work.

Communication and Assertiveness

The module offered a comprehensive package for understanding own and others' behaviours and offered clear, easy to understand skills to practise being more assertive. The content was mainly 'generic' in that it addressed the subject matter *outside* of the context of incapacity. However, some of the role play scenarios were based on workplace situations. The module did not include any approaches to managing bullying or intimidation in the workplace which some participants described (Chapter 8).

There are two potential strands of problem conception and programme theory relevant to this content. Firstly, participants may have experienced bullying or difficult relationships at work which might have encouraged avoidant behaviour. Assistance with managing relationships could equip participants with personal insights, understanding of others communication styles and communication skills that might have made them less fearful of people at work and more skilful at dealing with difficult relationships in the workplace. Secondly, participants may have become anxious or depressed as a result of difficult relationships at work. Assertiveness and relationship training could complement mood management (anxiety and depression) by addressing the original source of distress. It is noteworthy that some theory and practise (Transactional Analysis) was common to both programmes which suggests that these modules were joined up in respect of the

problem conception and programme theory. These concepts are relevant to outputs derived from Smith's (2002) conception of incapacity (above). Addressing personal rights could, in theory, have helped participants to believe that they were able to work and that they had worth and capability making them employable. It had the potential to aid participant's revision of the view that they were permanently economically inactive and help to prevent stigma holding them back from a fresh attempt to gain employment. As such, it addressed some of the social causes of static incapacity claiming. Whilst some of the exercises reflected a work-focus, they were based on communication and assertiveness once back in work. However, the focus of Smith's (2002) conception of incapacity was on factors related to the experience of being on benefits rather than being in work.

Stress Management and Relaxation

Whilst work was not mentioned, if applied successfully, the skills taught in this module had the potential to *encourage* work-seeking as well as assisting in the management of stress once at work. The module included an exercise identifying life goals by helping participants to reflect on key life events that had personal meaning for them. It cannot be known if it was intentional but this intervention may have had a positive effect in encouraging more expansive thinking about life opportunities including the role of work.

In the programme materials, this exercise was presented as 'building resilience.' This was achieved by being *committed* to something, being in *control* and ability to deal with *change*. Underpinning this was research which found that resilient people were known to be committed to something (e.g. religious or spiritual beliefs, family or vocation). Knowing what one was committed to was ascertained by examining events that had been personally significant and deriving from these events what had been important to the individual. Answers such as family, friendship, adventure or creativity could then be measured in terms of their importance and the amount of satisfaction being gleaned from them (scoring each out of ten). Major discrepancies between importance and satisfaction could be addressed by setting of goals to rectify the situation. The theory was that existence of goals led to the feeling of being in control in life and therefore more resilient to stress; life's stressors were thought to be less troubling when seen to be irrelevant to an individual's personal goals in life.

The inclusion of this exercise was founded on an assumption that stress prevented people from being able to work or to maintain work. Whilst the exercise may have been helpful in opening minds to future opportunities, Smith's (2002) conception of incapacity does not allude to stress at all. Aside from Smith's key assertion that static incapacity claiming was caused by not ending claims, managing stress did not relate directly to programme outputs linked to the problem conception.

The testimony of claimants (described in Chapters 7 and 8) indicated that the stress they endured was frequently related to chronic threat of losing benefit status rather than inability to withstand pressures of work. As such, this module contained potentially helpful but was not presented with explicit rationale of helping participants to revise their view of their future.

Comparison of actual and explicit programme design

The first section of this chapter explored how the problem conception, as outlined by Smith (2002) could be interpreted into a coherent programme. CMP addressed health and some socio-cultural factors from Smith's four key components of static incapacity claiming. The remaining factors (economic/financial and effects of welfare systems and processes) were not addressed. Health and social factors were expressed in table 4.1 from the hypothetical perspective of claimants. The resulting solutions could be interpreted as programme outputs that are directly related to Smith's problem conception. The explicit programme design that followed has been examined by inferring concept and theory from policy documents, contemporary evaluation data and from promotional literature. Emerging from this, is a programme with a considerable focus on health management, acknowledgment of (but less emphasis on) social factors such as confidence and no attention on economic and financial implications. Viewed as a whole, Smith's (2002) components of incapacity represent a complete picture of the factors influencing individuals' ability and decision to seek employment or otherwise. Addressing health factors separately from the wider picture of individuals' incapacity may have impeded participants' understanding of their incapacity. It may have also have contributed to a primarily health focus within the programme.

The actual programme design, inferred from the programme content delivered in the Norfolk CMP, followed this trajectory. Emphasis was not placed on individuals' specific needs and circumstances. The programme was generic in its content and approach. Whilst some of the content might have been relevant to a holistic conception of participants' incapacity, it was not delivered with this explicit purpose. A key consideration in the evaluation of the skills the programme sought to train was *when* and *why* participants would use them.

The modular design of CMP suggested an incapacity conception that could be likened to a jigsaw puzzle. It sought to help participants to put in place the missing piece(s) of their ability to work. This reflects a deterministic view of incapacity in which a person either can or cannot work due to their impairment. The claimant would not be seen as able to work until they assembled the pieces of the puzzle: managing anxiety and low mood, coping with stress, believing in themselves, communicating their needs and maintaining a level of general physical fitness. The participant could be seen as

deficient on one or more (or all) of these areas. The programme would then compensate them appropriately.

This concept marks a significant deviation from the problem conception outlined by Smith (2002) which suggested that an individuals' incapacity was likely to be complex and influenced by many different factors. In this context, a programme that sets out to restore a person from a state of long term non-employment and poor health into a state of employability is highly ambitions. The implementation theory did not appear to be based on a consideration of the best circumstances to achieve desired outputs and, instead, identified a cost-effective approach. This was to provide health skills training based on a *compensation* approach which assumed that participants lacked skills to self-manage their health. This was influenced by the conviction that CBT provided an appropriate and cost-effective intervention as expressed by Layard (2006) and confirmed by the testimony of the Pathways-provider manager (above).

Chapters 5 and 6 examine the implementation stage of CMP delivery in Norfolk. Chapter 5 specifically describes and interprets changes that were made to CMP content and delivery after the initial model (described above) was judged as insufficiently effective.

Chapter 5 – Programme implementation: CMP Express

Introduction – programme redesign

The 'original' CMP ran for 12 months until March 2009. This chapter explores the changes made to programme content after the Norfolk CMP was revised following disappointing results from the original format. Whilst the Norfolk CMP was not formally evaluated during delivery, performance was constantly monitored by the Pathways provider which was naturally occupied with establishing the impact of CMP on return to work outcomes (and therefore, value for money). A Pathways provider manager responsible for CMP retrospectively described:

> "…feeling continually under pressure to reduce costs and modify the model and being confronted by those on the "employment side" wanting definitive proof that CMP was resulting in early returns to work. The expectations were sometimes highly unrealistic i.e. a belief that people just [recently] engaged on the programme should be back in work almost immediately!"

The specific changes suggest an alteration in interpretation of the problem conception and are evidenced by a greater focus on working. Whilst instigated by the Pathways provider, the changes were identified and implemented by CMP practitioners highlighting the potential for programme concept and design to be altered during its delivery. Examination of the process of change helps demonstrate strengths and weaknesses in the logical integrity of the programme.

Nice and Davidson (2010) recognised the difficulty faced by CMP practitioners in Norfolk who inherited a programme without accompanying facilitation guide or explanation of programme theory:

> "For sub-contractors, either CMP had been pre-designed by the Pathways provider, or sub-contractors had a role in designing their own programme working with the Pathways provider. The data is incomplete regarding views about these design arrangements, but there were signs that being given a pre-designed programme could be problematic where it was not accompanied with instruction for delivering some of the techniques and, as a result, practitioners' delivery could be inconsistent. In an area where this happened, CMP was later redesigned with greater input from the sub-contractor" (p.16)

An internal review in January 2009, led to the commissioning of a shorter, more intensive version of CMP. Interpretation of the 'express' format is helped by the existence of 'facilitator guides.' These were also written in response to requests from other practitioners who sought guidance on how to deliver the programme. Their need for clarity reveals a weakness inherent in programme implementation in which concept and theory may not be adequately explained to practitioners (Cronbach, 1980).

The internal proposal outlined the rationale for the 'express' version. The proposal was subsequently reviewed as guidance for Employment Advisors working for the Pathways provider. It offered advice on who would be an appropriate candidate for the programme:

> "Participants who are suitable for this programme are likely to be "high functioning" but suffer from fragile self-confidence and/or general anxiety and negativity about themselves and their prospects. They are likely to have greater natural ability and resources than they believe at this moment. They have the ability to pick up new skills quickly and practice them without prompting from others." (What is the CMP Express? p.2)

The essence of this description is a person who is functionally capable of adapting to the work place but lacks the *belief* that they can. The original design brief for CMP 'express,' was for an additional programme aimed only at customers who were closest to the employment market. However, the original programme was abandoned and 'express' was provided for all participants as discussed in Chapter 1. This may explain the omission of (un)employability factors in the participant description (above). In other respects, this composite depiction of an express participant focuses on confidence and self-belief as the key barriers to employment rather than functional impairment brought about by health conditions. The programme outputs based on Smith's (2002) problem conception expressed from the perspective of participants (as described in Chapter 5, page…) are appropriate for the programme candidate described above.

A promotional brochure opens with a brief description:

- This is a four week intensive programme (one day per week)
- It is aimed at providing customers with focused help with stress, bullying, anxiety and depression
- Aimed at swift intervention prior to return to workplace

- Dedicated therapist throughout programme and review.

The term 'focused help' implied a robust intervention. It did not include the terms 'treatment' or 'condition management' though it did offer help for specific conditions. It is explicit that the rationale for the programme was for return to employment.

The brochure continues:

> "The Condition Management Programme is focused around supporting people on health related benefits with anxiety, stress and depression along with physical problems such as chronic pain. The programme will equip you with knowledge, coping skills and peer support that will enable you to gain and sustain employment while living with your health condition."

Here the implementation theory was alluded to if not made completely clear; provision of knowledge, learning skills and support from peers. The latter might be assumed to be identification, advice and encouragement. The programme theory is also alluded to:

> "Through the provision of knowledge, skills and peer support to help manage health conditions, the participant will become able to firstly gain employment and then maintain it whilst living with the condition."

Condition management did not infer a cure to health problems but the means to live with them. This was further clarified in the booklet:

> "Condition management is the process by which we manage our lives in order to achieve and maintain a level of health and wellbeing that enables us to enjoy a satisfying work and personal life."

The word 'process' suggested a series of steps, as opposed to a set of skills, which would result in ability to manage health and wellbeing. These steps might have included making a decision to attend, becoming willing to join a group and then participating in it. The booklet was very clear that management of health should enable satisfaction at work as well as at home.

> "You will learn new skills, practise them in a safe environment and steadily implement them in your personal life ready for transmission into the workplace."

Here the implementation theory is more transparent. Skills would be learned in a safe (classroom-based, tutor-led) environment and then practised at home before use at work. Whilst the phrase

'transmission into the workplace' seems unlikely to hook a potential customer, it re-enforced the notion that work was the destination. Some of the micro-processes by which the skills are learned are explained in the following section:

> "CMP Express is an intensive, four week, group based programme of personal change.
> During this period, you will get to know yourself and your health condition better. You
> will receive support and encouragement from your peers. We understand that people
> are often nervous about groups but these anxieties soon disappear after the first
> session."

The expressions 'programme of personal change' and 'get to know yourself' implies an emphasis on personal development suggesting changes in attitude, belief or direction. It should be remembered that this was the second iteration of CMP in Norfolk following concern that the original programme was overlong and lacked work focus. It was designed and promoted as a high impact programme in which change was expected. The term "personal change" also represented the thinking of the practitioner and management team that reflection and insight, in addition to health education, was needed to assist participants out of their current situation. Alluding to the group support and encouragement, it acknowledged feelings of nervousness and expressed that group process was a key component of the programme.

The process of integrating skills and insights was re-asserted in the booklet:

> "Each week, new skills are introduced and are expected to be practised in your own
> time. Each session builds on the last with continuous home-based assignment work.
> To get the most benefit out of this programme, you are required to attend all four
> sessions, together with an exit interview in week five."

In terms of implementation theory, this passage implies that the programme content alone was inadequate to bring about significant change in individuals' health and job-seeking behaviour. Rather than providing compensatory skills and support over a period of weeks (or months on the original CMP), the 'express' was designed as an intense period of opportunity. During the period of attendance, participants were required to make particular efforts and make use of encouragement from peers and programme staff. It is noteworthy that, unlike previous programmes, participants were 'required' rather than encouraged to attend all the sessions.

Table 5.1 compares module composition and timings for 'express' and 'original' programmes. Table 5.2 summarises the 'express' programme content.

Original CMP Module title	Duration	Express CMP Module title	Duration
Introduction to Healthy Living	1 x day	Introduction to Healthy living and Working	1 x day
Depression	6 x 2 hours	Mood Management	1 x day
Anxiety	6 x 2 hours		
Communication and Assertiveness	2 x 3 hours	Managing relationships at work	1 x day
Stress Management	2 x 3 hours	Managing stress in the workplace	1 x day

Table 5.1 Summary and comparison of CMP modules for Original and Express programmes

The day-long modules were based on the similar content to the original programme with but the method of delivery was suggestive of a different priority. Being brief and focused, it implicitly communicated the message that management of health conditions was now in the hands of claimants themselves. This short programme would offer psycho-education and some hints and tips but *not* long term support and encouragement. The assessment meetings were held the week immediately prior to the group intervention and exit interviews were held the week after making it a six week programme overall. The assessment gathered the same information as the original programme and orientated the participant to CMP. It did not assess the individual with a view to formulating their unique picture of incapacity. The 'express' concept was a programme that helped participants to improve their health and wellbeing with a view to a prompt return to work. The specific concept and theory (and its differences with the original programme) are discussed below.

Introduction to Healthy Living and Working (CMP Express)

An unambiguous difference from the original programme was the inclusion of the phrase 'and working' in the module title. This was more than cosmetic. The topics of work and incapacity were raised as the first part of formal input (after housekeeping and orientation). The input areas that followed were similar to the original version; relaxation, diet, exercise, sleep and stress management. In introduction CBT orientation was added (basic understanding of CBT was required in order to complete homework tasks). The significant modification was a section on understanding illness, impairment and disability.   Participants were asked to consider a 'five areas assessment' (description of thoughts, emotions, physical sensations and behaviour in relation to their environment) for their illness or impairment. They were asked to include their experience of not

working and of being an incapacity claimant. To assist with this the group was first asked to comment on their experience of being off work and on incapacity benefits within the context of 'the system' (DWP, NHS etc), wider society, family and friends and 'self.' The results were written on four quadrants on a flip chart. The comments from the group were normally negative (see chapters 7 and 8). The facilitator guide described it as follows:

"Before we move on, looking at work – how does it feel not being at work? What is it like?

"The system" NHS, DWP, Work	Society generally
Self	Friends and family
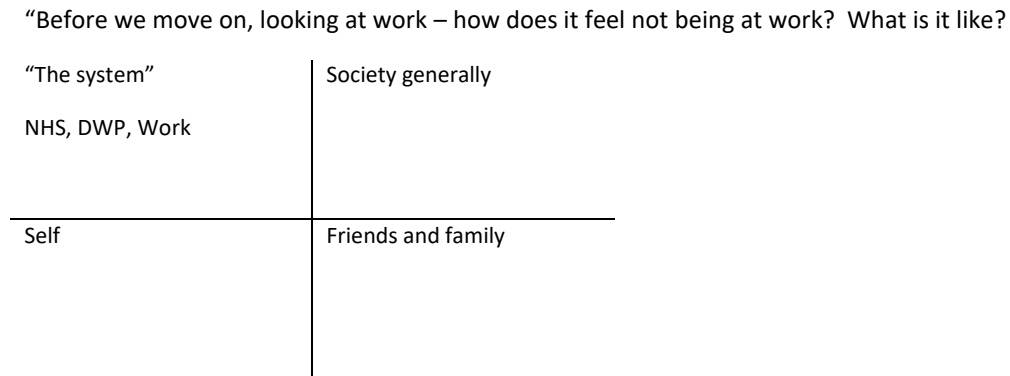
Key Points: - Long term illness starts with medical condition e.g. depression but develops secondary condition – unemployment/isolation from the economy. *CMP helps with both."* (Introduction to healthy living and working facilitator guide p.1).

Figure 5.1 Facilitator guide – Impact of incapacity claiming

The problem conception as understood by the writer of the programme is evident in the 'key points.' The stated purpose (key points) and the inclusion of 'the system' resemble the problem conception outlined by Smith (2002) as discussed in chapter 4. Smith noted the negative impacts of welfare systems and processes which variously failed to help claimants and discouraged change. The 'system' was a word frequently used in group discussion about how services designed to help frequently failed to do so or were discouraging or even hostile. The social and cultural components of Smith's conception are also included but health was omitted. This exercise was designed *without* knowledge of Smith's (2002) problem conception. It arose from the testimonies of participants in the earlier version of the programme

This group exercise was scheduled for the first morning of the programme. It was intended to acknowledge the distress experienced by claimants and allow free expression and discussion about their experiences of being a claimant. This specific intervention helped bond the group and also established a culture of openness and trust (including with facilitators). It communicated to the group that their experience of being a claimant was not going to be judged, that they were understood and believed.   Its value in setting the tone for the course was noted by practitioners

(chapter 7). The picture commonly described in these sessions is examined in detail in chapter 7. What emerged was recognition that, after a period of claiming, it was common to feel isolated, low in mood, anxious, lacking in confidence and potentially shame. In this psychological state, job-seeking activity was restricted and the security of an ongoing incapacity claim was sought. These processes are explored in more detail in Chapters 7 and 8.

Module	Course input	Course outcomes	Content/topics	Exercises
Introduction to healthy Living and working 1 x 6 hours	Understanding the CMP process Understanding illness, impairment and disability Minimising life's stressors Quick hits – Diet, exercise and relaxation Introducing CBT – the five areas approach	Undertaken a self-assessment Developed a personal action plan for CMP Developed a stress reduction plan Understood the basics of CBT Prepared for week 1 activities (homework).	Five areas (CBT) self-assessment Effects of being an incapacity claimant Cycle of change Introduction to CBT Basic health management (diet, sleep, stress and relaxation, exercise)	Orientation and ice-breaker Group discussion – impact of incapacity claiming. Group discussion – cycle of change (employment – incapacity 0 recovery – re-employment) and the role of CMP.
Mood Management 1 x 6 hours	Understanding the link between mood, thinking and behaviour Understanding depression Understanding anxiety Facing fear (systematic desensitization) Slowing down (strategies for tacking physical anxiety) Activity scheduling Tackling negative automatic thoughts	Successfully used a Thought Record Recognised and challenged Negative Automatic Thoughts Developed an Activity Plan for the week Prepared a plan for tackling situations that cause fear or anxiety Learned to counter the adrenal stress response	Cognitive restructuring Behavioural activation Progressive de-sensitization (fear ladder) Case studies	De-arousal techniques (good breathing, peaceful place meditation, progressive muscle tensing and various distraction techniques) Use of thought records
Managing relationships at work 1 x 6 hours	Defining bullying and successful responses to it Your personal rights at work Model for improved communication Successful communication styles Assertiveness techniques Dealing with difficult people	Undertaken as assertiveness self-assessment Examined and understood your communication and relationship styles Developed a plan for managing relationships at work Prepared for scenarios involving difficult people at work	Communication styles (drawing on Transactional Analysis) Definitions of assertiveness Dealing with manipulation and Bullying - definitions and responses	Assertive beliefs questionnaire Assertive 'bill of rights' LADDER (mnemonic for assertive communication) Role play scenarios based in work contexts.
Managing stress in the workplace 1 x 6 hours	Defining stress and resilience Quality of life and life goals Workplace stress busters Time management Stress drivers Embracing change	Undertaken a stress management self-assessment Examined and understood your working styles Learned skills for coping with stress Developed a plan for managing stress at work	Stress - definitions, causes, signs and symptoms Developing resilience Stress moderators Dealing with change – impact of returning to work	Quiz - causes of workplace stress Stress drivers questionnaire Quality of life exercise (meaning, purpose and goals) Transition curve Time management – urgent v important

Table 5.2 Summary of Express programme content

In terms of programme theory, the purpose was to introduce present the conception that health could be both a cause and an effect of incapacity claiming. It provided the basis and rationale for the rest of the programme. Having gathered the group's experiences of incapacity claiming, the session moved on to an idiosyncratic cycle of change model. This was based on Prochaska and DiClemente's (1983) transtheoretical (stages of change), commonly used in treatment for addiction. In the CMP version, illness was followed by loss of employment and subsequent social impacts that the group had previously described.

The *social* component of incapacity, which 'express' focused on, was reinforced by the inclusion of two related vignettes. These described individuals who had developed health problems and become subsequently entrenched in their non-employment through aversion to seeking employment brought on by fear of further distress.

The programme theory could be described as:

The participant may recognise that a significant aspect of their distress is the social consequences of incapacity claiming (isolation, social exclusion and marginalization). These (rather than health) have resulted in safety and avoidance behaviours (including reduced job seeking activity and identification with illness for the purpose of maintaining the security of benefit payments).   This insight may encourage them to engage with the programme to learn skills of managing health conditions effectively to increase their energy and motivation and increase the likelihood of a return to employment.

The implementation theory for this intervention could be described as:
Guided discussion, understanding and empathy from course practitioners and identification and encouragement from peers will encourage reflection on the passage from work into long-term incapacity. Appreciation of being 'stuck' in the stage of long-term (negative) consequences may encourage the participant to embrace change out of self-interest. This will encourage engagement with the programme.

WORKiING → Unwell → Signed off work → Stay off work → Long term sick → Lose employment → Personal, social, financial consequences → Understand condition → Learn new skills → Implement skills → Gentle return to normal functioning
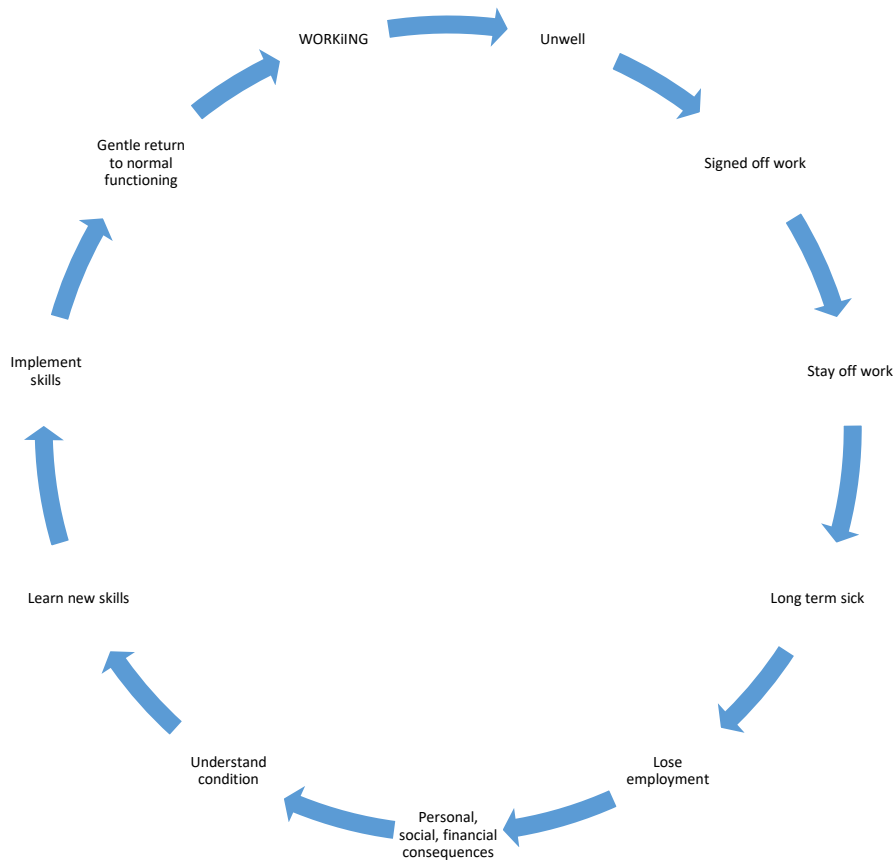
Figure 5.2 Idiosyncratic cycle of change model from CMP Express

Mood Management: tackling negative thinking (Express)

As with the anxiety and depression modules on the 'original' programme, the title does not mention work. The programme input was appropriate for managing mild depressive episodes and generalised anxiety disorder. The express Mood Management module built explicitly on week one (Introduction to healthy living and working) in which participants examined their health condition in the context of a long-term incapacity claim. The use of two vignettes based on incapacity claimants (one who was depressed and avoidant and another who was anxious and avoidant) who faced psychological barriers to employment mirrors some of the characteristics of incapacity claiming described by Smith (2002). In one vignette, the fictional Vic, a former print worker who left work due to stress and had subsequently become depressed, anxious and avoidant, had been invited to an interview. However, he refused to attend due to feelings of fear brought about by the negative automatic thoughts "I don't have anything to offer" and "I'll fail and let my family down." Negative automatic thoughts (NATs) are identified in cognitive behavioural therapy as thoughts which lead to specific moods and related, maladaptive behaviours (Greenberger and Padesky, 1995). Participants were invited to identify thinking errors and produce a rational alternative thought which would

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reduce Vic's anxiety and encourage adaptive behaviour. They were then invited to consider their own beliefs related to work and their health.

The effectiveness of this and other interventions is discussed in chapter 8. The theory underpinning Express Mood Management was:

Individuals may become entrenched in social situations that reduce self-efficacy and limit likelihood of applying for work. Incapacity claimants can learn to appraise their fears rationally in order to overcome fear of returning to work.

This marks a significant deviation from the explicit theory apparent in the original programme and pilot CMP which saw anxiety and depression as conditions which limited *ability* to work. In the 'express' version, mood management skills were taught for the purpose of addressing belief-based (psychological) barriers to *seeking* work. This difference resonates with the problem conception of incapacity described in *Pathways to Work* (Smith, 2002). The psychoeducational input and homework exercises for this module mirrored the content from the original programme almost exactly but the purpose was markedly different. Therefore, the 'express' mood management module could be seen to mark a significant re-alignment with the problem conception.

Managing Relationships at Work

This module replaced 'communication and assertiveness' from the original programme. Whilst the content was similar, the 'express' version more focused on the workplace. The workbook contained specific information and advice regarding bullying in the workplace and details of organisations offering advice and support. The role play exercises were also based in the workplace.

The module differed from *mood management* in that its relevance centred on the period *after* the participant returned to work as opposed to when they were considering or preparing a return (which was the focus of *mood management)*. This does not align with Smith's (2002) problem conception for incapacity. The conceptual basis for its inclusion is that lack of assertiveness or poor communication skills hinder *ability* to work. This is in keeping with the 'original' CMP concept. It is possible, however, that some participants may have previously experienced interpersonal problems at work and feared returning for this reason.

An alternative theory may have been that learning effective communication skills and sharing of experiences with others may have encouraged participants to believe that coping with the social aspect of the workplace was possible. Accompanying implementation theory may have been that the role play exercises were a form of 'exposure therapy.' If the input was successful in encouraging

self-belief, it may have helped participants to believe in their worth and capability in the workplace, to believe that they deserved a chance at employment and to manage fear of stigma.

Whilst the module included a substantial amount of theory, it allowed only a short amount of time to learn and practice it. However, the participants would, at this point, have spent three full days together. It is feasible that the impact of the day's content and skills may have been enhanced in the context of a strongly supportive group. Viewed as a whole, the module's theory reflects a *compensation* approach in which inability to function socially in the workplace is assumed to represent reduced ability to work. This is in keeping with the original CMP concept.

Managing stress in the workplace

Much of the content was transferred wholesale from the 'original' programme. However, the context for management of stress was more obviously, the arena of work. The first exercise invited participants to examine the 'top ten causes of stress in the workplace' which, to the surprise of most, placed workload in tenth place behind other factors such as trust, uncertainty, fairness, being supervised effectively, feeling appreciated, clear communication and a sense of control. Discussion on these subjects led to participants identifying solutions but also invited them to talk openly about the idea of being back in work. In terms of implementation theory, this might be regarded as a form of guided exposure therapy.

The 'original' stress programme alluded to resilient people being able to cope with change but did not offer specific input on it. The 'express' format used the 'transition curve' (Fisher, 1999) to describe the predictable psychological stages associated with major life changes. It was presented in the context of resilience (commitment, control and change) which was explained in the 'original' format. However, the purpose was to invite participants to consider and prepare for the impacts of returning to employment. The facilitator guide explains:

> "Change – Brainstorm changes that participants might go through (new job, meeting new people, no-longer available at home, child care implications, more income, less time for hobbies, new working structure, tired etc
>
> Encourage group to think about the impact of changes on significant friends/family too.
>
> Introduce transition curve (p.13) Learning to drive is a useful example of fear replacing excitement. Key Point – it is necessary to "go through" the stages. It is also possible to slide backwards." (Stress Management Facilitator Guide p.2)

This exercise was followed by a discussion on stress moderators directly related to work such as getting feedback, being organised, tackling one task at a time and taking breaks. This input could

only be of use to the participant when at work. Continuing this theme was further input on time management using an *urgent versus important* matrix to help prioritise tasks. Whilst it was possible that it could be immediately helpful to participants in their everyday lives, it re-acquainted participants to the world of work and attempted to normalise it through open discussion.

The portion of content that was taken directly from the original programme adopted the *compensation* approach which assumed that if participants learned skills of stress management, they would be able to remain at work. This could also help participants to be less fearful of work, especially, if stress had been a significant factor when they lost employment. The new content focused on transition from claiming into work and could be seen as a *capitalising* approach. It raised the notion of returning to work and harnessed the strength and wisdom of the group to *build* on participants resources and encourage them to believe that work was something that they *could* cope with. The 'express' stress concept represented a hybrid between the health-focused concept of the original and pilot CMP and re-alignment with a socially focussed concept of incapacity.

Implications of the 'express' programme

Viewed as a whole, the 'express' CMP could be seen as a stepping stone between the health-focused original programme which addressed the health conditions which prevented work and a socially-focused intervention that addressed the factors which prevented claimants from leaving the security of benefits. The 'express' contained elements of both approaches. The first week (introduction to healthy living and working) invited participants to re-evaluate the basis of their incapacity and to re-consider the possibility of returning to work. The following three sessions (mood, relationships and stress) encouraged further insights, taught skills and promoted sharing and encouragement within the group with the dual purpose of improving wellbeing *and* encouraging a return to work. The 'express' programme acknowledged the presence of non-health related factors preventing return to work. However, it continued to offer advice and skills related to health. As such, it represented a move closer, but not fully, to the problem conception of static incapacity described by Smith (2002).

The 'express' CMP programme theory could be described as follows.

Problem conception:

Long-term IB claimants lose employment because of (or whilst suffering with) a specific health condition. They are likely to have endured further harm to their wellbeing caused by the negative social impacts endured during their incapacity claim. These include social isolation, stigma and the restrictions of living off low income. The long term result may be low mood (depression) and fear

(anxiety) of returning to the workplace. This fear may be exacerbated if previous experience of work included stress or interpersonal problems such as bullying.

Programme theory:

Discussing and sharing their (primarily distressing) experiences of claiming incapacity will encourage participants to acknowledge and understand the subtleties of the trap of long term incapacity claiming. It may encourage participants to consider returning to work to reverse the negative effects of incapacity claiming they have identified. Skills of managing mood, relationships and stress will help to lift mood and reduce fear and build confidence and self-efficacy. They are helpful (and possibly necessary) to help participants to lift themselves out of their current situation.

Implementation theory:

Harnessing the strengths and experience of the group and delivering course input and exercises that are focused on work, engenders a sense of being back in employment and builds participants' confidence in their ability to return to work.

This programme design may be examined in the context of programme outcomes extrapolated from Smith's (2002) problem conception (explored in Chapter 4) The 'express' programme contained elements that could help increase participants' belief in these outcomes. However, this did not guarantee that participants *would* adopt different beliefs about their incapacity or act on them if they did.

The 'express,' like the original programme, offered skills, insights and support. In both formats, it remained the *choice* of participants how or whether they would make use of it. The programme literature stated a 'requirement' to attend but the impact and meaning of attendance remained the concern of the participant. In this sense, the programme may be similar to mainstream training events in which people learn skills relevant to work or leisure. The impact of the programme may be seen in terms of its *relevance* to the attendee. It had been observed that many incapacity claimants wanted to work (Acheson, 1998; Grewal et al 2002). The CMP express may have been relevant to them but its concept was less appropriate for participants who doubted the likelihood of their regaining employment. Close analysis of the 'express' CMP shows that it could be active and engaging as was reflected in practitioner accounts and in participant feedback. It focussed on the *issues* of incapacity rather than on the *person* who was the subject of it. The next chapter examines the programme delivery and its relevance to the concept and underlying problem conception from the perspective of practitioners.

Chapter 6 - Delivery of CMP in Norfolk

Introduction to practitioner accounts

As discussed in Chapter 2, for a programme to be successful, its concept and mechanisms should demonstrate fidelity with the problem it addresses (Rossi, 2004). Programme delivery must then remain faithful to the principles underpinning the concept. Chapter 5 described how content and delivery of the Norfolk CMP was adapted following pressure from programme referrers. The direction of change (greater emphasis on returning to work) was led by the Pathways provider. However, the specific changes were driven by participants' presentations and testimonies. The result was programme theory that was more closely aligned with the government's conception of static incapacity claiming.

This chapter examines programme delivery from the perspective of practitioners. Programme delivery represents the point of contact between the commissioners of the programme (politicians and civil servants) and the participants it is aimed at (IB claimants). Practitioners described a sense of the claimants in front of them and the commissioners behind them and of holding the tension this created. Programme delivery also marks the stage where discrepancies between the problem conception and the organic problem may become apparent. It is the point at which unanticipated difficulties may be encountered and where practitioners may remain faithful to or deviate from the programme concept and theory.

This chapter describes programme delivery from the perspectives of all of the (four) practitioners who delivered CMP in Norfolk (including the author). Accounts were gained from three volunteers who participated in in-depth, semi structured interviews. These were held in 2015 (four years after the programme closed). The interviews yielded themes using Interpretative Phenomenological Analysis (Smith and Osborn, 2002). For each practitioner, a brief summary of their professional background is followed by an account of the main themes emerging from the interview. Tabular summaries of subordinate and superordinate themes can be found in appendices 6,7 and 8. An account of each interview highlights suggestions of fidelity or otherwise with the programme and implementation theories outlined in Chapter 3.

This chapter also includes the author's own account. This was originally written in 2010 to capture reflections and insights into CMP at the time of delivery and has been re-interpreted for this chapter. The chapter closes with a discussion comparing and contrasting the different practitioner viewpoints and summarising the points at which programme delivery demonstrated fidelity with the other stages of CMPs design and implementation.

Sonia

Sonia (not real name) was employed as Assistant Psychologist. Her previous professional experience was running psychoeducational programmes in prisons. Her role in CMP was to deliver interventions in line with the purpose and structure of the programme.

Sonia expressed her understanding of the concept of CMP:

> "…my understanding of the programme was that it was going to be a mindfulness/CBT
> programme that drew from an existing piloted programme that got done up in…the NHS
> in Cumbria I think who were the ones who first piloted it and they found it to be
> successful in terms of getting people to address their health in order to return back to
> work…so to come off benefits and actually go back to work." (Passage 2)

She described the CMP concept:

> "CMP is a programme that helps to promote healthy behaviours and activities that will
> enable the individual to maintain or improve their wellbeing." (Passage 20)

This concept assumes that participants lacked skills and required compensation or 'up-skilling' and is consistent with the explicit programme concept and theory. However, she was less clear about specific mechanisms and anticipated outcomes within this overarching programme theory. She did not receive formal training on the mechanisms (programme theory) of CMP and they only became clearer after a team meeting. The final sentence in passage 15 reveals a broad but unspecific theory.

> "I don't think I was told…it wasn't until we had one of the meetings down at London
> …and I think it was very clear then some of the outputs from it but prior to then I think it
> was more hinted I guessed that they wanted people to go onto the programme, come
> out with better outcomes than they had been at baseline (clinical outcomes?) yes…and
> then a hope from there was that when they went back to Shaw Trust, they would be in a

better position, then to seek training or further education depending on what it was they wanted to do but…I guess to put it in simple terms, the outcome they were aiming for was that the person would be bucked up in terms of their wellbeing so they felt well enough to actually start engaging with the world I guess." (Passage 15)

Her expectation of the implementation theory was that it would be a brief intervention for individuals with mild to moderate symptomology and would provide motivation and guidance:

"When I first started I thought it would be more people who were mild to moderate in terms of severity of their symptoms, come in, do it and so it would be a short course because from…thinking back to it now, I'm pretty sure it was supposed to have been something like six weeks so they would come on, do the course and it was a prescribed course at that time and they would do, boom, boom, boom, boom, boom, reach the end, be evaluated and hopefully by the end they would be well enough to start looking into education or job training or possibly other help if it was needed…so mainly those three arteries that they were sort of headed towards but the main idea was that they would be in a situation where… they just needed that extra bit of motivation and guidance that then would allow them to return to the working world once they finished." (Passage 2)

Sonia alludes to other factors affecting participants including finances, poor self-worth and anger.

"Most of it was they just felt they had been through a loop too many times and that this was just another hoop they had to jump through to prove they weren't well enough to return back to work…I guess as a rough guess were quite angry…so some of them felt like they would be better off staying on benefits than going back to work so they didn't see any point in actually doing the programme because it wouldn't make things better for them in the long run so they kind of felt begrudging having to be there because they were told they had to attend or their benefits would stop." (Passage 6)

Whilst Sonia does not draw any links to programme concept and theory, she is aware of the importance of motivation in participant's reaction to the programme. Rather than seeing CMP as an opportunity to *overcome* a health problem (in order to regain work), some saw it as a process in which they had to *prove* they were ill in order to maintain their benefit income (since this was most

financially advantageous to them). If Sonia's observation was correct, this indicates a *decision-making process* on the part of the participant based on an assessment of their situation and circumstances.

> "I think the… self-worth so they didn't feel any self-worth because of a,b,c or d which is why they were no longer working – whether it be an accident or mental health or something like that so I think sort of…I got a sense from some of them that it almost felt degrading because they'd – something had happened to them – they couldn't work…even though most of them wanted to work but they just weren't able to and then they had to prove themselves time and time again to the government that they weren't well enough to work even though from the outside of it, they looked absolutely fine and I think that was a part of it…" (Passage 7)

This passage describes participants in terms of being in a trap which was not of their making and from which they were unable to escape. This resulted in them having to prove their credentials for incapacity benefit demonstrating the extent of their illness. However, Sonia suggests that the reason for them not working was lack of self-worth. She noted that secondary problems emerged after the original health issue and that it was these secondary social issues that now formed the primary barrier to work.

> "…probably not as great a health problem…it wasn't… they still had a health problem which was why they were referred anyway because otherwise they couldn't be referred…but it may have been that that was standing more in their way than the actual health problem in itself… (Passage 8)

Examining these two passages together, it could be said that participants acted according to their own motivation and sought to make use of the programme *if* they thought it was in their best interests. However, 'best interests' were viewed through the lens of low confidence and self-worth. What emerges is a twin track view of incapacity. A deterministic view of mental health meant that they "couldn't work… even though most of them wanted to" (passage 7). On the other hand, is the less distinct conception that long-term incapacity result from poor self-worth. The distinction is important. Participants may have *believed* that their best interests were served by remaining on benefits based on the misconception that they had no worth. CBT theory describes this as *emotional reasoning* (Greenberger and Padesky, 1995): I *feel* worthless therefore I *am* worthless. CMP had the potential to provide a forum in which this view could have been

challenged. Instead, it focused on generic health management without encouraging thorough self-evaluation required to challenge low self-worth (explored in Chapters 4 and 5).

Furthermore, the deterministic view that illness prevents work requires assessment of health to justify benefit payment. The work capability assessment and the CMP were both health-focused. It is possible that some claimants may have feared quantifiable improvement in their health as a consequence of health-status being the gateway to maintaining their benefit claim (Dorsett et al, 1998).

The validity of the programme concept (provision of health management education enables a return to work) might therefore be challenged. Sonia explained that some participants became trapped between safety in their current role and fear of moving from it.

> "…but if [I – participant] change then I am going to have to be responsible for something or have to do this or have to do that - there's no longer that safety net and I think that's what possibly was stopping them and causing that fear of what am I going to do now because if I get better then that means that I am going to have to take responsibility and actually start looking for a job – I may not be able to maintain benefits, that I have to go out into the world and that's scary." (Passage 9)

Some treatments for addiction work by challenging a similar misconception (Carr, 2008). The long-term effects of substance misuse are to erode confidence, self-esteem, concentration, social contact, energy and general wellbeing. The greater the deterioration in functioning, the greater the sense of relief felt when intoxicated. Relief from distress may be misinterpreted as pleasure. The individual is faced with a choice between the distress of 'reality' and the pleasure or relief provided by the substance. 'Reality' is feared, not because the individual is fundamentally incapable of managing their life but because the substance misuse has caused them to *believe* they are incapable. The alcoholic or addict concludes that life without the substance would leave them perpetually unhappy. Treatment involves challenging the misconceptions that substances ever 'helped' and that sobriety equates to permanent unhappiness.

The longer an individual receives incapacity benefit, the longer they may experience its effects on confidence, wealth and social status. The greater these effects, the more mainstream (working) life may become feared. A guarantee of incapacity benefits, in the short term, may offer relief from this

fear. The effect, like with addiction, may be to lock the individual into a maladaptive view on their ability to function. The central issue is loss of confidence rather than health. Opportunities that threaten the security of benefit status may be rejected through fear and low confidence. This was noted by Sonia below and in the case studies (Chapter 8).

On occasions, Sonia recalls how fear, resistance and ambivalence were expressed in the behaviour of some participants. She described some behaviours which, she believed, prevented them from having to address their issues:

> "Occasionally you got some people who would divert from what we were doing so they would kind of get a bee in their bonnet if you like and they would kind of go off on a tangent and suddenly it would become about them and the rest of the group would sort of lose if you like…when that sort of happened and then you got those who were sort of trouble maker as I recall them where they deliberately caused problems in the group so then they didn't have to address the issue that we were trying to address." (Passage 5)

Sonia reflected on why the programme was ineffective for some people. She looked to the quality of the relationship between the participant and the course content and practitioner. Accepting the key assumptions of the explicit programme theory, she concludes that there has been a problem or failure in some aspect of its delivery if a participant fails to respond positively to the programme.

> "I suppose that's…where the realisation dawned on me when I had a few people going – 'oh well I've already seen somebody for this or I've already done this programme and that hasn't worked' and 'this hasn't worked' or 'it worked for a short time but then it stopped' and then you've got to find out all the intricacies – so why did it work and why did it stop? Because you didn't continuing practising what you were taught. Or why didn't this programme work at all – because you didn't get along with the practitioner… it was going to be pot luck as to whether they actually got on with us… Most of them gave a willing shot…I think I can pretty much count on one hand the number of people who caused me real issues because they decided they didn't like the practitioner or didn't like me." (Passage 10)

An alternative interpretation of an unfavourable response to the programme might be that the theory underpinning it did not resonate with the problem as experienced by the participant. Despite

experiencing challenging behaviour and ambivalence, Sonia's enthusiasm for the concept is clear as is her conviction that a more comprehensive and wider-reaching course would have served participants better:

> "I've got very affectionate memories of CMP – I loved delivering it… and to be honest I thought the actual programme itself was a really good idea but it was – when it was first piloted and it went out, it was a fantastic idea that, as with most things unfortunately, when the funding drops and people lose interest in it, it gets diluted down a little bit and although I think it's still really valuable now, it's just one of those things where I just look at it and go – come on, put some more money into it, get some more people and let's make this a little bit broader… give the programme that you know is working some more money so they can actually do something more with it and sort of help more people – but that comes from my own frustrations. I know it can work!" (Passage 20)

Summary

Sonia described an approach to CMP which remained faithful to the programme concept as espoused by CMPs commissioners and in the promotional literature available to participants. Her enthusiasm for CMP is grounded in her belief in its concept: if claimants are unable to work because of poor health, a programme which helps them to improve and manage their health would result in ability to return to employment. Sonia is aware of other dynamics affecting participants which influenced the likelihood of a return to employment such as anger, alienation and disenfranchisement and fear of change. These factors are treated as threats to the effectiveness of CMP rather than an alternative subject of the programme. The problem-conception remained the poor health of participants.

Sonia describes some difficulties she faced working with people who could be ambivalent or challenging. Her response was to look to ways of making the programme more comprehensive; in other words, to expand its embrace of clients' difficulties and provide solutions to them. She emphatically describes her frustration that the original CMP was shortened to create the 'express' version which reduced the opportunity to work with individuals over a longer time period.

Clare

Clare *(not real name)* joined the CMP team during the transition between the 'original' and 'express' CMP formats. Previously, she worked with substance misusers in a residential rehabilitation centre

and, before that, with prisoners. Her professional status was counsellor/psychotherapist. She was trained in a wide variety of modalities and was experienced in running therapy groups in both unstructured and structured (psychoeducational) formats.

Clare's understanding of the programme theory was shaped through the lens of her previous experience of group work. She understood that the programme incorporated two features: the therapeutic processes of the group and the course content itself. The latter, she saw as the secondary, rather than central, component.

> "Yes, I suppose, because my background is in rehabilitation, residential rehabilitation for individuals who have been sick through addiction and disenfranchised in other ways as well, working in the criminal justice system, I guess my understanding of the theoretical rationale or therapeutic rationale was getting isolated individuals into group situations would facilitate the process of identification and a context in which relationships would be made possible – facilitated – so the concept, the therapeutic concept of group therapy was something that I am familiar with in other contexts and would have understood I suppose in terms of the content, the sort of psycho-educational content, that's in addition to the therapeutic benefit of getting people together." (Passage 4)

She described her interpretation of the difficulties faced by long term IB claimants.

> "I think that came over really strongly in the first session of the CMP programme really that the…you know looking at the process of them becoming too ill to work and…being ill in a short-term way and then longer term and then feeling increasingly marginalised from the working environment. Whatever the connect of that was and sometimes there was clearly a very pressured situation at work, lots of combinations of complex things that have people be too ill, designated as too ill, self-designated as too ill to work… looking at that process, it's almost like seeing a picture where somebody is out of the workplace for a short period of time, quite easy to get back into work again but the longer they are out of it, the harder it is and there was very much a sense I think that would come back in those first sessions from people in the group of feeling judged, socially judged, marginalised you know as spongers or wasters in some way, sort of carrying that and feeling burdened but also increasingly pressured by it as well." (Passage 10).

Claire uses the term 'self-designated' as too ill to work. The overall effect of those social forces was to leave many of them feeling un-resourced and fearful of mainstream life. This could be experienced (and expressed) in terms of *illness* hence Claire's description of self-designation.

The passage portrays her observation that being out of work and claiming benefits led to marginalisation and stigma and that this, rather than the illness that preceded it, was the principle barrier to employment. She describes the problem as a 'social state' (passage 13) with an interaction of complex factors leading the claimant to feel distressed. The passing of time leads to increasing marginalisation causing the person to lack currency in the workplace and feel un-resourced. This combines with their feeling of being judged and stigmatised, adding to their burden. Alongside these feelings, was concurrent pressure to return to work. The pressure could be internal or from outside agencies. Like an alcoholic being constantly told (or telling themselves) to stop drinking, this only added to the strain.

This interpretation of the problem resonates with the problem conception as expressed by Smith (2002) (most claimants do not have a severe health condition; the longer a person is out of work the more their mental health declines; claimants eventually lose the confidence to apply for jobs). However, this interpretation is inconsistent with the explicit programme concept.

Clare describes how the tension experienced by the participants caused them to seek improvement in their circumstances whilst, at the same time, fearing change. The factors involved in this tension are both internal (cognitive and emotional) and external (financial and social).

> "I think fear of…fear of failure, fear of not…coping, of getting ill again…there was almost a sort of vested interest in being a little bit ill because then you know there wasn't the need to …get back into…the situation in which they became ill so there was something a bit avoidant about that." (Passage 13)

> "…there was always this sense that 'that's all very well but I daren't actually get well because if I actually got well than I would lose the higher rate of benefit and I'll have to go back to work.'" (Passage 15)

The two passages above are important in relation CMP's programme concept. CMP was a health-related programme designed to help participants understand and manage their health better in order to work again. However, this programme concept contains a potential contradiction. Due to the negative effects of being out of work, the claimant may fear returning to employment causing loss of confidence and motivation. Improvement in health and ability to manage conditions better would *increase* the likelihood of returning to work which they have come to fear. The effect of this

could be to lead participants to disengage with the programme or re-invest in their identity as a person who is too sick to work. Clare sidestepped this potential contradiction by framing the programme in terms of the social, emotional and psychological impacts of claiming in terms which participants themselves described and understood.

She was positive in her assertion that CMP was a 'social' programme.

> "It was a social programme and, and it was a psychoeducation programme, health skewed and also directed towards the context of work." (Passage 42)

For Claire, the purpose of CMP was to help participants to see that they were caught in a trap consisting of social, financial, psychological and emotional components.

> "there's the catch 22 because then the level of benefit goes down, you're on jobseekers erm there's a whole lot of stress about getting a job, being interviewed for a job, managing on much less money, I mean substantially less money and 'what if I don't get a job or what if I do get a job and fail and then I've got to get really ill again, acutely ill again to get back on to the higher level of benefit.'" (Passage 17)

The sense that participants were stuck in a 'catch 22' situation is continued in the following passage. She describes the solution for participants as becoming 'creative' about how to deal with their situation as opposed to simply improving their health.

> "People really did seem to need to be able to interpret their situation more positively in order to be a bit more creative about what they did with their options for work you know because there was a real sense of being trapped…that you couldn't get better without risking going down the long snake." (Passage 28).

Clare considers the long-term impacts of benefit claiming compared to long term substance misuse which results in entrenchment of negative self-concepts.

> "Yes, there's a parallel…I think there is a lack of being able to imagine anything else other than this high level of dependency on the, on the benefits, the high level of benefits and a sense of feeling awful. It becomes a sort of self-fulfilling reality really." (Passage 32).

This resonates with Sonia's assertion that loss of confidence and increasing fear grow in parallel with the length of the incapacity claim. Like an addict whose life has become unmanageable, it becomes hard for them to conceive that it could ever return to manageability. Meanwhile, over dependence on one solution (the substance) may result in loss of creativity required for a different

response to the problem. Similarly, the incapacity claimant may come to rely on their benefit status. Whilst it does not guarantee satisfactory wealth, it *does* provide temporary relief from fear and insecurity. The unsatisfactory level of income may be a trade-off for this benefit. The phenomenon of adjusting expectations in line with reduced income is widely reported in the exit interviews (Chapter 7) and case studies (Chapter 8).

She explains that her sense of the 'problem' of incapacity claiming evolved over time and through her own experience rather than from training.

> "I think what evolved was my sense of the complexity of individual situations and the commonality actually of this stuck place." (Passage 41).

Clare explained how the programme focussed, from the outset, on the social context and consequences of long term benefit claiming and how this had a galvanising effect on the group.

> "I thought it grabbed it quite early on actually…and there was often a huge bonding effect in that first session when people were talking about their fear of being stigmatised so the feeling that you read the national press or the tabloids and it's talking about benefits spongers and cheats and that sort of thing and I think that a lot of people felt very personally bad about that and at the same time bad about being ill and further, less and less worth I suppose and I think there was something about the programme tackling that issue, or I suppose, naming it, early on that was quite helpful – doesn't make the issue go away but it helped it to be named as an underlying belief really or …projection possibly; or assumption whichever it was – it's complex but it definitely was identifying it as being out there in the world and also in the individuals in a sort of feeling of stigmatisation." (Passage 11)

She described her belief in group processes:

> "I have a positive belief in the therapeutic value of groups and of the self-help group getting isolated individuals…I think I have a sense that people in isolation become more deeply entrenched in whatever the illness might be – anxiety, depression, addiction that there's something about bringing people together that will at least make change a bit more possible." (Passage 6).

She sees the sense of isolation and entrenchment as the principle barrier facing the claimants she encountered and the goal of the course was to enable change. Clare joked that the content was scarcely relevant or 'almost subsidiary' (passage 7) saying:

> "…even if we were going to play board games with them, that the benefit would really be about getting to know each other and understanding that they weren't alone in their troubles." (Passage 8).

She referred again to the positive effect of recognising and naming the social impacts of being a long-term benefit claimant and how, through the process of identification, participants were able to engage in later parts the programme having first rooted their understanding of it in their lived experience.

> "I thought that was pivotal actually because it became a basis for them…people really wanted to say what it was like. They wanted to talk about it. Even those who had been so anxious, they were having to practise some breathing outside before coming in…there was something very, very bonding actually about that piece of identification of recognising that it felt bad but also there was a….I don't know if this came up in that first session – I think that it was something that developed over time…the effect of having that discussion early on in session one made it possible to begin later on the programme to identify the … the sort of slight catch-22 really." (Passage 12)

The outputs that Clare hoped to see are consistent with her concept of the problem and the mechanisms (programme theory) of CMP. She noted, with irony, that these were hard to measure.

> "I think, vision , hope, the choice…very good intangible outputs that don't possibly translate into scores although there were questions on the output interviews about how, how can you envisage yourself being back to work in three months or three weeks or whatever so there was something about visualising it and it's interesting because the people who could make a positive visualisation of being back into work were the ones that possibly got more out of the process of CMP and were more likely to keep visualising it really and going for it with adequate support because I never knew what happened to them afterwards but…that lack of hope or vision or sense of personal agency that, yeah I could get a job and if I didn't like it, I could change it and get another job because I don't have to be ill in

the workplace…that is something that would be a very good, intangible outcome

for me as a therapist." (Passage 33).

This passage indicates the role of participants visualising a different future in order to make use of the programme suggesting a two-stage, alternative programme theory.

Clare acknowledges that these desired outputs were of her own devising rather than from her employers or the commissioners of the course. Her concern was to put the participant first and to consider what could help each person. This potentially contradicted the explicit course rationale. Clare described being aware of the tension between the explicit 'agenda' and the desire to help people in distress.

"Cynically, I felt it was … the subtext was…clawing back some money…but beyond

that actually, that there's a stuck place in which the people who were on those

higher-level benefits really became in a slipstream of …of society and therefore

not able to do that thing…" (Passage 47).

She recognised that this therapeutic tone was part of the overall approach to CMP within the Norfolk team:

"Well I think that says a great deal…actually for the way in which you [the

researcher]…not just designed the content of the programme, but held as the

manager of the programme, the…facilitating the whole thing…and I think that all

of us who were delivering the programme…did so in our own way along a similar

ethos but there is something about prizing the individual and honouring their

lived experience as well as delivering the goods according to the commissioners

so I think that was well done in that case, that was a success story." (Passage 48)

This passage suggests a culture of prizing the individual running through the delivery team. If, as Claire suggests, this was to some degree set by the manager, it reveals a sense of autonomy around how the programme was approached by the team as a whole. Clare reveals that, despite feeling the tension of sitting between the DWP and the participants, she had no doubt as to which element influenced how she delivered the programme.

"…there, there comes the discomfort for me where I felt that I was holding a

…role in-between being a therapist and being a kind of arm of the department of

work and pensions and that felt uncomfortable to me because my interest is in

wellbeing and if somebody's wellbeing is better supported by not going back to a

working environment where they became ill then I wouldn't be doing my job if I

was encouraging them in or …trying…attempting to motivate them to do something that wouldn't support their wellbeing even if it was what the DWP wanted for their own reasons" (Passage 21)

and:

"one of the tensions for me was er we had a sort of one size fits all programme even though it had a lot of scope and a lot of content and it was a good way that we held the process…I felt that it was very warm, that the culture of the way that we delivered CMP was very friendly and warm and supportive for the individuals in the groups." (Passage 40).

It can be seen in the passages above that practitioners held significant leverage in the delivery of programmes in line with commissioners' designs or otherwise.

Clare's account shows that her understanding of the 'problem' and the programme were driven by the participants reflecting the counselling process (Rogers, 1961). It is built on a relational basis: understanding participants' issues, reflecting them back accurately and prizing rather than judging them.

Summary

Clare's description demonstrates congruence through her understanding of the problems described by participants, her sense of what the course could do to help them and how she then delivered it. Her understanding of the problem had three strands: fear of change, increasing social and economic isolation (with associated feelings of disenfranchisement) and factors unique to each individual including specific health and biographical details. These were features of Smith's (2002) conception of incapacity. As Clare saw it, the key component of the problem, which crossed all of these features, was a sense of stuck-ness and disempowerment.

Her understanding of the programme theory was that CMP should empower the participant and enable them to exercise positive choices. These choices would be in the individual's best interests and might *not* include a decision to return to work. Whilst Clare's inferred programme theory was inconsistent with the explicit theory discussed in Chapter 4, it offers an alternative change mechanism for CMP based on the activation of participants' sense of choice. Part of the programme theory was that they should feel more resourced to act in ways that support positive decision making and the idea of having choices in life. As such, the specific health interventions within the programme could be seen, not just as increasing ability to be well enough to work, but as a means of increasing the individual's ability to act in their own interests. She saw the mechanism for this as

working with the *person as a whole* rather than focusing on diagnoses and symptom management in isolation. The starting point for this was for her to demonstrate an understanding of the participants' situation and what was like for them to be a benefit claimant.

Hilary

Hilary *(not real name)* was a counsellor-psychotherapist who was completing her professional training in CBT during the CMP. She was familiar with the CBT component of CMP and was experienced in delivering psycho-education. Her previous work had been in counselling services and in primary health (GP surgeries). Before training in counselling, Hilary had a successful career in finance. She joined the organisation specifically to deliver CMP.

Hilary explained her conception of the core problems facing long term IB claimants at different points in the interview:

> "There was lack of money… struggling financially. I wouldn't say that was common to everybody but that was the theme I remember. The stories that stick in my mind were those of 'I just haven't got enough money,' and the stress it brings and the lack of opportunities and where you can get stuck in environments that aren't good." (Passage 13)

> "I can remember the lack of structure, lack of status, lack of identity, lack of social interaction, money. These are the ones I can immediately remember." (Passage 28)

She described programme theory as providing tools, resources and encouragement to give individuals a better chance of improving their situation:

> "The way I saw it was that if people are better in themselves, they can engage in life more and most people want life to include work however you define work." (Passage 32)

Whilst Hilary saw work as a valid outcome, it was not necessarily an exclusive aim. Furthermore, the concept of people becoming fitter did not necessarily mean that lack of fitness was the primary barrier to finding employment. Her conception of the problem, as experienced by participants was of being cut off from the world of work through the social impacts being a benefit claimant: lack of status, loss of identity, limited social interactions and lack of money. For Hilary, the purpose of increasing wellbeing was to help claimants to be more resourced in tackling these problems. This view is concordant with the idea that poor health (or wellbeing) was the *result* of incapacity claiming as well as the *cause* of it. She described how the infrastructure of the programme assisted participants suffering these social impacts:

"Yes – for some people it was genuine attention to them – it wasn't formulaic. I think the whole atmosphere of the setup we had there, people we had there – always felt a very positive attitude I think. People genuinely felt at home – one or two people too much at home (laughs)…some I think felt that you were genuinely interested in what had happened to them…and I think all of that added together makes it a positive experience that you hope has desirable results but it may or may not depending on circumstances out of our control and maybe their control." (Passage 48).

She described her belief in group-work and the potential for it to help members to help themselves.

"I think it was all valuable but what the programme taught me was that group dynamics – how powerful it is and most people wouldn't willingly do group work…most people with mental health problems and…that really taught me that if it's a good group, it's incredibly powerful. If it's average, it's still valuable. Very occasionally you'd have some disruption and probably it wasn't that helpful…I think there's nothing like groups for telling you you're not alone…you sympathise with their problems. They sympathise with yours so it is possible to have an understanding and non-judgmental attitude." (Passage 36).

She explains how the group was discursive rather than didactic and how effective group facilitation, rather than delivery of materials, was key to engaging individuals and encouraging them to experiment with change. For Hilary, the benefit of the programme was derived from simply attending as much as in the course content itself which resonates with Claire's view.

"I suppose you could, especially in a good session have a rah-rah about you know you've got an interview and you might be getting back to work and …whereas it was much more about – what's your fears around this and will this be appropriate for you, this work. What are the pluses and minuses?" (Passage 23)

"This is my personal opinion…with content I think a certain amount of psychoeducational stuff was really useful for people but if that is delivered really badly, they won't be absorbing it…I think some might get through. Some of the content was a tool but no more than that. I don't think it's…I suppose it depends on who the trainers are…there's a wealth of material in the people who you've got in front of you" (Passage 49).

She describes how delivery was driven by the observable needs and opinions of the customer in front of her whilst remaining mindful of policy makers behind her. This raises the question of

whether CMP delivery demonstrated fidelity with policy makers' conception of the Incapacity problem.

> "Yes, and I think you know also it's based on the understanding that if you did it in a formulaic way and those are people who had received the attention of the job centre and, what were those assessments? (The work capability assessment), yes. If you had given them the whiff that this wasn't for their benefit – it was about ticking the box, you wouldn't have had the engagement and you wouldn't have had so much openness maybe and so much willingness to try experimenting with different things." (Passage 24)

Like Clare, Hilary realised that participants thinking differently about their experience was an essential precursor to using specific skills.

She described autonomy in how the team delivered CMP whilst expressing awareness of a tension between the return to work agenda and her own motivation to help individuals improve their quality of life.

> "Well I suppose for me it did have two strands. There was the bit about getting people back to work ultimately and being financially inclined, I could see that's how it had been justified but I suppose why I enjoyed doing it was…and I think that was partly you…that never obscured the therapeutic point which was that people were struggling and could they be helped?" (Passage 1).

However, Hilary is clear that she felt comfortable with the programme rationale but is emphatic that she would not have worked on a programme that promoted welfare to work at any cost. Like Clare, Hilary believed that work was not necessarily in a person's best interests.

> "It seemed to me …that the way the programme was run there…and again, I would put you as part of that influence, allowed it to be non-formulaic. Here's some good materials. Here's some good structure and then you work with what you've got in the room so…and I don't know what you would call it…it would be unethical if it was just literally all designed around getting someone back to work. If that was the only point to it and everything had that agenda, I wouldn't have worked on the programme." (Passage 19).

Hilary outlines her belief that CMP should, in itself, have been a helpful programme but explains why outcomes could never be predictable.

"I think there brings in other factors we talked about earlier about what jobs are available, the culture of employers, geography, peoples' own expectations, skills levels, you know, a hundred and one other things but in terms of people feeling more positive about their mental health and maybe their mental health improving, I can't see why that shouldn't have been…my impression from the people who received it was…it was helpful for people. That for me would lead people into wanting to improve things for themselves and as part of that is normally paid employment or if not at least significant worthwhile activity – I don't see how that doesn't follow on. How you prove that…I don't know." (Passage 68).

Hilary's conception of the problem shows sympathy for the welfare to work agenda but was essentially driven by the individuals she encountered; people with reduced competitiveness in the employment market through loss of identity, status and financial resources. As such, she saw that social conditions, rather than their health, led to individuals being stuck. This understanding drove her delivery style and content.

Summary

Hilary's recollections demonstrate a coherent view of the purpose and mechanisms of the programme and of the problems it set out to solve. Her recollection of presenting problems common to participants was of being stuck socially, psychologically and financially. She described contexts of work and home that might either help or hinder this situation. Hilary explained the programme theory as equipping participants with skills and resources which could help them to ease their way out of the 'stuck-ness.' In her role as a therapist, Hilary expressed how she felt tension in delivering a programme with a clear agenda (to assist people off benefits and into employment) alongside a desire to support each participant in ways appropriate to them. Implicit in Hilary's desire to help individuals out of their difficulty was her trust in their agency and resources. For Hilary, the principle mechanism for drawing out these resources was the group.

Whilst she was favourable about the course content and resources, these were secondary to the power of the group. Hilary was pragmatic about the likely effectiveness of CMP citing a number of reasons why return to work outcomes would vary. In her view there was no reason why CMP should not work but uncontrollable variables dictated whether the outcomes met with policy makers' intentions. She is clear that her views developed from her own experience rather than being inferred from others. She also described a sense of autonomy in the delivery of CMP and a tacit agreement within the delivery team that the individual came first (as opposed to the return to

work agenda) which sat comfortably with her personal beliefs and principles related to the programme.

The three practitioner accounts each provided different insights into the concept and theory underpinning CMP. It is notable that Clare's account is explored at greater length. This may reflect the extent of her own consideration of CMP and its relationship to her perception of the explicit programme design.

Researcher's account

The next section outlines the researcher's personal reflections on the delivery of CMP. It draws heavily on accounts written in March 2010. These were deliberate attempts to capture thoughts and experiences about CMP. They were influenced by brief notes from personal interest and for supervision. The account was written without contemporaneous editing in the hope of exposing honest opinions rather than simply reporting events. This was intended to be a 'warts and all' account which could reveal personal beliefs and possible prejudices. This process of intentional honesty is naturally limited by a desire to express only those 'private' views that are permitted to be expressed publicly. However, this principle applies to all the accounts drawn on in this chapter. The reflections are presented within three broad themes: problem conception, programme theory and programme delivery.

Problem conception

It is apparent that I conceived the problems as experienced by participants as primarily social rather than medical:

> "I became aware of a sense of clients having been 'lost' to the economy. Some clearly had substantial health problems (most frequently anxiety and depression) and others had multiple problems of poor physical and mental health. However, many were unemployed (incapacitated) *and* in poor mental health and it was not easy to see which came first. My sense was of a group of people whom the problem was not as 'simple' as poor health and the solution or cure not as simple as *treatment*" (p.1. 3/03/10)

I realised that participants had often attended similar programmes before. I also noted that problems presented were social as well as health based.

> "My CMP clients appeared similarly 'disabled' having lost confidence…in their own ability and, critically, feeling isolated in an…uncaring and critical world. I also picked up

on the various 'programmes' that clients had done before by way of managing their health problems and potentially gaining employment. Clients exchanged their experiences of past courses and organisations with helpful sounding names like Stepping Stones, Bridges…and the like. I was determined that Priory's CMP would firstly be different, better and more memorable and secondly that it wouldn't join its predecessors in the graveyard of self-improvement programmes" (p.1. 3/03/10)

The following passage described my personal experience of some course participants. It also clarifies my impression of what it was like to be live as a benefit claimant. This reveals a keen sense that a component of incapacity was (low) employability. I noted that being sent on courses might further dent their confidence and self-respect and lead to passive aggression or blame of others.

"I experienced in these groups a strong sense of defensiveness. These were people who were used to feeling oppressed and blamed. Whilst having to claim ill health benefits is something that could happen to anybody of any social background, people at the lower end of the social (wealth) scale appeared more vulnerable. They were already more likely to look less presentable, have less family and community support, be more vulnerable to illness and disease, likely to have achieved lower academic results as a result of poorer schooling and have lower spending power. Since they are sent on a course having become unemployed then they may assume that they did not know enough of the right stuff or too much of the wrong stuff. As such, they were not just unwell they are also 'wrong' on the level of knowledge and life skills and, as such, ended up feeling that they were at fault for their predicament. It was common in each group for one or more participants to want to pass the blame elsewhere; either 'up' to the government or 'down' to dubious benefits claimants who gave them a bad name" (p.3. 3/03/10).

I saw the problem as *related* to participants' health but not essentially driven by it. My belief was that health conditions had their greatest impact at the beginning of a claim and that, whilst their overall wellbeing often appeared to have worsened, their condition had changed in character from one which was in the first instance primarily biological to a presentation that was more social.

"How well participants seemed to cope on their sickness benefit seemed to me to vary enormously. I assumed that this variance must have been due to the level of support they received from family members or to accumulated wealth from before they fell ill. As far as their health was concerned, this appeared to vary considerably too. My

impression at the time was certainly one of surprise that some simply did not present as ill at all. Certainly, some were chaotic or unsupported… but not 'ill' in a clinical sense. Many, it seemed were bewildered, angry, confused, lacking in confidence and self-esteem, lacking assertiveness and generally beaten but this did not meet the clinical criteria for the conditions we were meant to be treating. The discontentment spoke loud and clear, drowning out the illness that had existed prior to loss of employment. I reasoned that however incapacitating the original illness was, these people were now suffering something much more oppressive" (p.4. 3/03/10)

Programme theory

I did not write in terms which could be described as *programme theory*. What I have understood to be CMP's programme theory can be inferred from my recollections of what I believed to be the change-agent of the programme and what I felt it was not.

> "I began to see the health component of the overall Welfare to Work agenda as a much more complex set of problems than was suggested by the provision of health advice and skills" (p.1. 3/03/10)

My sense of the key helping-component of CMP was not formed from any coherent strategy that was explained to me. Instead, it was driven by my previous professional experience and interpretation of the difficulties I heard described by my new client group.

> "I felt reminded of my experiences in drug and alcohol treatment. In that context, my clients needed to decide to not drink or use [drugs] again and had to learn some skills of mood management and relapse prevention. That was really the easy part. Most of them had little apparent difficulty in not using whilst in treatment and many did not use whilst in prison. Their problem was *living*. Rehabilitation was about learning to respect themselves, take note of the challenges in their lives and respond using their own resources and…encouragement of helpful people around them" (p.1. 3/03/10)

Unlike my previous client group, few CMP clients had been in prison and few had problems of substance misuse (I noticed that very few of them smoked). However, I noted that the fundamental problem was that they had come to be living outside of normal society. Like both Hilary and Claire, I believed that the key component of CMP was the encouragement and support generated in the group setting. As discussed above, I was aware that some CMP participants felt blamed for their situation and therefore simply providing health advice implied further blame. I felt

that this was to be avoided. My theory, though vague and naively expressed, was to help people find a way out of the hurt and blame amongst other feelings as described in the passage below.

"If they perceived an implied criticism, I was certainly unsurprised. The individual claimant is told, trained or educated to change their ways (depending on how they perceived the 'help') and so they felt blamed and then desperately looked for an alternative cause of their predicament. It could be argued that schemes like CMP were not about blame but were instead about helping and supporting those who have been unfortunate in ways other than, and beyond, simply offering financial support. My personal approach certainly went along those lines. I thought, 'yes it is awful for you to be in this predicament and I don't think you deserve to feel this bad but I really see how much you dislike it and so I will do my best to offer you help out of it'" (p.3).

"My instinctive reaction was to provide our clients with as much dignity as could be mustered in the context of a programme which was designed to lift them out of benefits and place them back into the world that they had come to fear. I and my colleagues put particular emphasis into redressing the power balance by providing a warm welcome, making drinks for people (rather than pointing them towards the drinks machine) and by giving them our time between sessions and between groups" (p.1. 3/03/10)

The following passage indicates that my developing programme theory was based on identifying what factors activated participants or inspired them to give employment another try.

"I was struck by the trust and rapport inspired within groups and was frequently touched by individuals' determination to "give it another try." It was during this period that I became inspired to study what I saw as a movement "towards" in some individuals and a persistent movement "away" in others. I wondered if any aspect of our courses inspired a latent sense of agency in some of these people. Had the programme helped individuals capitalise on their strengths or had it provided compensation for their weaknesses? Alternatively, I wondered if the "successful" clients would have attained employment regardless of our input" (p.1. 3/03/10)

Delivery reflections

As described above, my intention was express what the 'idealistic me' thought about CMP. My response indicates how ideals can be compromised in the effort to *get the job done*. It is apparent from my thoughts at the time that I needed to be practical rather than ideological. However, it is

interesting to compare this with the recollections of my colleagues who, as discussed earlier in this chapter, felt that I was partly responsible for the *helping people-first* ideology within the team.

> "It is hard for me to put my finger on what the 'idealistic me' thought and felt about our programme because I was the manager as well as a practitioner. I felt that I needed to be practical rather than idealistic. I also felt that I had to balance the weight of idealism amongst the therapeutic team with some practicality otherwise no work would get done" (p.2. 3/03/10)

This suggests that the implementation theory for CMP in Norfolk was a compromise between ideology and the need to 'deliver' objectives. This suggests a divergence between the needs of participants and programme commissioners as described by participants (above). Whilst my writing at the time did not allude to it, there were 'targets' set out in the contractual arrangements between DWP and CMP providers in the form of referral to treatment timings and various other measures that were reported.

By coincidence, whilst writing my 'reflections' I bumped into a participant from early on in our delivery of CMP. I was delighted to hear that he found employment very shortly after completing the programme but my account reveals scepticism over the specific helping component:

> "I could say that our (CMP) input was irrelevant really and that he just needed a push. I remember clearly (he was in our very first cohort) that he did not take in the manualised CBT element of the programme… When I asked him at the time, he confirmed that it just wasn't sinking in. It is possible though that he knew and felt that he was cared for and that he mattered to us. I provided additional one to one sessions with him at the end of his formal course because I was determined that he would not leave disappointed. He had touched me with his sheer loss of self-confidence and his heartfelt wish to be back at work without feeling so anxious" (p.2. 3/03/10)

More generally, it is evident that I was sceptical about the impact the course was having and believed that CMP did not improve the prospects for all participants but, instead, merely 'reshuffled the pack' (Peck and Theodore, 2000) by identifying the stronger members of the group and inspiring them to seize employment opportunities.

> "In a society of winners and losers, it was likely that a CMP group of eight to ten people would have a small proportion of people with a winning mentality or just some objective, circumstantial advantage and would seize the opportunity of CMP and use it as a platform for obtaining paid employment. I saw others in the group appearing to

come out of their shells, contribute at least sparingly and begin to share socially with their peers. In my eyes, they may have shone briefly but I honestly expected the moment to pass them by. I thought about courses that I had been sent on or chose to attend through work. Had I concentrated fully and diligently throughout? Did I carefully write down those moments of clarity or inspiration so that I could apply them at a later date? Did I go home and make it a priority to reflect on my learning and transform it into something tangible to improve my life? Or had I just carried on with my life with the best intentions but ultimately allowed the memory of the course to fade? I imagined adding to this scenario several years of unemployment, feeling like a 'nobody,' the only security in my life being social security. Would I not feel first of all exceptionally anxious about facing my fears and, secondly, deeply distrustful of these people who suggest that I might relax my grip on benefits, the one thing I can rely on" (p.3. 3/03/10)

Like my colleagues, I was keenly aware of participants' fear of losing the safety net of benefits. It is interesting that I compared myself to the participants. This suggests that I had considered some commonality in our experiences. Whilst I might appear as fortunate due to being employed, I also had opportunities to further myself such as seeking promotion (or *not to)* in line with my beliefs and experiences up to that point.

"In the Introduction to Healthy Living module, I added a section where participants could feed back on the 'reality' of being out of work through poor health. I would carefully capture their comments on four quadrants [see figure 6.1] on a page of flip chart paper. In each quadrant, they were asked to describe what life was like from each perspective. It seemed to me that I had to allow the depth of feelings to be expressed whilst at the same time ensuring that the learning opportunity wasn't lost in the discontentment. I also appreciated that the voice of discontentment was frequently the loudest and I was sometimes told during break times by quieter members of the group that they wanted to do more than just moan. Capturing the discontent also allowed me to reflect a focused account of the misery of life on benefits as a counterpoint to the benefits of a return to economic contribution. In drug and alcohol treatment, it was frequently said that if we don't transform our hurt then we transmit it. This exercise, I hoped, would provide the starting point of the transformation" (p.3. 3/03/10)

I was aware of potentially negative impacts of our delivery if we stuck purely to a compensation methodology which worked on the assumption that our clients lacked self-care knowledge and therefore needed upskilling. To have done that would have been to blame their social and employment status on inability to manage their health. In my thinking at the time, this added insult to injury. It was quite possible that I was less competent at managing my own health yet still managed to obtain paid work. As such, I did not see health as the only reason for their *current* non-employment. To deliver the programme from that perspective would, in my thinking, have risked disengaging the participants.

> "I reasoned that selfish capitalism had also left some people unskilled and vulnerable given the pace and direction of economic change, especially in terms of the movement from manufacturing to service based industry. As such, our society had also created unnecessary, superfluous people. It seemed to me to be a strange contradiction for society to suggest that the legions of disaffected, the unemployed, incapacitated and the drug addicted must blame only themselves" (pp. 3-4. 3/03/10)

Society generally	Health/employment services
Scum/dole scum/on the make/fraudsters	Useless
Feel excluded	GP doesn't help
People turn their noses up at us	Job centre treat us like dirt
Second class citizen	Been on numerous courses that never helped
There are no jobs	Feel abandoned
I used to look down on benefits recipients but now I understand and sympathise	Promised help with condition but you never get any
Society doesn't recognise mental illness as real	

Self	Family and friends
Loss of confidence	Feel embarrassed
Depressed	Lose touch with people
Bored	Don't want to have to explain self
Feel like there's no purpose	People think we're lazy
	Family are supportive
	Family are not supportive

Figure 6.1 Example of CMP participants' comments on effects of benefit claiming.

This section ends with a long passage in which I considered my own life experience in the light of the experiences some participants described.

"In myself, I could recognise anger and an on-going feeling of stress and worry. I had experienced it myself, if not to the same degree, and I feared it. I certainly felt grateful that I was not in their position but I knew that I *could* be. I pondered when I might simply stop trying to keep on going? I felt similarly aggrieved that I lived in a society that appeared at times to be uncaring, a society that looked no further than individual wealth as a marker of successful living. I was well aware that my personal reasons for working included my need to feel acceptable in the eyes of my family and peers. I wondered how *I* would feel and react if my peers faded away, if my parents died or if my wife left me or if I was thrown out of my job for any reason. My external drivers towards continued employment would be lost alongside a source of motivation and encouragement. A few bad rolls of the dice and I too might not bother or have the energy to bounce back immediately. I noticed from the stories I heard even early on that when people did not bounce back into employment, a clock would start ticking and the longer it did so, the likelihood of returning to work (at least at the same level of pay and status) decreased. The effects of unemployment might sink into me as they had done with the people I was witnessing – disconnection, shame, depression, anger, lethargy, disillusionment, anxiety, blame and helplessness" (pp 4-5. 3/03/10).

It is interesting that I chose to imagine myself in changed circumstances like those of some course participants. In imagining the loss of external drivers to employment, I emphasised the role of social context. This passage also hints that social problems point to movement in both directions and that factors involved in movement *into* a problematic social situation may differ from factors that help move a person *out* of it (a person may lose employment in the course of a health problem but not regain it because a significant source of encouragement is no longer present). This accords with Smith's (2002) conception of incapacity in which causes of inflow onto benefits differed from the causes of low outflow.

Finally, this 'imagining' is interesting because it suggests that movement towards or away from changes, threats or opportunities infers phenomena commonly experienced by both the employed and the non-employed. A person with a long-term health problem may avoid applying for work out of fear losing the security of incapacity benefit. Similarly, an employed person may resist opportunities for promotion in a new organisation out of fear of losing *their* current security.

It is clear that I saw health problems as the gateway to a lifestyle which led to further problems. I believed these to be primarily social both in context and in their effect. My conception of the 'problem' was based on these views. I developed these views from my experiences working with

participants rather than being informed by others. Similarly, the programme theory I subscribed to was of my making.

My understanding of programme theory consisted of providing the health focused materials at our disposal whilst recognising the social context to the problem. This could be described in terms of *what* we were doing; a health management course and *why* we were doing it; because being on health related benefits led to alienation, marginalisation and further social disadvantage. In terms of implementation theory, I saw a need to be honest about the social context of the course as well as a requirement to listen to and acknowledge the reality (frequently distressing) of their lives and experiences. The course, as we delivered it, had to not only teach skills well but be delivered in a fashion that recognised and challenged the social effects hence my (and the teams) desire to treat participants with dignity and to help them feel welcomed and important.

Deviation from explicit programme design

There is commonality across all the accounts with occasional significant differences of opinion. Only one practitioner (Sonia) expressed the explicit programme theory as set out in Chapter 4: *help people return to work by improving management of health*. The others saw management of health as an aspect of the course theory or as the structure for the programme but saw the key programme mechanism as: *increasing self-efficacy and empowering individuals to make positive choices.*

All the practitioners experienced the course participants as being alienated and socially excluded and trapped partly by fear of loss of benefit security. All practitioners saw barriers to employment in 'social' rather than 'medical' terms and all agreed that they had arrived at the problem conception, programme theory and their mode of delivery principally from their own insights rather than any external direction. Practitioners' beliefs regarding the problem conception are in accordance with policy makers (Smith, 2002) but at odds with the programme theory as explained in Chapter 4. Three of the four practitioners (including the author) recognised an internal conflict between an obligation to deliver the programme according to the rationale proscribed by its commissioners and a desire to support the best interests of each participant. This suggests that programme delivery may be influenced by ethics, beliefs and values which may or may not accord with the problem conception and programme theory as espoused by CMP's commissioners.

As discussed in Chapter 3, the problem of increased incapacity claiming can be seen from various perspectives. Practitioners delivered CMP in accordance with the problem as they heard it expressed by incapacity benefit claimants themselves. This corresponds with the research underpinning the

principle policy documents that preceded CMP but *not* with explicit programme theory (provision of health management skills). Whilst explicit CMP programme theory did not demonstrate fidelity with the problem as conceived by policy makers (discussed in Chapter 4), the local programme theory and implementation theory seemingly did.

Whether CMP delivery ought to have been grounded in participants' needs or in commissioners' expectations, it is evident that most of the practitioners on the Norfolk CMP recognised the importance of *acknowledging* the lived experiences that participants expressed to them. The practitioners who described this process also reported group processes as helpful whilst the practitioner who supported a primarily health focused solution reported difficult group processes and challenging behaviour.

All the practitioners saw the value of the course materials but only one saw that thorough teaching of the course content was the primary mechanism of the course. The others believed that the *therapeutic processes of the group* were the significant mechanism for change. Differences in opinion over the change-agent within the programme reflect the varying backgrounds of the practitioners. The facilitator with a background in taught, manualised programmes in prisons described strong faith in the taught element of CMP and erred towards a *compensation* model of therapy where health-management skills could be taught to address a deficit. However, the three who had trained in counselling saw the group as the primary therapeutic agent that helped participants to *capitalise* on their resources. Two practitioners who had previously worked in centres for treating addiction recognised the component of rehabilitation. This does imply that either approach is preferable but demonstrates that programme theory and implementation theory may be interpreted through the practitioner's own world view. This could potentially pose a threat to programme fidelity.

All practitioners agreed that programme outcomes were unpredictable but the course had the potential to be effective for many people. However, outcomes depended on the participants' willingness and motivation to make use of the programme and on external circumstances which could not be controlled for such as social and individual financial contexts.

This chapter has demonstrated that the interaction between practitioner and participant may create an iterative process in which programme concept, theory and delivery evolve. In the case of the Norfolk CMP, the process deviated from explicit CMP concept and theory. Most significantly,

practitioners noticed that participants could self-assess the likelihood of their situations improving by seeking employment and decide, accordingly, what action to take. All practitioners noted fear associated with leaving the security of incapacity as playing a prominent role in this decision-making process. The decision the participant arrived at could influence the extent of the benefit they received from the programme. It is notable that two participants stated clearly that they would not encourage a participant to return to work if they felt it was clearly not in that person's interests. Whilst this was based on an ethical stand-point, it contradicts the programme concept which assumed that claimants could work if they managed their health effectively. The implied programme concept, for three of the four practitioners, was to address the fear and learned helplessness associated with long term claiming for participants to decide if seeking work was appropriate. The implied implementation theory was to use the group to identify with other participants, share experiences or advice and encourage positive behaviour change (including seeking work if deemed appropriate or possible). The problem conception inferred from practitioners' perspectives was characterised strongly by participants' loss of identity, stigma, lack of confidence and, most prominently, fear of losing stability.

Improvement in health and functioning were seen by most practitioners to promote a positive cycle of mood, activity and thinking rather than for the specific purpose of managing health conditions. The group itself was seen to contain the necessary wisdom and experience to benefit participants (rather than the taught element of the programme). As such, practitioner accounts have demonstrated that CMP could be an *experiential* rather than didactic programme. The next chapter presents and discusses the programme outputs. This allows the themes identified by practitioners to be examined from the perspectives of participants.

Chapter 7 – Programme Outputs

Outputs and outcomes

Observation of programme outputs may reveal both anticipated and unanticipated behaviour change. If a programme is formed of coherent logic, participants' behaviour change should be traceable back to the problem conception and may be described as *anticipated*. The stages of programme design (concept and theory) and delivery should follow the same thread of logic.

Chapter 4 demonstrated that the desired behaviour change anticipated from CMP (expressed in the programme design) was *not* consistent with the problem conception outlined by Smith (2002). However, alterations to the programme (discussed in Chapter 5) and the testimony of practitioners (examined in Chapter 6) reveal a re-alignment with policy-makers' problem conception. This chapter investigates outputs that were observed and collected from the Norfolk CMP. The data gathered and presented in this chapter are summarised in table 7.1.

Measure	Male	Female	Total	Date	Notes
Demographic data	52	44	148	March 2008 to March 2011	Data retrieved from participant files. Sex not known for 54 records.
Return to work survey	61	57	118	May 2012-July 2012	Participants contacted by phone to establish work status up to 12 months after completing CMP
Hospital anxiety and depression score	95	96	232	March 2008 to March 2011	Standard CMP data Sex not known for 191 records
Occupational self-assessment	95	96	230	March 2008 to March 2011	Standard CMP data
Work confidence questionnaire	57	51	108	April 2009 to March 2011	Standard CMP data
Return to work timescale	41	37	78	April 2009 to March 2011	Standard CMP data
'Express' programme feedback sheets	4	3	7	Feb 2010 to March 2010	Voluntary participation
'One to one' programme feedback sheets	4	8	12	April 2010 to March 2011	Voluntary participation
Recorded exit interviews	5	4	9	Dec 2010 to April 2011	Standard exit interview - additional questions concerning CMP and incapacity benefits. Voluntary participation. Ethical approval granted Nov 2009

Table 7.1 Summary of programme output data

It is helpful to view outputs alongside return to work outcomes (hence the inclusion of these outcome data in this chapter). If a participant obtained work but did not demonstrate anticipated behaviour change resulting from the programme, then the outcome could not be regarded as attributable to the programme. In such cases, the outcome could be investigated to identify the *actual* cause-mechanism. As such, *accidental* outcomes may contribute to alternative formulations of problem conception and related programme design.

Chapter 5 revealed a straightforward programme concept:

Health conditions and loss of confidence constitute a barrier to employment. Learning to manage health conditions will lessen or minimise the impact of this barrier.

A corresponding output might be:

Participant's clinical outcome measures indicate improved management of health.

Chapter 6 analysed the revision of CMP into the 'express' programme which provided a greater focus on returning to work. The concept could be described as:

Participants suffer with health conditions but they may more able to work than assumed. Poor health and wellbeing is exacerbated by long-term incapacity. Improvement in health may enable participants to improve their lives further by helping them to seek work.

As set out in Chapter 4, programme outputs based on this concept could be described as:

- Increased ability to manage condition.
- Improvement in health condition.
- Ability to describe or demonstrate skills of health condition management.
- Belief that their health condition is no longer an impediment to obtaining work.
- Confidence in ability to manage their health whilst at work (and sustain employment).
- Belief that work will not cause health to deteriorate.
- Making plans to find employment.

This chapter seeks evidence of these and other outputs. Programme outputs, such as increased job seeking, are mainly *described* by participants rather than observed. Given that data are gathered at the end of the programme or during its progress, outputs are normally expressed in terms of *intended* rather than actual behaviour change. Aims and intents, at this stage, may be regarded as

an output if they can be attributed to the programme. The longer-term impact of these intentions are regarded as outcomes which are examined in case studies (Chapter 8).

The purpose of examining outputs is not only to ascertain whether CMP made a difference but to evaluate *what* difference it made. Data should help to confirm how the change occurred and whether it was relevant to the problem as previously conceptualised. As described in Chapter 6, an inferred output identified by practitioners in Norfolk, was for participants to re-appraise their work or benefit status and to commit to personal change if it was in their best interests. This could be described as a 'hidden' output since it was not explicit in the explicit programme theory. This chapter draws on a range of qualitative and quantitative data and seeks to identify reliable evidence that desired behaviour change was achieved.

Demographic comparison

Demographic data were gathered from 148 participant assessment reports. The data are summarised in table 7.2.

	Returner		Non-returner		All records	
Age	**No.**	**%**	**No.**	**%**	**No.**	**%**
Records	30	-	63	-	148	-
Mean age	45	-	45	-	43	-
Mean age (male)	46	-	44	-	43	-
Mean age (female)	45	-	46	-	42	-
Living arrangements	**No.**	**%**	**No.**	**%**	**No.**	**%**
Records	21		69		129	
Alone	-	42.9	-	47.8		48.8
With spouse/partner	-	38.1	-	36.2		34.9
Single parent	-	9.5	-	4.3		5.4
Caring responsibility	**No.**	**%**	**No.**	**%**		
Records	20		67			
Caring for parent or dependent		35		31.3	-	

Table 7.2. Demographic data for CMP participants

Not all assessments records contained complete information. The number of available records indicating age, caring responsibilities and living arrangements are shown. The data show no age differences between the returner and non-returner populations. Returners were slightly less likely to live alone and slightly more likely to be single parents. These figures are based on a small dataset so statistical significance is not certain.

Return to work data

Return to work data contextualise the programme outputs hence their inclusion in this chapter. 118 former participants were surveyed by telephone to establish if they returned to work *at any point* within 12 months of completing CMP. 34 participants (29%) obtained employment and 84 (71%) remained on benefits (see table 7.3). The results show an improvement across the three formats. The final programme format (one to one) achieved a return rate of 61.5%. However, this is based on a small dataset so this output cannot be reliably attributed to the one to one format. The 'original' and 'express' results are based on similar sized datasets (54 and 51 respectively). The 'express' format achieved a considerably improved return to work rate. This may reflect the greater emphasis on work and greater conceptual focus on Smith's (2002) conception of incapacity as discussed in Chapter 6. Alternatively, the chronological improvement across all formats may reflect increased competence of practitioners over time.

	Original		Express		1 to 1		Total	
	No.	%	No.	%	No.	%	No.	%
Contacted	54	47.8	51	49.0	13	86.7	118	50.9
Contacted male	31	57.4	26	51.0	4	30.8	61	51.7
Contacted female	23	42.6	25	49.0	9	69.2	57	48.3
Male returned	6	19.4	8	30.8	2	50.0	16	26.2
Male not returned	25	80.6	18	69.2	2	50.0	45	73.8
Female returned	4	17.4	8	32.0	6	66.7	18	31.6
Female not returned	19	82.6	17	68.0	3	33.3	39	68.4
Total return	**10**	**18.5**	**16**	**31.4**	**8**	**61.5**	**34**	**28.8**
Total not returned	**44**	**81.5**	**35**	**68.6**	**5**	**38.5**	**84**	**71.2**

Table 7.3 Return to work outcomes by programme format.

Outcome Measures

Hospital Anxiety and Depression Scale (HADS)

Scoring for HADS is outlined in figure 7.1. The schedule applies to both anxiety and depression.

Normal   0-7
Mild   8-10
Moderate   11-14
Severe   15-21
Case-ness   11-21 (Moderate or worse)
Figure 7.1. HADS scoring schedule

The HADS score totals seven questions each for anxiety and depression with a score of 0-3 for each response. 'Case-ness' is determined as moderate or severe (11 or above).   The HADS question schedule can be found in Appendix 15. HADS scores were taken at the assessment and exit meetings. The terms 'case-ness' or 'case-worthy' signify a score of 11 or over. C*linical improvement* denotes movement from 11 or above to 10 or below (Snaith, 2003). 232 complete sets of clinical outcome data (HADS) were available for analysis.

HADS depression

	Returners		Non-returners		All records	
	No.	%	No.	%	No.	%
Presentation	34		84		232	
Severe	3	8.82	16	19.05	37	15.95
Moderate	10	29.41	28	33.33	77	33.19
Mild	13	38.24	21	25.00	66	28.45
None	8	23.53	19	22.62	52	22.41
Case-worthy	13	38.24	44	52.38	114	49.14
Mean score	9.47	(Mild)	10.71	(Mod)	10.27	(Mild)
Post CMP						
Severe	1	2.94	7	8.33	14	6.03
Moderate	4	11.76	10	11.90	29	12.50
Mild	6	17.65	26	30.95	67	28.88
None	23	67.65	41	48.81	122	52.59
Case-worthy	5	14.71	17	20.24	43	18.53
Mean score	5.94	(None)	7.59	(Mild)	7.12	(none)
Impact						
Depression decreased	26	76.47	67	79.76	174	75.00
Depression increased	6	17.65	11	13.10	32	13.79
Depression unchanged	2	5.88	6	7.14	26	11.21
Mean reduction	3.53		3.13		3.16	
Case-ness to non*	9	69.23	29	65.91	76	66.67

*denotes % of those displaying case-ness on presentation and improved post-CMP.

Table 7.4. HADS depression clinical outcomes

HADS depression scores (table 7.4) suggest that CMP was successful in helping many participants to reduce their depression scores. The scores improved for 75% of all participants whilst 66% showed clinical improvement. A greater proportion of the non-returners were case-worthy in depression before CMP than the returners (52.4% and 38.2% respectively) suggesting that those who did not return to work were more likely to be depressed before CMP. However, there was similarity between the groups in terms of mean reduction in scores and proportion of those improving

clinically by the end of CMP. This suggests that measuring improvements in depression in isolation from other factors (including anxiety) is not helpful in predicting return to work activity.

HADS anxiety

	Returners		Non-returners		All records	
	No.	%	No.	%	No.	%
Presentation	34		84		232	
Severe	15	44.12	32	38.10	101	43.53
Moderate	14	41.18	32	38.10	84	36.21
Mild	4	11.76	12	14.29	32	13.79
None	1	2.94	8	9.52	15	6.47
Case-worthy	29	85.29	64	76.19	185	79.74
Mean score	13.82	(Mod)	13.31	(Mod)	13.64	(Mod)
Post CMP						
Severe	3	8.82	18	21.43	41	17.67
Moderate	14	41.18	23	27.38	71	30.60
Mild	7	20.59	24	28.57	59	25.43
None	10	29.41	19	22.62	55	23.71
Case-worthy	17	50.00	41	48.81	112	48.28
Mean score	9.50	(Mild)	10.71	(Mod)	10.65	(none)
Impact						
Anxiety decreased	29	85.29	59	70.24	171	73.71
Anxiety increased	2	5.88	17	20.24	35	15.09
Anxiety unchanged	3	8.82	8	9.52	26	11.21
Mean reduction	4.32		2.60		2.98	
Case-ness to non*	12	41.38	27	42.19	73	39.46

*denotes % of those displaying case-ness on presentation and improved post-CMP.

Table 7.5. HADS anxiety clinical outcomes

Unlike with depression scores, a greater proportion of returners were case-worthy than non-returnees before CMP (85% and 76% respectively). The level of case-ness in anxiety for both populations was considerably higher than depression suggesting stronger association between anxiety and incapacity. The overall (returnee and non-returnee) score for anxiety at presentation (79.7%) was higher than for depression (49.1%). The mean reduction in anxiety score was lower (2.6) for non-returners compared to 4.3 for returners). A possible explanation of the reduced impact on anxiety for the non-returner population is increased fear of returning to work or loss of benefit security. Ford and Plowright (2008) noted that stress caused by greater focus on work during CMP could adversely affect outcome measures. In keeping with this, 20% of non-returners and 15% of all

participants increased in anxiety over the course of CMP. Given the higher frequency of anxiety in the returner population, returning to work may be associated with ability to overcome anxiety.

However, a slightly *greater* proportion of non-returners improved clinically compared to the returners (42% and 41% respectively) which suggests that improvement in anxiety, alone, may not predict return to work. The concept that anxiety forms a significant component of sustained incapacity is mirrored in the recollections of practitioners (Chapter 6) and in the Case-studies (Chapter 8). The anxiety described in those data is frequently experienced in the context of *being a claimant* rather than as organic mental illness. The contexts may include previous bullying or stress in the workplace, social isolation and avoidance, threats to identity and the threat of loss of benefits.

Mixed anxiety and depression

There are examples in both populations where participants presented with both anxiety and depression but improved in only one. CMP was designed on the premise that ability to manage health conditions was required to facilitate return to employment. Participants' overall clinical outcomes should indicate whether they improved in *both* conditions where relevant. Table 7.6 summarises outcomes for participants who displayed case-ness in anxiety, depression or both.

	Returners		Non-returners		Total	
	No.	%	No.	%	No.	%
Presentation	34		84		118	
Non-case-ness in both	4	11.76	14	16.67	18	15.25
Case-ness in depression only	1	2.94	5	5.95	6	5.08
Case-ness in anxiety only	18	52.94	25	29.76	43	36.44
Case-ness in both (mixed)	12	35.29	39	46.43	51	43.22
Case-ness total	31	91.18	69	82.14	100	84.75
Improved on completion						
Non case-ness in depression only	0	0.00	3	3.57	3.00	2.54
Non case-ness in anxiety only	8	23.53	11	13.10	19	16.10
Non case-ness in both (mixed)	5	14.71	13	15.48	18	15.25
Impact						
No improvement overall	18	58.06	42	60.87	60	60.00
Improved overall	13	41.94	27	39.13	40	40.00

Table 7.6. HADS mixed anxiety and depression clinical outcomes

Whilst both populations included individuals who displayed case-ness in neither condition, 84.7% demonstrated case-ness in either or both conditions. Whilst a significant proportion of participants

(49%) presented with depression as part of their overall picture, very few (5%) presented *only* with depression. This suggests that anxiety was more significant in CMP claimants' incapacity. The majority within both populations were those who were either anxious or anxious *and* depressed. The non-returner population presented with single anxiety less frequently than the returners (29.7% and 52.9% respectively) but *more frequently* in mixed anxiety and depression (46% and 35% respectively).

Discussion – HADS data

Taking overall improvement to mean movement from case-ness to non-case-ness in either or both conditions, the returner population improved slightly more frequently than non-returners (41.9% and 39.1% respectively). However, clinical data revealed little overall to differentiate those who achieved re-employment from those who did not.

The mean reductions in scores for all participants were 3.2 for depression and 3.0 for anxiety. Of the 232 sets of results, 75% improved for depression and 74% for anxiety. In terms of clinical improvement, 66.7% of those with case-worthy scores for depression and 39.5% for anxiety reported non-case-ness after CMP. Viewed in isolation, these scores indicate positive outcomes. However, health may be a separate concept from *ability to manage* health which was the explicit focus of CMP. Improved clinical outcomes may not indicate improved in ability to manage health in the future. Furthermore, the direction of causation between incapacity and mood disorders remains ambiguous. The negative social and financial impacts of incapacity claiming described vividly by both practitioners (Chapter 6) and claimants (Chapter 8) may have led to case-worthy HADS scores.

Absolute improvement in health may not signify increased intention or ability to return to work. Many returners (58%) did not improve clinically yet gained employment within 12 months (table 7.6). Conversely, 40% of those who did *not* return to work, improved clinically. 15% of those surveyed to establish whether they returned to work, presented as non-case-worthy both before and after attendance (table 7.6). Both depression and anxiety scores show minor differences between the two populations. 43 per cent of participants presented with both anxiety and depression. Where improvement is taken to signify non-case-ness in anxiety, depression *or both*, there is little variance between the two populations. This could mean that HADS data are not a useful determinant of *ability* to manage health or that ability to manage health is not significant factor in return to work outcomes.

It is possible that non-returners had other worries (anxieties) which *CBT for anxiety* failed to address. Mixed anxiety and depression is a diagnosable condition (World Health Organisation, 1993). The biopsychosocial model of illness (Engell, 1977) explains that environment (social factors) form a significant component of a health condition. Anxiety related to social contexts specific to long term incapacity may differ to generalised anxiety disorder in its response to CBT. It is noteworthy that most returners (58%) did not improve clinically yet re-gained employment within a year of completing CMP. Other outcome data were examined to find reasons for this discrepancy and to identify potential alternative outputs related to job seeking.

Occupational Self-Assessment

The occupational self-assessment (OSA) is based on the Model of Human Occupation (MOHO), (Forsyth and Keilhofner, 2006). Participants rate competence (belief in ability) and value (how important it is) across 21 items (Appendix 16). 230 pre and post OSA data sets were collected. 118 were compared with return to work data (table 7.7).

	Returners	Non-returners	All records
	No.	No.	No.
Presentation			
Competence (mean)	49.7	49.6	56.4
Importance (mean)	68.5	70.8	79.2
Difference (conscious skills deficit (mean)	18.8	21.2	22.8
Completion			
Competence (mean)	61.4	56	65.6
Importance (mean)	69.9	69.8	79.5
Difference (conscious skills deficit) (mean)	8.5	13.8	13.9
Impact			
Competence change (mean)	11.7	6.4	9.2
Importance change (mean)	1.4	-1	0.3
Overall change: conscious skills deficit (mean)	-10.3	-7.4	-8.9

Table 7.7 – Occupational Self-Assessment

The items vary from lower order tasks such as *taking care of myself* and *managing my basic needs* through to higher order tasks including *accomplishing what I set out to do* and *effectively using my abilities*.

Participants self-rated using the scale below (figure 7.2).

	Competence			Value
1	I have a lot of problems doing this		1	This is not so important to me
2	I have some difficulty doing this		2	This is important to me
3	I do this well		3	This is more important to me
4	I do this extremely well		4	This is most important to me

Figure 7.2. OSA scoring schedule

Competence indicates individuals' subjective evaluation of their ability to function across the items measured. Almost all participants rated the importance for each competency higher than competence implying a conscious skills deficit. The reduction in this deficit is measured in the final row (overall change). The data show a greater reduction (improvement) in conscious skills deficit in the returner population. The initial mean competence score was almost identical for both populations but the returners improved by a mean of 11.7 compared to 6.4 for the non-returnees. The scores represent perceived rather than actual ability. Individuals who subsequently regained employment displayed a greater sense of self-efficacy on completion of CMP.

Work Confidence Questionnaire

The work confidence questionnaire was completed during the exit interview. It gauged whether participants believed that health remained an impediment to work and whether they felt confident in their ability to manage their condition at work. Results for CMP in Norfolk are found in table 7.8.

	Returners (n=17)		Non-returners (n=39)	
	More confident %	Same or less confident %	More confident %	Same or less confident %
Q1. I am able to work	82	18	64	36
Q2. I am able to find work	64	36	44	56
Q3. I am able to manage my health condition at work	76	24	56	44
Q4. Work will not make my health condition worse	59	41	46	54

Table 7.8. Work confidence questionnaire by returner/non-returner populations

The questions within the work confidence questionnaire form the basis of the explicit programme theory CMP described in Chapter 5. However, the questionnaire suffers from several flaws. It did not measure confidence before and after the CMP. Instead it surveyed participants only at the end, asking them to estimate whether their confidence had increased, decreased or remained the same. Furthermore, the questionnaire had not been tested for validity against data for return to work rates or ability to manage conditions at work. Despite its limitations, it is an indicator of participants' subjective confidence level at a specific moment in time and enables a comparison between the returner and non-returner populations.

Table 7.8 reports the data for returners and non-returners and summarises the responses into no change or less confident versus increase in confidence. 'No change' in confidence was frequently reported for all four questions (more than 95% of responses). Here, it is assumed that a positive change is required to represent a favourable output. Therefore, 'no change' has been grouped alongside reduction in confidence in table 7.8.

There are notable differences in responses for the third and fourth questions. Ability to manage health at work is seen as different to the potential for work to worsen health. Whilst work has been said to be generally good for health (Waddell and Aylward, 2010), these results suggest fear that the reverse is the case. This was particularly the case within the non-returner population. Ability to work and ability to manage health are factors over which the individual maintains influence. However, ability to find work and work's capacity to be harmful to health involve factors outside of their control. An individual may feel capable of working but remain fearful of circumstances beyond their control. This may explain why clinical measures of improved wellbeing were not translated into action for some of the non-returner population.

There are variations between the non-returner and returner populations across all four questions. Whilst both suggested an increased confidence in ability to work, this was overwhelmingly the case for the latter (64% and 82% respectively). More than half of non-returners felt no change or less confidence in ability to find employment. Employability is related (amongst other factors) to individuals' qualifications and experience, capability of locating employment opportunities and ability to present favourably at interviews (Fothergill, 2006). Long-term IB claimants are known to be less well qualified compared to job seekers (Lonsdale et al, 1993; Fylan et al, 2011) and non-employability recorded as incapacity is cited as a cause of 'hidden unemployment' (Fothergill, 2006). It is possible that the responses given to this question by non-returnees related not to their health but to their beliefs about their own employability (which was not intentionally influenced by CMP). The significant differences in responses from the two populations suggest that the work confidence

questionnaire was a more accurate indicator of returning to work than the clinical outcomes measured by the HADS questionnaires. This implies that confidence was more influential than health status.

Return to work timescale

Predicted return to work timescales described the time participants believed they needed to return to work after completing CMP. It may be seen as an indication of their decision to return to work.

	Returners (n=10)		Non-returners (n=22)		All records (n=66)	
	No.	%	No.	%	No.	%
Immediate return	6	60	10	45.5	29	43.9
1-3 months	1	10	1	4.5	2	3
3-6 months	2	20	2	9.1	12	18.3
6 months+	1	10	9	40.9	23	34.8

Table 7.9 Participant return to work timescales predicted at exit interview.

Most responses were for either an immediate return (43.9%) or a return after 6 months or more (34.8%). This suggests that, for many, the question of returning to work was a matter of 'go' or 'no go' which may imply the presence of a decision. What action the individual takes during this period influences whether employment was attained. The passage of time, alone, is associated with lower likelihood of a return to work (DWP, 2006).

There are notable differences between the returner and non-returner populations. The non-returners were almost equally divided between immediate (one month return) and six month timescales. This may indicate a binary 'can' versus 'cannot' thinking, suggestive of a *decision*. Conversely, the returnees heavily favoured a shorter timescale for returning to work (though this is based on a small sample). Like the work confidence questionnaire, predicted return to work timescales may be a more accurate predictor of return to work outcomes than the health status reported in clinical outcomes.

In this chapter, clinical and non-clinical measures have offered some evidence confirming whether or not CMP met its desired outputs and whether the desired outputs themselves were relevant to the problem conception of static incapacity. Whilst HADS data provided a measure of health at a specific moment in time, this could not be extrapolated as an indicator of whether participants would be able to manage their own health in the longer term. Failure to return to work despite health improving (in non-returners) and returning to work despite health not improving (in returners) are strong indications that health status represents only one aspect of a person's

rationale for remaining on incapacity benefit. This is consistent with Smith's (2002) conception of static incapacity claiming but raises questions over the explicit programme design explored in Chapter 5.

However, the data show that health remained prescient in as much as whether participants *believed* that they could manage it. Lower confidence that work would not make health worse was associated with not returning to work within one year. Participants who returned to work within a year were more likely to believe that work would not make their health deteriorate and that they could manage their condition at work. They were also more likely to believe that *obtaining* work was likely for them in the short term. Both returners and non-returners expressed confidence in ability to work (regardless of their health) but non-returners were less likely to believe they could find work and more likely to say that they needed more time. The latter may indicate avoidance which is examined in Chapter 8.

Quantitative measures do not establish participants' ability to demonstrate skills of health condition management or plans to find employment. This chapter now presents qualitative data which were sought to demonstrate evidence of anticipated participant behaviour change.

Participant Feedback

Two additional feedback forms were used in addition to standard programme documentation for this evaluation. The first was applied to the 'express' format and consisted mainly of questions with spaces to provide brief written answers. The second applied to the one to one format and consisted of a Likert scale.

Express Programme Feedback

Feedback was gathered from one cohort of four male and three female participants during February and March 2010. Participation was voluntary. The form was identical for each of the four day-long sessions. The survey questions are listed in figure 7.3.

1. What (if anything) did you enjoy or like doing during the programme today?
2. What (if anything) stood out (or made you think) about the programme today?
3. What (if anything) has been useful for you in the programme today?
4. What (if anything) will you do differently as a result of your experience today?
5. What (if anything) have you disliked about the programme today?
6. Of all of the above which (numbers) are the three most important to you?

Figure 7.3 Express questionnaire

The questions were designed to prompt reflection on the programme and elicit brief but considered responses. They sought to answer two lines of enquiry. Firstly, whether the programme's content was significant compared to other aspects of the programme delivery such as impact of colleagues or participation. This relates to programme and implementation theory and seeks to identify the change mechanism influencing positive behaviour change. Secondly, whether participants indicated that their experience would encourage job-seeking behaviour. This gives further indication on the effectiveness of the programme content itself but also relates to *intention* to use what was learned.

The data were reviewed by week rather than by participant in turn in order to lend sensitivity to the element of time. For example, a proliferation of comments about feeling understood is better understood in the context of the first week of the group programme when participants first met each other.

Analysis Week 1: Introduction to healthy living and working

What did you enjoy or like doing during the programme today?

Two participants appreciated meeting new people. A further two referred to discussion, interaction and 'opening themselves up.' One referred to 'truth and lies,' a light-hearted 'ice breaker' exercise. The overall impression is of valuing interaction with others.

This theme continued in the question; *what (if anything) has stood out (or made you really think) about the programme?* One person commented on 'how alike' we are, two referred to realising they were not alone and another to realising he or she was 'not abnormal.'

When asked what they had found useful, there were further comments suggesting an 'opening of minds' which were expressed in general terms such as realising they were not alone, managing things better, understanding themselves and knowing that they can do something about depression. Three people added specific examples of 'usefulness' including hints on sleep, strategies for reducing stress and learning how to change how they think and feel.

The responses were not as clear when related to what they might do differently as a result of the day. One was 'not sure,' whilst four described general intentions such as trying to be more positive and not taking things out of proportion. Two focused on specific issues such as sleep and diet and communication with family members but nothing was identified from the programme in terms of skills which could be specifically implemented.

Overall, participants were pleased to discover that they were not alone. The day had a 'normalising' effect which may have helped to 'open minds' and encourage self-reflection. The session helped participants to identify positive intentions regarding their lives generally but there was no evidence of specific intended behaviour change. As discussed in Chapter 6, emphasis was placed on the cycle of incapacity and participants were given the opportunity to discuss the effect of workless-ness on mental health. It also provided practical input on everyday management of health (diet, sleep, exercise and relaxation). The comments do not suggest that this part of the programme input would be acted upon. Whilst, the 'normalising' impact of the day, interaction and the encouragement of self-reflection are evidenced in the responses, they form only a pre-curser to positive action. There is evidence that the first part of this objective was achieved but not for the latter.

However, emphasis on feeling accepted and 'normal' may indicate that this was the only realistic outcome for the initial group session in which participants met for the first time. Failure to take on additional skills might suggest a lack of energy rather than appetite.

Analysis Week 2: Mood Management

What did you enjoy or like doing during the programme today?

All respondents cited relaxation and breathing exercises. This suggests that participants were not relaxed at other times in their lives or that undertaking the deliberate act of relaxation was new to them. Alternatively, the rest of the days input (CBT theory and practise) may not have stood out by comparison.

In terms of what *did* stand out (question 2), one respondent continued to point out the breathing exercises, another did not know and two alluded to the importance of thoughts. One reported this in a general sense of turning negatives into positives whilst another reflected on how thoughts can 'wreck lives' suggesting a more profound impact.

Responding to what had been found to be useful, three participants indicated strategies for remaining calm. Relaxation and minimising the stress response were relevant skills in their own right but were also provided for the further purpose of addressing negative thinking and experimental behaviour change such as increasing comfort zones. Participants' responses here suggest immediate impact rather than the potential to use insights and skills to improve the negative situations they had described the previous week.

Regarding what participants might do differently, the responses reflected the focus on immediate impact as described above. One expressed her response in terms of a commitment to herself to 'wind down, have fun and not feel guilty,' indicating self-reflection as well as a general commitment

to herself. This suggest that the workshop helped raise self-awareness and promote a sense of commitment and self-care. However, when reporting what 'stood out,' most participants repeated terms from the day's content implying a passive response. There is no evidence of intention to transform personal insights into action. This might imply that the programme was based on incomplete theory (lacking a motivational component) or was based on a flawed problem conception (that prolonged incapacity was founded on deficient mood-management).

Analysis Week 3: Managing relationships at work

Concerning what had been 'liked or enjoyed,' two returned to the theme of discussion and interaction while another referred to enjoying 'role play' (which also involved interaction). One specified the 'assertive bill of rights' exercise suggesting particular meaning for them. This comment was in keeping with a previous session in which they referred to a need to communicate differently with their family. Two respondents focused on the main theoretical component of the week (communication styles). One described how the content was interesting but already familiar.

Regarding what had stood out, two participants wrote about thinking about their past whilst a third described 'self-discovery' implying that this had provided a platform for self-reflection and insight. One respondent stated that they could 'forget the past' suggesting considerable personal impact. This person had written previously of how thoughts can 'wreck your life' hinting that they experienced the programme in terms of private meaning and renewed personal commitment. One person stated that the course content was familiar but the delivery was better than previous programmes hinting, possibly, at passive response to the day.

Comments reflecting on perceived usefulness were limited. One stated 'assertiveness' whilst another wrote 'assertive, passive, manipulation' which they also gave in response to two other questions. Another simply wrote 'condition management programme.' These responses suggest that the respective participants were possibly unsure or not committed to responding. However, it may have been that they were tired, in a hurry or experienced a reluctance to think or write any more that day. It may also reflect the suggestion, in Chapter 6, that lack of assertiveness was not recognised as part of policy makers' problem conception of static incapacity.

One respondent expressed an intention to 'be more assertive' whilst two others communicated the same intention but with hints of personal reflection including placing personal needs 'up there with someone else's' and being 'more thoughtful towards me.' One participant again alluded to personal insight and impact when expressing her intention to shut the door on her past suggesting that this

person's past was very 'present' in her thoughts during the course and that CMP was acting as a form of encouragement to recommit herself to her future.

That some participants responded by turning their attention towards personal meaning and insight suggests that they were engaging with the 'implied' programme theory which had been inferred by some practitioners in Chapter 7. This theory held that participants needed to gain greater self-awareness prior to being able to engage with the skills component of the course. No participants indicated a specific identified behaviour change in response to week 3. However, they all expressed a *general* commitment to personal development. This points to a growing divergence in programme theory between development of personal insights and acquisition of health management skills. Without accompanying insight, the skills content may have been an interesting and helpful but immaterial component in the context of job-seeking.

Analysis Week 4 (Managing stress at work)

One participant described enjoying 'discussion' which they had also stated after two of the three previous sessions. The other two respondents stated the subject titles of two parts of the day's programme (change/transition curve and task-prioritising).

Regarding what had stood out, the responses were in line with answers from question 1. The third participant responded with 'stress drivers' alluding to another part of the day's input which had included completing a self-administered questionnaire on responses to stress. This person had consistently hinted at personal impact and insight throughout the course of the programme which was now in its last week of group intervention. Their feedback is suggestive of using the programme content to relate to personal experience.

In terms of usefulness, one respondent repeated previous answers relating to prioritising demands (using the urgent v important matrix). Another described a specific intention to invest energy into her house and home to enjoy it in the summer. This response suggests not only a translation of course content into personal insight but also as application of specific skills which it was hoped the course would impart including increasing pleasure and mastery and goal setting. Whilst this outcome is not directly related to job-seeking behaviour, it raises the possibility that increased self-efficacy through use of skills might be translated into job-seeking later. Alternatively, in the absence of a *decision* to return to work based on insight and identification of best interests, the increased use of skills might be restricted to their home improvement plans (and not seeking work).

In keeping with previous weeks, most participants described general behavioural intentions in response to the programme and fewer participants expressed specific techniques or skills that they

would implement in their lives. That some participants' comments relay personal meaning and impact whilst others focused on (or repeated) course content suggests that the programme could act at different levels of participants' consciousness depending on personal characteristics and situations. This could be described as *personal relevance* which may arise when an individual apprehends both content (skills) and implications (application to personal goals).

Discussion - 'express' feedback sheets

CMP participants commonly expressed valuing the discovery that they were not alone with their experience of being out of work and on health-related benefits. Providing a platform for this, the CMP had a normalising effect on participants. Interaction and teamwork were valued and evolved throughout the course of the programme. CMP was seen to have an effect of opening minds and encouraging self-reflection in some participants. The programme appeared to promote a renewed sense of self-care through the process of self-reflection. Participants' responses suggested that the programme had helped them to identify and, for some, engage with positive life intentions.

However, there was no evidence of participants applying learning to the arena job-seeking. Positive intentions were commonly expressed in general rather than specific terms. Most participants did not express specific goals. The divergence between personal insight and application of skills suggests that the programme content was meaningful but not in the sense of altered behaviour. This raises questions for the programme concept. Participants may or may not have improved clinically or have learned skills to manage their health more effectively. However, these outputs were sought through CMP on the basis that they should remove a barrier to work and result in increased job-seeking activity.

One to One participant feedback

The final iteration of the Norfolk CMP was based on one to one meetings. The explicit purpose and the written materials for this format were the same as for the express programmes however the delivery allowed for more personal interaction and engagement with the client. Feedback sheets were offered after each session for those who were willing to complete it and consisted of a five point Likert scale as follows:

1   Strongly disagree

2   Disagree

3   Neither agree nor disagree

4   Agree

5   Strongly agree

The objective was to provide a broad range of factors for participants to comment on. These factors related to their experience of CMP rather than wider expression of their lives. A limitation of the form was the large number of factors to rate (23) which may have led to reduced consideration. However, the large number of items may have made it less uncomfortable for participants to give lower ratings on some factors. The 23 factors were spread across criteria which were identified to give balance to the survey (see Appendix 17). These were: core therapeutic conditions (Rogers' (1951), personal impact (the immediate effect on the participant), environment (building, comfort and administration), change (perception of personal growth or development), usefulness (whether practical benefit was perceived) and facilitation (the impact of the therapist).

Twelve participants volunteered to complete the forms after each session. The average number of sessions undertaken was six. 78 forms were collected in total. Across the twelve sets of records, a maximum score of 5 was common across most categories making it difficult to establish meaningful data on most of the factors rated. However, the generally high scores showed the low scores in sharp relief.

Each set of results was analysed to find the mode score for each factor. The lowest and second lowest ratings were identified for each participant (table 7.10)

Statement which was least or second least highly scored	Total from 12 participants
The session will be helpful to help me manage my mood better at work	6
The session has made me think that work might be more possible for me	4
The administration was helpful	4
The buildings, rooms and facilities were helpful	3
I feel more able to face challenges in the world	3
I have learned new skills that I will use	2
I found the course interesting	1
The things the therapist said in response to me	1
Being welcomed and looked after	1
The time and space provided to think about myself	1
The session was enjoyable	1
Being helped to feel safe and secure	1
Feeling connected to the therapist	1
Overall welcome and atmosphere	1
I feel better now than when I arrived	1

Table 7.10 Lowest scored items measuring impact of one-to-one CMP

Of the twelve volunteers, 6 found the factor: *This session will be helpful to help me manage my mood better at work* to be either their lowest or second lowest mode rating. Alongside helpful administration, the factor: *The session has made me think that work might be more possible for me* was the next lowest rated with four out of twelve participants indicating this opinion.

This does not indicate that participants necessarily found it *unhelpful*. However, it does suggest that they found it *less* positive compared to other aspects of the course evaluated. The factor: *the session will be helpful to help me manage my mood better at work* was the only category that two people consistently marked as negative (disagree or neither agree nor disagree).

Recorded Exit Interviews

Upon completion of CMP, participants were required to meet for a final 'exit interview.' This reviewed progress and established ongoing plans. Responses to the 'standard' questions were recorded on a form and returned to Shaw Trust.   A submission for ethical approval was granted (Appendix 2). Nine participants volunteered to take part in recorded exit interviews.

Where participants agreed to recording their exit interview, additional questions were asked seeking insight into the broader experience of receiving health related benefits. Additional questions related to personal and financial impacts of being out of work and experience of the CMP and Pathways to work. Nine interviews were transcribed and analysed thematically.   The relationship between participant and the author during the programme had been 'therapeutic.' This character was maintained in the interviews. The author occupied the role of practitioner and researcher rather than researcher alone at this stage. Table 7.9 provides a summary of clinical and return to work outcomes for those whose exit interviews were recorded.

Name (not real)	Programme	HADS Anxiety		HADS Depression		Overall change in case-ness			Return to work?
		Pre CMP	Post CMP	Pre CMP	Post CMP	Case-ness (pre)	Case-ness (post)	Overall change	
Lyn	One to one	None	None	Moderate	None	Case	None	Improved	No
Martin	One to one	Severe	Mild	Severe	Moderate	Case	Case	Not improved	No
Mick	Express	None	None	Mild	None	None	None	No change	Yes
Richard	One to one	Mild	Mild	Moderate	Moderate	Case	Case	Not improved	Yes
Fen	One to one	Moderate	None	Severe	Mild	Case	None	Improved	Yes
Graham	One to one	Mild	Mild	Severe	Severe	Case	Case	Not improved	No
Geri	One to one	Mild	None	Moderate	None	Case	None	Improved	Yes
Sue	One to one	Mild	Mild	Moderate	Moderate	Case	Case	Not improved	Yes
Si	Express	Mild	Mild	Moderate	None	Case	None	Improved	Yes

Table 7.11 Summary of clinical and return to work outcomes for recorded exit interview participants

The questions (see figure 7.4) were used as a guide to the interviewer and were not necessarily asked on all occasions or using the same wording.

Welfare to work Programmes

- How helpful is the Condition Management Programme in helping people back into employment?

- Does Pathways to Work help people regain employment?

- What specific help would you value in order to get back into employment?

Personal and financial impact of being out of work and receiving health related benefits

- What are your aims for your future life?

- What is your biggest concern regarding returning to work?

- What is your preference currently? – return to work or maintain your current status?

- What is it like for you being currently out of work?

- What is your experience of claiming benefit payments?

- How feasible is it for you to live satisfactorily on benefit payments?

- How much would you value earning more money if possible?

- What would be the effect on people in your position if your benefit payments were reduced (e.g. placed on jobseeker's allowance rather than Incapacity benefit?

Figure 7.4 Exit interview question guide

Whilst these questions cover a range of subjects, the data discussed below relate to programme outputs only. Therefore, broad conclusions on programme concept and theory cannot be extrapolated from them. However, they demonstrate the range and type of information imparted in the exit interview.

Fen described a clear transformation over the course of her programme which centred on her relationship between work and her perceived ability to cope.

"Before I saw you I was worried and it was affecting my work…my feelings about work and whether I could cope at work and whether I was good enough at work. Now, I've gone through this and I know work is not going to be a problem, work's going to be okay…Work is one of those things I *can* cope with" (Fen)

The mechanism for this change was described in terms of personal identity. She was aware of competing voices in her thoughts and her ability to be an observer of these thoughts indicates that she may have benefitted from the mindfulness component of CMP.

"Work is fearful, of course it is after everything I've been through but um…it is hard it's fearful because my head still labels me as that person and I keep reminding myself that I'm not that person any more…that doesn't define me. My past doesn't define who I am today." (Fen)

Having gained personal clarity that work was possible and having resolved to re-define herself by distancing herself from her past, she sought work as an immediate priority:

"Two days temp in March - hopefully there will be some positions coming up [at the school where she volunteered] - as soon as one does I'm going to go for it - I'm ready" (Fen)

Richard was similarly able to highlight specific changes, which he attributed to his sessions, drawing on feedback from family and friends:

"They say that I'm not the same person I was since I came out the other side of the depression and since I've been able to organise my thinking more. I've certainly become much more assertive and it's helped me no end." (Richard)

As far as the mechanism for this change is concerned, Richard suggested that the helping agent may have been related to attending rather than specific skills.

"There could be a placebo effect of just by attending something of that nature – pathways to work course – that you may not have taken on board any extra skills but just by attending, you feel more confident!" (Richard)

Others who obtained work within a year of completing the course were less precise in their assertions. Mick gave a confident account of the CBT component of CMP:

"It associates different aspects of your mood, your frame of mind and how to go about getting…making improvements to your mind-set so you can enjoy life better you know and not be quite so afflicted by the anxiety and depression moods I think." (Mick)

However, his assessment of his own position in relation to health and employment did not relate directly to this observation and suggests an uncertain level of commitment to change at that stage.

> "I'm gonna do a course with OU with computers and I wanna learn more about computers and IT. So that's in the pipeline and I think it starts in October. Work wise, I'm trying to get more hours - hopefully more hours where I am at the moment [supermarket] to come off benefit and just carry on working where I am" (Mick)

Whilst Mick had a clear view of the future, he described uncertainty over his health even though he scored as non-case-worthy before and after CMP.

> "From my point of view, I think I'm more or less sorted I think. I mean I've got a little bit of a way to go but I think I'm more or less there." (Mick)

This suggests that Mick had identified that further work would be beneficial but was not immediately necessary. This may have been influenced by his receipt of Incapacity Benefit, income from permitted work and a further Return to Work allowance. Further insight into this is found in Mick's case study account (Chapter 8).

Si's account of CMP strongly implied that his health was already improving but does not give any suggestion that the programme impacted on him in terms of motivation. As such, he portrays himself as interested but not engaged.

> "I found it beneficial and stuff. I just think that perhaps … I think that some of the other people on the course…their needs were slightly more severe than mine and more…I could have benefited more from it had I attended earlier in my illness sort of thing…when things were a lot worse…I was already on the road to recovery when I joined the course I think so it helped to explain more what I had been through sort of. There were definitely things that helped I mean…but for example trouble with sleep was something that I had but the medication and getting into a regular routine helped me overcome that." (Si)

His example of work related activity gave a further indication of disengagement with the process:

> "I went to Shaw Trust on Thursday and the lady there took me through the CV and she has emailed me my updated CV pointing out that you don't have to put date of birth on any more to stop discrimination…There was a couple of other things that didn't have to be on any more and there was a couple of extra things that needed to be on like

character profile and...she's sent me a jazzed up version....I have to confess that I

haven't actually opened the email yet." (Si)

Others' work-related plans implied a sense of uncertainty and indecision. Martin saw time and further counselling as the immediate priority. It is not clear whether illness or lack of confidence prevented a decision to engage with job-seeking. His vague plan of self-employment may indicate difficulty conceiving of working with other people:

> "To be honest I think another couple of months is going to be needed. I need you know, more counselling for a couple of months then I'd like to say March time then I am on my way and then I think to be honest, I am going to look to start something up for myself." (Martin)

When asked what she would do with additional time before seeking work, Lyn was unable to offer a specific plan:

> "I don't know - it would just give me a bit more time." (Lyn)

Whilst Lyn improved clinically from moderate depression according to her HADS scores, this did not translate into job-seeking behaviour:

> "Well jobseekers don't pay a lot. The money I'm getting now is good... I'm happy with what I'm getting now but I don't think I'll get a lot more if I go to work than what I've been getting...If it went to jobseekers I would want more money... I don't think you should get as much as they give you really because you think I might as well not go out to work." (lyn).

Lyn's description suggests that her inactivity in job-seeking was based on an appraisal of her earning capability. This resulted in a decision to not seek work.

Richard outlined work related activity and, like Martin, suggested self-employment.

> "My work-related plans are to um engage more with charitable organisations that I'm already working for and to complete my teacher training which is on-going and also to maybe set up a little business" (Richard).

Martin's and Richard's suggestions that they might seek self-employment indicate that they must have given future employment some consideration. Their focus on self-employment may be significant and is worthy of further investigation. Both described previous negative experiences at work. In terms of employability, they may have sensed that their best chance, in a competitive job market, was self-employment. By the end of CMP, Martin bemoaned being in receipt of benefits:

> "Horrible - I mean unless you're actually in this position - I've seen it before. You don't
> get …I mean you get benefit but you get no help. You're living on rock bottom - it's not
> good. I wouldn't want to… it's not where I want to be. I hate it." (Martin)

However, his plans were vague and his responses suggest persistent negative conceptions of work and of his employability. As such, Martin lacked volition concerning employment following participation in CMP. These passages indicate how Martin's desire to work was inert without the *decision* to do so. In his insight, his interests were best served by not engaging with change.

> "To be honest if I can pay my way and we have a little bit left over at the end of the
> month whether that be three or four days…I don't want to be tied down to a nine to five
> job…I think also with my age now and the way the job market is, I think I'm going to find
> it very hard to get into a job that I would want to do. I don't want to go back into a
> factory because I know that's just going to knock me back - being stuck inside four walls,
> I'm an outdoor person and I want to be doing an outdoor job." (Martin)

The qualitative data collected during CMP sought to identify outputs related to plans to find employment and ability to describe or demonstrate condition management skills. It also looked for further evidence to substantiate or challenge quantitative outputs related to improvement in health and confidence in ability to manage health inside and outside of work.

The 'express' feedback revealed that some participants found the experience to have helped them to reflect on their lives and, in some instances, open minds about applying this learning. There was evidence of gratitude for the group setting and enjoyment of it. There was less evidence that participants had remembered specific skills or made a concerted effort to use them. The feedback forms and exit interviews did not yield examples of job seeking behaviour or of plans to implement skills taught and practised on the programme. Responses were usually reflections of how the course had left each person feeling that day. Most commonly, this was an acknowledgment of the value of the other team members. Comments concerning intentions for future behaviour change were normally confined to broad aspirations such as thinking positively or being more assertive. These could be seen as necessary but insufficient for CMP to have made a sustainable impact. Clear evidence of using insights and skills for the pursuit of work is hard to discern.

Discussion – CMP output data

A summary of CMP output data is presented in table 7.12.

Anticipated outputs	Evidence for	Evidence against
Ability to manage condition.	Express feedback – non-specific mentions of some skills that were included in the programme. Some evidence of wishing to improve lifestyle generally including intention to be more assertive. Exit interview – Responses included a broad description of the process of CBT.	Express feedback – No clear evidence of intention to use specific skills within the data. Some specific comments that participant would *not* change behaviour. Exit interviews – absence of descriptions of skills or intention to use them. One to one feedback - Ability to manage mood at work ranked lowest or second lowest in half of all respondents.
Improvement in health condition.	75% improved with HADS depression 72% improved with HADS anxiety Exit interviews – Responses included improvement with depression and assertiveness. Responses included feeling recovered.	66% did not improve clinically (HADS) yet gained employment. 39% of non-returners improved clinically (HADS) Exit interview – responses included feeling recovered but still having some way to go. Responses included requirement for more counselling. Responses included CMP coming too late as already much better
Ability to describe or demonstrate skills of health condition management	Returners OSA data showed an increase in competence in occupational skills.	Non-returners OSA data showed smaller increase in competence in occupational skills
Belief that their health condition is no longer an impediment to obtaining work	70% of all respondents reported increase in confidence in ability to work (Work confidence questionnaire): 82% of returners and 64% of non-returners.	30% of all respondents reported no change or less confidence in ability to work: 35% of non-returners and 18% of returners
Confidence in ability to manage their health whilst at work (and sustain employment)	64% of all respondents reported increased confidence in ability to manage health condition at work: 76% of returners and 56% of non-returners	44% of non-returners reported no change or less confidence in ability to manage condition at work.
Belief that work will not cause health to deteriorate	51% of all respondents reported increased confidence that work would not make condition worse: 59% of returners	49% of all respondents reported no change or less confidence that work would not make their condition worse: 54% of non-returners and 41% of returners.
Making plans to find employment	Exit interviews – Responses included immediate, specific plans. Responses included thoughts of self-employment (but no immediate plans). 50% of all respondents reported increased confidence in ability to find work: 65% of returners and 44% of non-returners. 47% of all respondents described being ready to commence work within 3 months: 70% of returners and 50% of non-returners	50% of all respondents described no change or less confidence in ability to find work: 56% of non-returners and 35% of returners. 53% of all respondents described not expecting to be ready for work within 3 months: 50% of non-returners and 30% of returners. 35% of all respondents described not expecting to return to work within 6 months: 41% of non-returners and 10% of returners. One to one feedback – Belief that work might be possible ranked lowest or second lowest in third of all respondents. Exit interviews – Responses included not considering work as IB pay discouraged it. Responses included needing more support and would only consider certain types of work. Responses included not acting on support available. Responses included needing more time. Responses included lack of financial incentive to work.

Table 7.12 Summary of evidence for anticipated programme outputs (identified in Chapter 5)

The 'one to one' feedback sheets were hindered by excessively 'positive' responses. Though scores on all items were high, the scores that were consistently lower related to beliefs that the session had made work more possible or that it would help them to manage their mood better at work. It is interesting to note that an intervention could help a person to feel better overall but not manage their mood in the context of work. This suggests that working held a particular meaning for some respondents to the questionnaire. The concept of work may also be thought of as the *ending of incapacity.*

The recorded exit interviews revealed a broad spectrum of reflections and beliefs. One person emphatically believed that their sense of ability and employability had changed considerably and that they could start work imminently. Others were less urgent and alluded to a need for more time or more support. One was happy to remain on IB if benefit income was not reduced. There were no distinct, commonly occurring themes except that all implicitly revealed that they had considered their current position regarding employment. This was consistent with the inferred programme theory espoused by some practitioners that participants would engage with the concept of work if they believed that it was in their best interests.

This chapter has investigated how successful CMP was in achieving desired outputs. The outcome data also suggest unanticipated outputs. A potential *negative* output of CMP may have been a strengthened conviction that health alone stood between the claimant and working and that more time was required for health to improve.   This was observed in return to work estimations and recorded exit interviews. As described in Chapter 6, inferred programme theory, described by some practitioners, was that individuals would only use skills to manage health for gaining and retaining work if they could first see that it was *in their best interests*. This concept was not discussed openly with participants. Explicit theory remained that ability to find work required management of health. This may have re-enforced the notion that health status was the significant barrier to employment. Where an individual did not experience a clinical improvement in their health or a subjective feeling that they were better (such as feeling less fearful of change), this may have strengthened their conviction that their health still prevented employment.

Furthermore, some participants might have waited for an improvement in health but not addressed whether it was in their interests to return. It is possible that some participants gained the impetus to work not realising that their confidence and insight (rather than their health) had changed.

However, others may have become further entrenched in their incapacity, not because their health had not improved, but through inability to see their future in work.

The data also suggest *positive* unanticipated effects, specifically, giving participants the opportunity to re-evaluate their situation. This was most apparent in the 'express feedback form.' This provided evidence of increased reflection, insight and self-awareness and improving self-care and commitment. This was expressed in terms of participants wanting to improve lifestyle overall identifying positive life intentions. These outputs are consistent with the programme theory espoused by practitioners who sought to provide the opportunity for participants to make changes in their lives if these were in their best interests. The exit interview data also suggested that CMP could be helpful simply by increasing effort to attend and benefit from social contact; a *placebo effect.*

The work confidence and work timescale questionnaires indicated a divergence between those participants who believed that returning to employment was possible and those who did not. A discernible output for CMP in Norfolk was a clarification in the minds of participants as to whether they would return to the employment market or remain avoidant of it. There is evidence, from the express feedback, of individuals benefitting from the group setting. This included a sense of their experiences being normalised, discovering that they were not alone and feeling accepted and encouraged. There is some direct evidence, in the recorded exit interview transcripts, of participants moving from a position of fear to a belief that work was possible within (Fin).

Outputs, viewed in isolation, may not yield obvious findings. *Combinations* of outputs may be more helpful. For example, knowledge of a condition and how to manage its effects is of limited benefit unless there is an *intention* to use this skill. In the context of seeking employment, both knowledge *and* intention were required if participants were likely to seek employment. Even when these outputs are achieved, the participant must be willing to overcome uncertainty which might be both psychological and financial and could present genuine risk to livelihood.

The observed outputs from the Norfolk CMP suggest that changes in thinking and behaviour were not related not to enhanced skills in managing health but to confidence and decision making. This implies that the programme concept (teaching people to manage health conditions better) may have been flawed. The problem conception, viewed through the lens of output data, appears to be related less to the functional impact of a health condition and more to each individual's conception of themselves and their position in regard to employment. This might include whether they believed their interests were best served by being employed, whether they believed they had the capability to thrive in work and whether they were confident that a change was worth the risk of potentially

negative outcomes.   These outputs suggest that anxiety may be composed differently in different people (including in those who are able and willing to seek re-employment and those who are not). As such, ability to manage a condition might not be the critical factor in determining a person's likelihood of seeking employment. These themes are explored in greater detail in case study interviews in the following chapter.

Chapter 8 - CMP Outcomes: Case Studies

Introduction – Case study format and structure

Six case studies were undertaken to assess the impact of CMP on participants between three and five years after completing the programme. To achieve balance in the sample, three interviewees had obtained employment and three remained on health-related benefits within one year of completing CMP. Within each of these groups were three categories of clinical improvement with one representative in each (summarised in table 8.1).

Participant (not real names)	Programme	Clinical improvement	Status 12 months after CMP
Tami	One to one	Improved	Employed
Pete	Express	Not improved	Employed
Mick	Express	Not case-worthy (pre or post CMP)	Employed
Irwin	Original	Improved	Incapacity Benefit
Marianne	Express	Not improved	Incapacity Benefit
Alastair	Original	Not case-worthy (pre or post CMP)	Incapacity Benefit

Table 8.1. Summary of case study participants

Identification of themes, using interpretative phenomenological analysis (IPA), enables the emergence of a *formulation* of the individual's incapacity. These present a broad picture of each person's incapacity and a holistic appraisal of why they were not able to work. Illness is part of the picture which may also include personal, social, psychological and financial components. Each case study explores the relationship between these factors in the context of their life story prior to CMP, their experience of the programme and the subsequent paths their lives took. The formulation of each participant's incapacity allows an analysis of the appropriateness and relevance of the CMP concept and programme theory to them.

Case Study 1 - Tami

Biography – Pre CMP

Tami is a married mother of one in her early-forties who obtained employment with a firm of solicitors within a year of completing CMP. She subsequently lost this job and has remained out of work since. Tami is regarded as a 'positive outcome' according to Pathways to Work contractual arrangements (see Chapter 1) as she maintained employment for more than six months.

Tami was raised by her single mum who had unspecified mental health problems. She completed a B-Tec in Sport and Leisure but did not find work in this field. She initially undertook administrative roles before finding long term work with a large public sector employer with whom she had three main roles over thirteen years. She described periods of bullying and stress during this time which contributed to a poor sickness record. Following the birth of her child, Tami struggled to manage the pressures of combining work and being a mum. She also experienced interpersonal problems with some members of staff. She lost confidence and was eventually dismissed for poor attendance.

Tami found the experience very distressing and experienced acute rejection coupled with a sense of loss. She described taking 'a year out' after the dismissal to regain her confidence. During this time, she claimed ESA. Tami was referred by the Job Centre to Shaw Trust who referred her to CMP which was then in its final "one to one" format. This consisted of one to one counselling focused on self-esteem and work confidence.

IPA Formulation

From 65 sub-themes, a total of eight superordinate themes emerged.

- Health
- Tension and 'stuck-ness'
- Time out
- Forward movement
- Backward movement
- Psychological needs
- Threat and fear
- Personal problems

It can be seen how these themes interacted to keep Tami in a sense of 'stuck-ness.' She described several factors which encouraged movement towards her goal of earning money and finding fulfilment. However, she is described a pulling back from her goals and towards safety. The forward movement was motivated by personal needs whilst the backward tendency was driven by fears or sense of threat. These tendencies were born out of her personality and what she describes as her

'issues' (described here as personal problems). Tami considered that her health problems were manifestations of negative life experiences.

Whilst Tami disliked receiving benefits, she acknowledged that ESA removed pressure and provided the opportunity to take time out. The initial relief offered by the time out became another factor contributing to tension between safety and employment. Tami became preoccupied with her health and wanted to be certain that she was well enough for work.

Health

Tami described two periods of long term sickness during her 13 years at work, her main complaints being depression, diabetes and endometriosis. She was unsure of which led to her ESA claim but believed it was depression.

> "I think I had just had probably post-natal depression and I was just stressed all the time totally and (baby) never slept at all and I was still feeding her myself over-night and going into work. I mean it was only 18 and a half hours a week but I seemed to have really struggled and I couldn't concentrate because I had no sleep so I was probably getting on everyone's nerves because I couldn't take things in and I was asking questions." (Passage 14)

She remained preoccupied with her health and continued to have treatment for endometriosis. She describes feeling well at the time of the interview but feared a worsening of her health. Her sickness record also held her back by playing into her fears and heightened awareness of personal 'issues.'

> "No one wants to have a high sickness record we all know that but the problem is I'm dragging it around with me like a massive sack behind me every time I go for a job and it stops me." (Passage 19)

Tami strongly believed that her health was linked to other events in her life (stressors) and to her confidence and self-esteem. She regarded her time on ESA as an opportunity to recover and, though upset at being dismissed from employment, she was relieved to take time out and ESA made this possible.

> "I just wanted to recover…I didn't have any firm plans at the time although at the back of my mind I knew at some point I would have to get a job but at first I wanted to think of me and get me right" (Passage 41)

Tension and Stuck-ness

Tami described being 'stuck' at various points in the interview and on two occasions, asserted a need to 'push through,' her fears to move forward. Her state of 'stuck-ness' sat between the desire to move forward with its unavoidable risks and the temptation to pull back which promised safety. Tami was aware that she lacked self-confidence. She attributed this to a series of events at work when she was either bullied or ostracised and pointed to difficulties and disappointments in late childhood and early working life. Tami now says she is waiting for her confidence to return or rise to a point when she feels able to face employment.

> "I think it probably gave me space to be honest. I don't think I'd have ever been…even
> now I feel like, am I ever going to be that confident again. I mean I do feel lots better
> that when I first met you for instance but … it's that next leap isn't it and I've got to go
> through that" (Passage 61)

Tami described how she hated receiving Incapacity Benefit due partly to her dislike of interviews at the Job Centre which she found demoralising.

Time out

Despite her aversion to receiving benefits in practical terms (dispiriting visits to the job centre) and psychological terms (damage to her role identity), Tami acknowledged that the benefits gave her the opportunity to recover from her illness and to take time out to rest and recover.

> "Well some days I was quite low and some days I was quite upbeat and the days I was
> upbeat and I was sort of seeing friends, I felt like a bit of a fraud. It's awful, I'm on ESA
> but I'm going out enjoying myself but enjoying myself was part of the process of me
> letting go of whatever I've just lost and I couldn't sit in all day…I would take (baby) out
> to babies and toddlers and stuff. I suppose at the time I kind of questioned myself, am I
> worthy of this? But I knew that I wasn't well enough to go back to work but that's pride
> for you. I didn't want to feel like I was on the dole like and that sounds awful. I didn't
> want to be like reliant on the dole or stuff like that because I had never ever had to feel
> like that and so I…when people asked me what are you doing now, I would be like I'm
> just a house mum. I didn't want to say I'm on ESA so it's almost like a bit of
> embarrassment." (Passage 42)

She remained conscious of her health but doubted herself and described slight guilt about the extent of her illness. Tami acknowledged that sometimes she felt quite happy and could enjoy social contact. In this state of 'time out,' Tami sat in limbo. She experienced pressure and was aware that

she wore a brave face and 'faked' happiness. She maintained the pretence she was choosing to be a 'stay at home mum' rather than admit that she was claiming benefits. She acknowledged concern about 'drifting' and compared herself unfavourably with other women who were full time mums or 'tough' enough to combine work and parenting.

Movement forwards

Tami described the need for forward movement in her life and of her difficulty in 'pushing' on. She explained that she had previously focused on a career and was disappointed not to have followed up on her earlier ambition to work in physiotherapy or leisure management. She maintained that she still wanted to work and did not feel satisfied by being 'just a mum.'

> "Some people love being just a mum; come home and do the housework, do this and do this …but that don't fulfil me. That's not me" (Passage 49)

Tami dedicated herself to work and saw herself as loyal and committed. This left her open to distress when her efforts were not appreciated or failed to achieve the desired results. She interpreted failure at work as failure of herself.

Psychological needs

Tami described psychological 'needs' which fuelled her desire to progress. Frequently mentioned was a need for belonging. Despite her difficulties with her longest employers, she enjoyed the camaraderie and returned to this theme several times. Linked to belonging is *meaning and purpose*. Tami could see value in her work in terms of protecting the public and in being courteous and respectful to people. Tami needed to feel acceptable to other people to negate the risk of rejection and feelings of being unworthy and un-loveable.

> "Even though how they treated me I miss the camaraderie. Totally miss the camaraderie of it all…but I suppose in a way I kind of was this bubbly, naïve person going into that place and I know a lot of people not just there, everywhere that will quite happily stamp on you and make you feel like not worthy and I think that's probably what's making me feel like I don't feel like I could ever go back to work (laughs). It's almost like…I'm okay but…because I feel I can't be myself in a workplace because people judge me differently to what I'm capable of doing in the work place…" (Passage 23)

Tami longed to 'fit in' and felt a need to make the 'right impression' even when this meant hiding behind a mask or even hiding certain truths (such as her status as a recipient of benefits).

Movement backwards

The backward movement in Tami's life sat in conflict with her desire to progress. She was aware of her thinking styles and how negative thinking hindered her in the past. She found the parts of the CMP related to tackling negative thinking the most useful and described referring to her notes. She gave examples of how translating positive thinking into action had brought pleasing results. She is aware that negative thinking played a part in her difficulty in moving into paid employment. Tami referred frequently to being hurt and how she fears further hurt and distress.

> "The thing is, I've always classed myself as a really loving, generally genuine person. What you see is what you get…I'd love to be strong in a way of not so sensitive so I could bat whatever they say off, I don't care, I'm doing my job. I don't care, you're alright, I'm alright, get on with it. I'd love to be like that but I think because of the experiences I've gone through in personal life and work life, I think it's really damaged" (Passage 59)

The hurt Tami felt could be personal as well as related to her work performance. She describes being an open person and how difficulties with people at work have led her to feeling rejected. Consequently, she protects herself and withdraws from threatening situations.

> "I still see my colleagues I used to work with and they say it wasn't that Tam, you were great at your job. And I just feel that everywhere I've gone…I just don't know. I don't know…whether I just don't give the right impression where I go somewhere, I don't know." (Passage 14)

She avoids situations which trigger feelings of threat or remind her of being hurt and rejected.

Threat and fear

Tami's avoidant behaviour is driven by distressing events from her past and by negative appraisal of present and future circumstances. She feels distressed because of criticism (justified or otherwise) and a sense of pervasive surveillance and scrutiny.

> "I thought that was bad enough at times but then you realise what a dog eat dog world is out there. And it kind of… you know they pick you on things like, your telephone manner is not up to scratch and things like that and I said like, look and so in 20 years of working in admin, I've never ever once had a complaint from a customer – internal or external. I've never once been picked up on my telephone manner. I just said it was a load of crock to me and my face obviously didn't fit." (Passage 15)

Tami frequently felt judged at work and experienced bullying. The sudden, unexpected experience of rejection from colleagues left her feeling distrustful of people.

> "I don't want to be questioned …I need to work for my own self-esteem really and my own worth. Give me back my identity as a person but I don't want to explain myself because I'm so sick of explaining to people you know I feel like I've been through a huge process about…you know explaining my situation and why and sometimes I don't want to tell people because that'll put them off and they won't employ me and that's another thing that …It's almost like I'm protecting myself against rejection. Cos the rejection will then knock on effect on my confidence" (Passage 52)

Tami fears situations in which she could be vulnerable to criticism or judgement. Knowing herself to be a loving person, she experiences rejection or criticism as cruel and has adopted a fearful stance.

> "Like in private industry, it's almost like everyone's selfish and there's no camaraderie an they're on their own and they'll stamp on you when they can and that's exactly how I thought it was, was exactly how it was when I went to those solicitors office and in fact it's even RSPCA" (Passage 66)

Personal difficulties

Tami described herself in terms of 'issues;" cognitive and emotional factors which play into the movement backwards described above. She returns to the notions of being damaged, needing healing and lack of self-esteem. She regards herself as a failure and is disappointed in herself. Tami defines life success in terms of employment status and compares herself unfavourably towards others; her lack of 'career success' plays into feelings of unworthiness.

> "Yes, oh she's happy and jolly, she's the joker, she's a kind of good time girl and when a person told me that …point blank, you're a good time girl, you're not a career girl, you just like to have fun. I'm like…the thing is…I was very career minded when I was young and I think that in itself…I feel that I've let myself down. You know, I've never had that profession under my belt." (Passage 24-25)

Tami's openness leaves her vulnerable to criticism and when people withdraw from her, she experiences intolerable rejection. Tami admits to being naïve and of always assuming the best in people.

> "But you see, deep down, I'm not that confident. Socially I am really outgoing but when it comes to things like with what has devastated me in the past I shy away from it. I try

to put a barrier up and try not to go there. That's probably why I haven't worked since

the solicitor's office because I failed there, I failed there, I didn't get the job at the

Council so I'm now like…so…it's just really difficult." (Passage 22)

Tami believes that she is lacking or flawed; that she is deplete in certain life skills which other people are imbued with in childhood. Her understanding of CMP is based on this premise:

"I have recommended it because there are tools that you can use to help you be you

know less negative or whatever, more positive whatever…but I think it's good,

definitely. I think it's almost like if you weren't brought up with the tools to cope with it,

CMP has given you the tools. You have to work on it but you have to…it's almost like a

life lesson, a life lesson tool to cope with harsh experiences." (Passage 68)

Impact of Pathways and CMP

HADS Initial	**HADS on completing CMP**
Anxiety – 12 (Moderate)	Anxiety – 7 (non-significant)
Depression – 15 (severe)	Depression – 9 (mild)

Tami described CMP in terms of counselling to help her to 'move on.'

"You know, obviously, the counselling sessions I had here helped but I know they

weren't long enough or enough of them for me to then really kind of move on" (Passage

41)

Whilst she managed to regain employment and believed that CMP helped her to make progress, her negative thinking re-asserted itself after she was dismissed for a second time:

"The CMP at the time when I had my CMP it did feel… feel like I was moving forward

whereas I then…the brakes were put on and I still remember the stuff that we discussed,

I still flick through the paperwork every so often when I'm feeling a bit rubbish to be

honest and I'm thinking, now come on, you can sort this out but I do think sometimes

that I slip into my bad ways of thinking like negative thinking which is very destructive."

(Passage 67)

Tami, referred to specific elements of CMP drawn from CBT and Transactional Analysis that helped her to address thought processes that held her back. These same negative thoughts are a component of depression. However, viewed from this perspective, depressed mood was a consequence of the primary issue of specific negative beliefs about herself that prevented her from

seeking work. As such, condition management skills for depression may have been useful for symptom relief but might not have addressed her principle 'barrier to employment.'

> "I was flicking through the notes the other night and try to remind myself of how you can train… retrain the way you think and there was lots of diagrams there and I'm thinking it's almost like I have to go back and redo a couple of sessions for myself but…it's easy to slip into the wrong way of thinking like for me coming here I'm thinking see there's things that you told me – 'I'm ok – you're ok'' and sometimes I have to I have to refer myself back to the notes to make myself aware that I am in control of how I can feel….but I have to look at the notes because if not, I'll go back and I'll be negative…so that is…to be honest I think maybe that has…I mean I've said to friends and family, you know that's the best thing that has ever happened to me to do that…this CMP but it wasn't enough" (Passage 67)

This raises the issue of whether CMP was best offered as a generic programme or specific interventions based on individuals' needs. It appeared that Tami's situation corresponded with the explicit programme concept and theory. She was not employed and was suffering diagnosable mental illness. On the assumption that her health condition prevented her employment (the foundation of her ESA claim), assistance in managing her anxiety and depression should have resulted in the removal or reduction of the barrier to employment. Tami responded well to CMP. Her HADS scores indicated improvement in health and she subsequently regained employment.

However, analysis of her interview transcript detailing her employment history in relation to her psychological drives suggests that her loss of employment resulted from emotional and relational insecurity and consequent interpersonal problems. Anxiety and depression arose from these 'issues' but cannot be said to be the primary cause of her non-employment. Tami's reaction to non-employment; a mixture of confusion, shame and avoidance also led to symptoms of anxiety and depression. The key focus areas of CMP as described in the pilot programmes (Ford, 2008) were symptom management, coping skills and activity and exercise.   From Tami's evidence the 'one to one' CMP appears to have assisted with the first two of these (she does not allude to the latter). Improvement of anxiety and depression encouraged Tami and possibly helped her regain employment but did not address the fundamental causes of her difficulty maintaining employment (neurotic relating style and loss of confidence).

Biography - Post CMP

Tami was uncertain of specific timings but her ESA was withdrawn and she was placed on jobseeker's allowance. The Job Centre' placed her with the RSPCA on minimum wages. The placement was meant to last six months but she cut this short when she took a job with a small law firm in Norwich.

Her new employment initially ran smoothly but she experienced interpersonal difficulties with some members of staff and with the office manager who became critical and judgmental. Tami thought she was good at this job but was constantly 'picked up' on aspects of her role which she took very personally including her manner with customers. She felt, again, as if she did not fit in. After seven months, she was dismissed.

Case Study 2: Pete

Biography Pre-CMP

Pete is in his mid-thirties. He attended the CMP Express in 2009 and regained employment with the local council shortly afterwards. He remains in that post.

Pete spent his most of his childhood in care (children's homes and temporary fostering). He was fostered semi-permanently in his teens. Aged 17, he was thrilled to be selected for an apprenticeship with a small motor-sport engineering firm but within two weeks of commencing his placement, he was involved in a life-changing road traffic accident. This resulted in physical, brain and emotional injuries requiring years of treatment. Pete was unclear on dates but estimated that he was out of work for nearly ten years while receiving physical and neurological rehabilitation.

Following a failed relationship, Pete moved away from Norfolk and found employment in South Wales where he had three successive jobs in garden and grounds maintenance. Two of these ended following disputes with his managers and he was laid off in his final role at the beginning of the 2008 recession.

Following the breakdown of his relationship in South Wales, he returned to Norfolk to live with his adopted parents. He immediately sought employment despite experiencing a bleak time whilst claiming incapacity benefit for depression. He was referred to CMP for help with depression.

IPA Formulation

Five superordinate themes were identified from 69 sub-themes.

1. Trauma
2. Identity and capability
3. Relationship
4. Transaction
5. Drives towards and away

Trauma

Pete describes a series of 'breaks' in his life. Some are traumatic in the sense of immediate risk of death or injury (road traffic accident and injury at work).

> "All I remember was waking up in hospital. Like I say with my head injury it was like having a stroke. I couldn't move my arm on my left hand side. I couldn't move my legs. I couldn't see properly. All I could see was light and a silhouette of a person… I couldn't see details." (Passage 16)

Other breaks were traumatic in the sense of losses or wide-ranging impacts (loss of two significant relationships and of regular contact with son, loss of three jobs and changes of geographical location).

> "I mean I was like I was still devastated coming back here like because…I didn't realise why it was so devastating. Alright, fair enough I had split up with (partner) but it was back to Norfolk back to that place that ruined my life in the first place so that was a trigger." (Passage 37)

Traumatic events and circumstances are triggers in Pete's life upon which he experiences strong *drives* either *toward* or *away* from psychological phenomena. The direction of movement is determined by a strong sense of self (*identity)*.

Identity and capability

Pete describes social identity in terms of being a proud working man. He has a sense of righteousness in choosing to work despite temptation to do otherwise. He is aware of people who reject work in return for benefits and describes deep distaste for this. His sense of personal identity is shaped by his experiences of trauma. He defines himself in the terms brought about by his traumatic car accident which required long term rehabilitation.

These terms include being tough, a survivor and a fighter which relates to his attitude towards health and sickness:

> "Three and a half years, I've had one day off sick. I've gone in with colds, flu and everything else. I've got to be virtually dying before I have a day off sick." (Passage 30)

Pete has a strong role identity which accounts for his drive to remain employed.

> "I'm a fair guy, I just want to work and I want to be proud of what I do. I want to pay my own bills. I want to work. I'm a proud man." (Passage 21)

He regards himself as principled with strong moral values and loathes reliance on others.

> "It makes me angry because what I've been through…Ok I could sit on my backside and live off benefits and everything else but I think the younger generation's had it too easy….cos when I was a kid you know what I mean if you wanted…you… we was like from a council estate so if you wanted something…I mean my mum was always working…I never saw my mum, my mum was working all the time like. If you wanted any decent stuff and everything else my mum said alright get yourself a part time job

like – a paper round, wash cars whatever. Fortunately my mum was working in a factory chopping up carrots and everything else and you always had some weekend jobs to go up tidying areas like where there used to be rotten vegetables and everything – just like pick all that up and put it into boxes you know what I mean and he used to give us money for it like…even when I used to be helping out my step dad with the lorries and everything else with the big old bolters we used to have like 27 tonnes of carrots in the bolters (laughs) and you've got to kick them out you know what I mean I used to think that was brilliant kicking carrots everywhere (laughs) I used to get £5 a bulker and I used to do three or four bulkers a day like…I used to love it. If you want something badly you get the money." (Passage 39)

He regards himself as having high standards of work, behaviour and morals. Pete's sense of self-worth is tied up in doing a job well.

"…and that was brilliant you know what I mean. I got so much feedback in the first year when I was doing that. They had never seen the lawns striped straight as a dye – fantastic and baskets, I used to do. It was lovely and full of colours. I had Fuscias outside the doors…it was nice just getting the feedback from the people coming to the garden of rest to pay their respects to their pets and everything and they said that's the best they have seen this garden look" (Passage 21).

Relationship

How Pete sees himself and the terms in which he experiences life are dependent on relationship. He reports his experiences in terms of conversations and interactions with others. He thrives on recognition and appreciation from other people. His story is punctuated with difficulties in relationships which sometimes resulted in breaks such as loss of employment or ending of significant personal relationships.

"I loved the job, I was getting on great guns but she was naughty … Me being me, quite hot-headed, I would have none of that (laughs) and … then there was, I had this letter saying I'm having a meeting with the company solicitors for bringing the company into disrepute and I said … fair enough. I was getting fed up of…I mean having someone looking over your shoulder at your work all the … so I said here you go, there's a letter. He said 'what's that?' I said it's my resignation. I said I'm not having this. I'm not having you…I've been through a lot in my life. I'm not having anyone tell me I'm this, that and the other I said cos I'm not." (Passage 21)

Pete is not afraid of conflict and admits to being hot headed, impulsive and sometimes bad tempered. If criticised, he feels hurt and sometimes victimised. Once a relationship ceases to be supportive and nurturing, Pete fights to defend his sense of righteousness rather than be hurt.

Transaction

Pete describes a 'give and take' approach to life and to relationships. If someone is respectful and encouraging, he will work hard for them. He believes in people getting their just deserts.

> "You see people nowadays and this generation, they want money for nothing…and unfortunately this is how this country is…and there you got this…me you got these like…argument now with the foreigners coming in and everything else like and I'm thinking well they're working and they've got the right to stay you know what I mean…but it's just demoralising because all they do is…you see it here like. I've got my neighbours here and everything else like. They aint at work but they're having a good time. Half the time they're getting drunk buying alcohol and I'm working cos it's just the standard that I've been brought up. Motivation!" (Passage 39)

He concurs with the deserving versus undeserving dichotomy and expects nothing back if he puts nothing in but also expects to be adequately rewarded for hard work.

> "I was there for six months as a seasonal just helping the regulars out doing the grass cutting, the hedge cutting and stuff like that and I had knowledge of doing that sort of stuff and also I thought to myself if I put extra effort into that and show them what I'm doing and everything else and get singled out as a hard worker and everything else and when a job come up you know what I mean, I'll probably get it and luckily there was a job coming up and I was like after was it two months off work I got made permanent by the borough council." (Passage 24)

Pete experiences distress when his 'rules for living' do not bear out. His sense of justice applies in the moral field as well as the labour market. He does not like living or working alongside perceived wrongness or immorality. This is not in a pious sense; it is more that he no longer feels safe. If he works hard, he expects his manager to be strong and effective and to look after him. This hope proves to be unfounded in his account and his leaders at work have sometimes disappointed him. The logic of transaction and patronage is extended to ownership. When he lost employment and required state benefits, he felt *owned* rather than being his own person.

> "When you talk to somebody 'Oh what do you do for a living?' – Well I don't work…and people look at you funny you know what I mean…You know what I mean, you don't feel

(sigh) don't feel part of society because you think society owns you because they're paying their taxes and pay you their money like you know what I mean so you don't feel like…you're pushed out like and that made me more determined…to go out there and work so…" (Passage 41)

Drive towards and away

Pete's account spoke of clear preferences, of likes and dislikes, hopes and fears. His life, though punctuated with traumas and breaks is always rebalanced and order reasserted if he knows what he is moving towards and what is to be avoided and moved away from.

> "I think depression kicks in because you're not at work…I think because you've had a taste of work and you're used to having that money coming in…and you just think you're in dire straits then…where's the money gonna come from to pay bills and stuff like that. The only answer is, you go out there and find another job. You know what I mean and you don't stop looking until you find one like. That's how I done it." (Passage 55)

His strong sense of identity and transactional approach mean that he is unlikely to drift off the 'righteous path.' To be unemployed was utterly unacceptable to Pete. He finds dependency to mean loss of himself.

> "I was alright happy go lucky like any other bloke earning money and everything else and then you haven't got that. You gotta depend on a government and that was a bit degrading to me because I'm used to working." (Passage 38)

He fears incapacity and dreads the potential for his injuries to prevent him working. He wants to be 'normal.' In contrast to his fear of being unable to work, Pete experiences self-reliance as part of his self-concept. He described how his mother drummed into him that if he wanted something, then he had to go out and get it. Pete understood what would earn him respect and he was happy to work hard if this brought him a sense of acceptability. He also describes a strong sense of place and belonging. This is both geographical and relational. Places as well as people give Pete a feeling of being wanted, welcomed and nurtured; the sense that he is part of something.

Impact of Pathways and CMP

HADS Initial	**HADS on completing CMP**
Anxiety – 15 (severe)	Anxiety – 11 (moderate)
Depression – 10 (mild)	Depression – 10 (mild)

At his exit interview, the following summary was provided to Shaw Trust:

Pete feels confident as long as he is shown what to do. He remains unsettled (domestically) and needs to continue to live a day at a time setting immediate goals in order to keep depression at bay. Pete is managing to stay relaxed without getting angry. He is desperate to return to work and will gratefully receive any help along these lines. He is more realistic about his personal life now and is being careful to remain so.

Plans – Pete does not question his ability to work but is dubious of job opportunities currently - is applying for jobs never the less. Pete plans to get on a course through his disability adviser to get 'ticket' in spraying/chain saw etc. If not, he may consider college.

Useful – Learning to think things through clearly and accurately - being able to deal with a depressed mood. Meeting people and learning new skills.

Work confidence questionnaire:

I am confident that I am able to work	5
I am confident that I will be able to find work	3
I am confident in my ability to manage my health	3
I am confident that work will not make my health worsen	4
Work confidence total	15
Timescale for returning to work	Immediate

Recalling the CMP, Pete said that the course had been helpful even though his brain injury made it difficult to get to grips with all of the concepts discussed. He referred to 'the circles' which relates to the CBT model of mood, thinking and behaviour and relates this to positive thinking particularly in relation to job interviews.

> "I think the skills that you showed us with the…if I remember rightly, with the circles…that really worked you know what I mean. At the time, with everything going around because I'm different the way I learn things – I take it home and let it slowly just get into me because of my head injury …but with the skills that you showed me and everything else…yeah, that really helped and you know what I mean. When you go for interviews don't be telling them this that and the other just be yourself and just if you want the job just show them that you want the job you know what I mean and just…basically be positive you know what I mean. Just be yourself." (Passage 43)

It is not evident that he used CBT methods specifically but they brought a sense of being supported and this gave him confidence. He appreciated advice regarding interviews though this was not a formal part of CMP or its method.

> "Basically you lose the skills because you've been to interviews before but you keep getting knocked back and everything else so you slowly use them sort of skills being confident and everything else like" (Passage 44)

When asked if he would have got a job regardless of CMP he replied:

> "Yeah! Yeah I would have done" (passage 56)

However, when asked if CMP had failed to help him, he added:

> "No, no, no it was helpful. I must admit it was helpful, yeah like you know what I mean, just reminding you of the skills you know what I mean it does help you…It geed people up you know what I mean cheer them up a bit and give them that bit of push and that's what they need sort of thing." (Passage 57-58)

Pete said that he enjoyed the social component of the programme but related that some of his colleagues were less motivated to find work.

> "Erm no because I've seen a couple of guys that were on the same programme as me and they're exactly the same – they're still on benefits yeah. Cos I think…yeah I bumped into them in town you know what I mean…erm but yeah, they…they haven't changed like…but…you don't get nothing for nothing sort of thing. If you want something and you got the drive, you go out there and find it. It won't come in time…" (Passage 48-49)

It is feasible that the group setting enabled him to compare himself favourably to his peers leading to confidence in his ability to compete in the job market.

Biography post CMP

Pete continued to seek work opportunities during and immediately after his attendance on CMP. After claiming IB for around six months, Shaw Trust found a temporary post for Pete cutting hedges for the local council. He was required to have a short break (from October to December 2013) in order to be employed on a permanent contract. He has obtained his own accommodation and has remained in this post for over three years.

Pete's account suggests that CMP was helpful but it is difficult to conclude that it was fundamental to his return to work. There is evidence of a strong work ethic. As such, CMP was unlikely to have

significantly influenced his decision to seek work. He described no change in confidence related to the likelihood of finding work or of his ability to manage his health. However, his account gives evidence to suggest that neither factor was relevant to his decision to seek work. In spite of scepticism about the availability of work, he immediately applied for jobs which was in keeping with his stated belief that work needed to be sought because it would not come to him. Ability to manage health lacked significance for Pete because he did not see health as a reason not to attend work.

Pete believed that he would have returned to work regardless of CMP. Though, he said that it was helpful and he may have felt encouraged in the group setting, it is reasonable to conclude that CMP was not a necessary intervention for Pete. This calls into question the programme concept and problem conception. Pete's health condition (situational depression) enabled his incapacity claim but it does not appear to be the *cause* of it. An accurate formulation of his incapacity might have concluded that he was depressed because of personal circumstances but this was not impacting on his non-employed status. He was out of work because of economic factors in South Wales and had relocated to Norfolk to find work. The most appropriate help for Pete was therefore advice on job availability and encouragement to keep applying.

Case Study 3 - Mick

Biography – Pre CMP

Mick is in his early-forties and lives with his long-term partner. When he attended CMP, he had commenced permitted work in a shop where he now is employed permanently.

Following school, Mick promptly obtained employment which was a source of pride. He had a series of jobs in his late teens and early twenties. He was a band-saw operator in a meat processing plant when, aged 22, he was diagnosed with Multiple Sclerosis. Unable to perform his role safely, he sought clerical work. He achieved an administrative role within a hospital but was again made redundant and he commenced a period of two years on incapacity benefits. Mick described being comfortable on benefits and was able to participate in his hobby of fishing. After two years, pressure from his mother and fear of being 'written off' led him to seek re-employment.

Mick became an administrator with a vehicle sales publication where he stayed for ten years before being made redundant. He sought work immediately being, by this time, a homeowner. His doctor diagnosed depression and advised him of eligibility for Incapacity Benefit rather than Jobseekers Allowance. Experiencing financial insecurity, Mick was grateful to receive the more generous benefit. Around six months after losing his previous employment, Mick obtained Permitted Work at a local supermarket and was referred to the CMP. During this period, his Incapacity Benefit was supplemented with the Return to Work Allowance due to his permitted work. The resulting financial improvement made job seeking less urgent for Mick and he continued to claim IB until it was withdrawn. He subsequently increased his hours of work. Mick revealed that he had already decided to increase his hours but, based on an assessment of his overall situation (socially and financially), he delayed this decision until it was necessary.

IPA Formulation

The initial analysis of Mick's transcript drew out 101 themes which were distilled into seven superordinate themes.

- Identity and value of work
- Health
- Optimism v distress
- Agency and control
- Risk/threat
- Insight and evaluation
- Organismic needs

Identity

Mick described how claiming benefits brought him into contact with other claimants who he regarded as socially undesirable.

> "It was so demoralising anyway and …(whispering) you see these people and you think God…the people, the state of these people, you think for God's sake. I don't wanna be here. I hope I get a job soon. I'd never been out of work…apart from when I'd been sick, I'd never been out of work for more than like six months in my work career. I thought, I hate this." (Passage 15).

Though Mick did not want to be associated with other benefit claimants, he identified himself in a victim role and conflated his experience (unfair treatment at the Job Centre and Atos Healthcare) with organisations facing cutbacks such as the NHS. He also blamed an out-group (immigrant workers) as an agent of injustice.

Mick defined himself in generally optimistic terms. He described a person with strong values and ideals. He took great pride in having a job and working hard.

> "There's no such thing as a free lunch. If you want something in life, you gotta earn it you know people aren't going to give you hand-outs. If you want something you gotta go out there and grab it and you ain't gonna get that without hard graft work and that's how I've always been brought up really. My mum and dad always worked you see so I've always been brought up in that environment." (Passage 32)

Employment was a source of pride:

> "I sort of had to go back to finish a couple of exams I thinks and they said are you coming down the city with us and I was, no, I've got to go back to work, yeah, yeah so that was good. I had my own money, I was earning my own money. I mean even back then I mean it was only fifty pound a week but…I tell you what, that pay packet in your back pocket, it used to feel bloody good that did." (Passage 41-42)

Other sections of the interview uncovered another side of himself that he sought to distance himself from (passage 52). He described himself as being a 'bugger' as a youngster explaining trouble he got into (Passage 29-30). He attributed this retrospectively to bipolar disorder but also readily accepts it as part of his character.

Optimism versus distress

Mick's determination to focus on positives permeated the interview. At the beginning, he described how he had passed five GCSEs adding that 'they weren't the best grades' and that his first two jobs hadn't 'worked out,' (passages 3-5). What might have been painful experiences were glossed over quickly in the interview. He describes a chronic health condition (MS) in optimistic terms:

> "I got the relapsing remission one which is the best one of the lot." (Passage 13).

On receiving this diagnosis, he immediately saw it as an opportunity to retrain in clerical work since 'the world was open to me.' (Passage 6). Mick's optimism and positive attitude could be seen as an extension and re-enforcer of his identity.

Control and agency

Mick does not dwell on misfortune but accepts it and moves on as best he can in the circumstances. Having set goals, he takes immediate and swift action to achieve them. On finding himself out of work for the first time in ten years, Mick's situation improved when his GP signed him off with depression enabling as incapacity rather than Jobseeker's claim. To some extent, this sat in opposition to his self-concept as a 'grafter' (passage 32) and he attributes agency for this to the GP:

> "I think, oh yeah that's it, that's what I done, I went to the doctors and said like I'm really, really getting down and that and then the doctor said I'll give you a sick note. I said, but the thing is doctor, I'm not working and he said well that will, that will…with the social security so that's what I did." (Passage 49)

The implication is that Mick's diagnosis was the gateway to the preferential IB claim rather than the precise *cause* of his inability to work. However, his previous insights made him aware of the hazards of not being required to provide sick notes. Mick was candid in stating that he could survive satisfactorily on his benefit income and that this discouraged job seeking.

> "I think because you're then…you're stuck…you're stuck in that rut when you're on benefit and…and you think…you're sort of comfortable cos I was living with mum and dad at that time anyway so I was not well off but you're sort of comfortable, you're getting by so you're not short of money because you're on incapacity because at the time then I was…I used to get like…cos the longer you were on it, the more you got whereas I think they call it ESA now or something like that. I was quite happy and then obviously, eventually after a while I thought …no I don't really wanting to be doing

this…I don't want to be like this for the rest of my life. I want to go back to work and I did." (Passage 14.)

The final sentences of this passage show how Mick had, during his previous incapacity claim, assessed his situation and decided to change it.

Insight and evaluation

This theme could be described as the cognitive component of Mick's sense of agency and control. Whilst quite separate to his self-concept, (Mick did not describe himself as insightful), he described a clear sense of himself in the world. He was keenly aware of tension between immediate relief from responsibility (the requirement to prove incapacity through sick notes) and being 'written off' as a person. This experience lead to an aversion to being out of work.

> "It feels like you're classed in that same boat as all the other people where you're classed as disabled, incapacitated whatever the case may be and it feels like at the time. I mean I was only twenty-three or something like that and they're writing me off…cos I got a thing from the social saying I don't need any more sick notes, blardy blah…and I'm thinking, they've written me off there. It's like I'm never gonna work again so that wasn't good so…yeah, so that wasn't much fun, not at all so yeah I didn't have a great time so obviously after two years I obviously decided then to do something about it which I did." (Passage 32)

These passages indicate the significance of personal insights on decision making. Once Mick saw his situation as unsatisfactory, he chose to address it. Throughout his employment, Mick described his occupations in the binary terms of 'nice' or 'not nice.' This theme was continued in his experience of benefit claiming and associated processes such as the CMP. Mick could be seen to evaluate his circumstances as favourable or otherwise. The criteria against which these judgments were made included financial or economic security but also the needs of his personal and role identity and other personal or 'organismic' needs. Mick seemed to recognise what was good for him and what was not. Pride, belonging and purpose are recognised and prized. Being written off was feared. Critically, he spotted the tension between them and, in his most recent period of unemployment, (prior to the CMP) he took immediate steps to prevent himself from falling back into the safety and 'comfort' of benefit claiming that he had earlier described.

Risk/threat

Mick was aware of the threats to his sense of security and was aware that benefits might easily be withdrawn. He described the process of medicals with Atos and the fear of losing benefits income.

He described his reaction to 'passing' his medicals (being deemed unfit for work) and the assessors being satisfied by his answers.

> "Answered all the questions. They seemed to be happy so my money was fine, there
> was no stoppage to the money…I weren't cut or nothing like that so that seemed to be
> okay" (Passage 18).

Mick was aware of risks to financial security. During his first period of long term ill health, he lived at home, had no financial worries and was able to engage with his hobby of fishing. After ten years working of stable employment, he had gained responsibilities including a mortgage. There was urgency in Mick's account when he was advised of his impending redundancy just before Christmas.

> "I was applying for jobs I didn't really want to do…but when you've got a mortgage to
> pay, you do whatever you can…and some of these jobs I was applying for they were
> really menial, really bad jobs but I thought they can fill the gap" (Passage 22)

Mick's urgency was based on an appraisal of his needs and was underpinned by his identity and need for control. This urgency emerged in Mick prior to engagement with CMP.

Organismic needs

In his descriptions of school life, previous jobs and of his current employment, Mick acknowledged his need to be appreciated and to belong. He described talking to customers and enjoying the social aspects of work.

> "I think its…sense of purpose…I'm getting my own money, I'm doing it for my own self. I
> think a lot of it is meeting other new people. You know, especially with the [shop], I
> mean, meeting different people and that and just talking to my colleagues and that and
> we all work really well as a team and it's just like the social aspect of it really Steve I
> mean it was the same thing at [previous employer]. We got the job done. We had a
> laugh, we had a joke and some good times there." (Passage 44)

Mick's need for social contact and for being liked predisposed him to working in a customer facing role. This, and his agreeable, nature made him attractive to employers in the role which he obtained.

Health

Mick was initially diagnosed with MS and later with depression. After CMP, he was given a further diagnosis of Bipolar Disorder. He described his initial response to his MS diagnosis as 'shock' (passage 13) but expressed a deep unwillingness to dwell on the negatives.

"Dad has been an inspiration cos he's been really, really quite bad cos he's got spinal
[injury] and he's on morphine but he's always kept busy. He says you've got to keep
busy because if not, you'll just sit in that chair and you'll get worse…and I think because
of what his outlook's been you never, you never and this is what people say about
me…you never, never hear him complain, you never hear me complain and you just get
on with it you know. There are people worse off than you. I haven't got anything
terminal you know so just accept it. A lot of the time now, a lot of the time, I don't even
know I've got MS. It don't even come into my brain…you know, I just get on." (Passage
13)

He spoke only briefly about symptoms and minimised the impact of his illness explaining that the
worst impact of MS was having to wear glasses. Noting that MS affects his balance causing him to
occasionally fall over, he said it was best to laugh about it. As such, Mick describes what might be
termed his relationship with his illness. He is aware that depression has led him to some 'dark
places' (passage 26) but it is not significant in how he sees himself. He describes forgetting that he
has MS most of the time (passage 13). His period of depression leading to his IB claim and
participation on CMP was described in situational terms.

"I got depressed I think because of the out of work business I think I do suffer with
depression anyway and I got very, very down and I think because I was out of work for a
little bit of time and that and to me out of work for that is a long, long while to me when
you been used to being at work for ten years…at first it's like a holiday you know and
then I think this…I'm starting to get a bit fed up now. There's only so much you can do
when you've done a bit of house work (laughs) you know." (Passage 25).

Mick's health was one of several personal factors influencing the likelihood of regaining
employment. The interaction of these factors, alongside financial imperatives, the availability of
work and his suitability for it inclined him towards employment.

Impact of Pathways and CMP

On commencing CMP, Mick no longer indicated case-ness for anxiety or depression on HADS. He
was favourable about CMP in terms of his personal response to it. In particular, he explains how an
'ice-breaker' exercise reminds him of positives in his life:

"I know one of the things if you remember, we had that time when we had to say – one
was a lie, one was a big thing in your life, an achievement in your life and one was what
you'd like to do if I remember rightly and that was actually quite good because like when

I do feel a bit bad I do look back and what keeps…and that always brings a smile on my face" (Passage 46).

HADS Initial	HADS on completing CMP
Anxiety – 9 (mild)	Anxiety – 4 (non)
Depression – 2 (non-significant)	Depression – 2 (non-significant)

At his exit interview, the following summary was provided to Shaw Trust:

Plan: Return immediately - increase hours initially from Permitted Work to Part Time then Full Time.

Most useful aspect of the course: CBT model and feeling positive about achievements. Enjoyed meeting other people and getting to know them.

Work confidence questionnaire:

I am confident that I am able work	4 (more confident)
I am confident that I will be able to find work	4 (more confident)
I am confident in my ability to manage my health	4 (more confident)
I am confident that work will not make my health worsen	4 (more confident)
Work confidence total	16/20
Timescale for returning to work	Immediate

Biography – Post CMP

Mick continued to claim IB with additional Return to Work allowance until his claim was cancelled by Atos after he failed to attend an assessment due to a holiday commitment. He described anger at the manner in which this transition was handled but acknowledged that he was planning to increase his hours at the supermarket and he was able to do this without delay.

"Luckily, they've stopped my money but I'd already got my extra hours at work so I think secretly…secretly I was going to come off ESA anyway." (Passage 19)

At the time of the interview, Mick had been diagnosed with Bipolar Disorder but remained employed by the supermarket.

Case Study 4 - Irwin

Biography – pre CMP

Irwin is in his mid-forties. He lives with his wife of two years and his two children (age 6 and 8) from a previous relationship. He is a former IT engineer who stopped working in 2008 with work-related stress. He has not returned to work.

Having gained 8 CSEs, Irwin worked in mainly manual based jobs in London. He achieved supervisor status on one role before finding an office based job. After this firm closed, he re-located to Norfolk close to his parents. In his early twenties, Irwin spent periods of time unemployed, on training courses and in short term jobs before settling in work with a major employer who provided IT support to government functions. Irwin found this role stressful due to workload and organisational practices that he disagreed with. His long-term partner struggled to deal with the demands of childcare. In 2008, he suffered a breakdown related to stress at work and he experienced profound symptoms of anxiety and, to a lesser degree, depression.

Irwin undertook the 'original' CMP course choosing the managing stress, anxiety and depression modules.

IPA Formulation

From the initial analysis of Irvin's transcription, 145 themes were identified and subsequently arranged into eight subordinate themes.

1. Identity
2. Stress
3. Health and capacity
4. Capability and function
5. Fear
6. Avoidance
7. Control
8. Reflection and insight (superficiality v depth)

Central to Irwin's experience is *stress*. He describes in detail how he succumbed to the joint pressures of work and home. At work, he experienced stress brought about by an intense workload but also by less obvious factors such as working practices, favouritism and unprofessional financial relationships between managers and staff.

> "Yeah I actually went downhill and then a lot of things went on at work. …I got blown
> out on a couple of promotions even after I'd taken some certain exams for them and
> taken CISCO exams so I was qualified CISCO network and they blew me out of a couple

of promotions at that point and that sort of that sort of just tipped me over the edge...that sort of just...it was really weird. I didn't realise what was happening until...I can actually remember driving home from work one evening and I was sitting at a set of traffic lights and I thought to myself...you know I was just sort of thinking about the fact that (child) was due in January and I was thinking to myself, I'm not happy. I'm not happy about it...I was just sitting in the car at the lights...I'm just not happy you know I'm not happy about...and from that it just (whoomph noise) everything just went...and by the Monday I was sort of...my doctor had signed me off...sort of low mood and that...and everything just sort of went from bad to worse for six months you know I wouldn't go near a computer, I was curled up in a corner" (Passage 24).

Stress impacted on his home environment and finances and in his mental and physical health. *Identity*, relates to his sense of himself, how he relates to others and how he made meaning out of his stress. Sub-themes making up identity included judgement and being judged or believed to be genuine, illness identity and adoption of the 'sick role,' and a sense of injustice, criticism, unfairness and resentment.

"Because of the way my mind was working, I always thought well people aren't going to believe me because it's not physical because you can't see someone with depression you know it's not physical, you can't see it...a lot of people don't consider that sort of thing to be classified as an illness. I mean if you're walking around with a busted leg, people can see you're on crutches and plaster cast but they can't see if you're walking around with damaging thoughts in your head, they can't see that... you think well, am I pulling a fast one? Cos you have a good day and you think, maybe I am alright, maybe there isn't anything and...I had to accept it as well but initially, it did feel like I was trying to pull a fast one and things like that with the benefits and when you did have the occasional chat with them or deal with them ...you know it always feels like...they never believe what you say...the benefit people or when we went up, the couple of times I went for an assessment at erm...Duke Street you know the Atos people. Before Atos went there I had a couple of assessments there as well and they always sort of make you feel like you're giving a load of bullshit" (Passage 51).

Stress impacted immediately on his health and capacity to work. In the longer term, it created further anxiety (fear). Health and capacity relates to his experience and evaluation of his physical and mental state. Linked to health and capacity is *capability and function* which describes occupational abilities and limits. Capability and function can be seen as behavioural or occupational

consequences of health and capacity. What Irwin was capable of accomplishing in practical terms was partly a result of his health but also a reflection of how he saw himself. Examples include loss of agency, passing responsibility to others such as his doctor, seeking support from others, isolating and identifying 'escape routes' in social situations. These effects contributed to Irwin feeling a sense of powerlessness and subsequent loss of agency.

> "All I could see at the time was me going down a hole…90 percent of the time back then, it was like there was a plug hole and I was just going sort of (sucking noise) straight down it, yeah. It just felt like that all the time. The idea of peeking over a fence to see what's going on behind it…no…I just wanted what was there sort of thing to make my little area." (Passage 62).

Loss of agency was reinforced by re-experiencing distressing emotions including trauma. He described how, during his CMP, he applied for a job but was unable to continue the application when faced with the requirement of putting his former employer down as referee:

> "I was getting terrified … they would be contacting [former employers] would give me a bad reference and I was absolutely petrified of that so I never finished the application… I just couldn't finish it." (Passage 86).

This reaction is consistent with trauma associated with bullying. For Irwin, fear is described as 'terror' (Passage 74) at the thought of returning to a work environment which had contributed to his original absence.

> "God knows what would happen if I got put in that situation. I don't know what way I would turn or what way I would go." (Passage 73).

Irwin is quite clear that his fear is of the *workplace* rather than work itself.

> "You could say I've had a scarring experience in the IT industry and the idea of going back into an IT environment…wouldn't touch it and then maybe if I went to a company and I was shown round and got to know people before and sort of thing maybe it would be a different situation. It's all about…for me it's all about the people that you're stuck in the office with." (Passage 84).

He fears further stress which leads to two superordinate themes: *avoidance* and *control*. Avoidance refers specifically to the workplace but also to less obvious features such as isolating, reducing social contact, ensuring he has an escape as well as cognitive denial, distortion and avoidance of painful thoughts and emotions:

"I just got that sort of feeling that if I do go back into one of those places, you know going into something like that then…you know six months down the road I'm gonna end up back at square one…the main thing is when I start working, I tend to put myself into it. If I start a job…I believe if you're going to do a job then you're going to do the job. You know, you don't do it half-arsed. I know full well that I would go back to work. I would do it, I would end up doing the hours, the overtime and everything else that comes along with it and I could just see myself six months down the road crashing out again whereas if I'm in the position where I can control the way I work and the hours that I work sort of thing but if I was put onto JSA and forced to look for work and that I wouldn't be able to fund…doing work for myself cos…we haven't got the financial backing to do it…We're getting by… If I was in a position where I had no other option then yeah I mean I'd try and go back to self-employed as opposed to going into any office environment basically nowadays…you know, the idea of being stuck in an office or in a building with anyone for 8 hours a day…you know every day, six… five days a week doesn't appeal.   If I have control over my hours, sort of go out and actually go out to meet customers or have customers come to me but set the hours…" (Passage 75-76)

Irwin presented with anxiety. The explicit programme theory suggests that his anxiety was a barrier to employment and that ability to manage anxiety would remove or reduce this barrier. However, this description gives insight into *Irwin's* sense of his anxiety. He is fearful of the office environment due to his past experiences which led to avoidance. This suggests that he might have benefited from specific advice regarding this precise fear rather than broad CBT for generalised anxiety. He suggests that he might have managed the transition into work had he been helped to get to know the environment and his colleagues.

In the passage above, Irwin's describes his anxieties but indicates that he was functionally capable of working, even doing overtime. He considered how a return to work might come about:

"I think it would have been it would have been more than anything, finding a place that I actually felt comfortable I mean…there's not a lot…I mean most of your job search is done solitary…you know you're sitting in front of your computer doing your job search or something like that. There wasn't somebody actually sitting down beside you with a list of jobs or something like that saying well how do you feel…you've done this in the past, how do you feel about doing this sort of thing, do you think…you know, having…if I'd had somebody sitting down with me sort of talking to me about the jobs that were available…sort of saying, well you've done this…you know do you, you reckon you could

do this again you know sort of talking to you about sort of even quite possibly you know getting on the phone to somebody at these places and sort of talking to the people before going into it. That sort of thing may well have…helped." (Passage 83)

Control refers to the range of behaviours aimed at ensuring that he does not have to return to the workplace and its associated feelings of re-trauma and distress.

"I never considered the idea of not going back to work in the long term…I figured I'd be out for sort of maybe six months something like that would do. When I got onto your course, I thought maybe another few more months or whatever cos I'd started doing photography you know…the idea of not being in working again wasn't something I'd even contemplated." (Passage 67).

This suggests that Irwin drifted into, what he regards as permanent non-employment. This challenges the conception that ill-health was Irwin's primary barrier to employment. The *drift* might be defined as *waiting for a decision to end a claim*. It is apparent that Irwin did not consciously *choose* to become a long-term incapacity claimant. However, a *conscious decision* was required for him to regain employment. For Irwin, addressing anxiety needed to be done in the context of a decision to return to work. Such a decision might require a candid, rational assessment of all relevant factors. Had this been undertaken, he might not have put off his decision to return to work for a few more months.

By the time Irwin commenced CMP, he was suffering with stress and anxiety and was, at that time, functionally incapable of working.

Impact of Pathways and CMP

Irwin described his initial reaction to CMP.

"Well I was when I got to your place I mean…I remember sort of whenever we was trying to go into the rooms I was always the one that was next to the door cos I can remember you asking and I said it was the easiest way to get out…I needed the door there to get out cos I wouldn't stay in the room otherwise…with like 10 or 12 people in the room, I wouldn't stay in there" (Passage 27).

By the end of the programme, Irwin had grown in confidence and presented in much brighter mood and his HADS score outcomes reflected this improvement.

"The course had sort of helped me sort of bring myself back up…put me into…I was able to sort of start thinking about things more logically and try and control that downward

spiral…erm…from that it sort of helped me work towards that although it didn't…didn't solve the problem but gave me the sort of tools to cope with the problem… Yeah I was I was in a much brighter place when I came out of there so it did help in that respect, yes" (Passage 3-4).

In terms of the explicit programme concept, the CMP achieved its aims for Irwin. However, in spite helping with anxiety, he felt that it had not impacted on the root cause of his problems.

"The materials that we got on the course…the information you gave us did help…it helped to manage it but there wasn't actually anything that I can remember that went into the side of actually trying to fix the issues. I mean from what I can remember it was sort of…you had to try and sort of control it when you went down that spiral and things like that …trying to do the different thinking but it wasn't sort of well what could you actually do to bring yourself out of it and sort of fix the actual issue that was going on there." (Passage 1)

The rationale for CMP was provision of skills for *management* of conditions rather than cure. Irwin's response indicates that it had been effective to this extent but overall, it fell short of dealing with his difficulties.

"You went to the course for three months, you put a band aid over your issue, you know, got the tools, learned how to sort of try and control it but there was nothing there to sort of get to the root to deal with what had maybe caused it or where it sort of…had it been something that had been underlying for years…I think it might have been more helpful to have something that sort of delved in a bit deeper to where you was sort of…I know from myself when I was there, there was things in my mind that I didn't bring up to the group…you know, they were personal things and that…but…maybe if you'd been in the one to ones really delving into those things would have brought up…and that could have made a difference" (Passage 95-96).

CMP helped Irwin with symptom relief for anxiety and depression but did not help him to solve the 'issues' which were the main barrier to employment. Irwin's comments indicate that CMP's generic approach fell short of his needs suggesting that individual contact, specific encouragement and assistance with job searching may have helped. Whilst he recognised areas where CMP was helpful, Irwin was less generous about the wider Pathways support.

"I done all the InBiz and stuff like that came through from the Shaw Trust so they sort of gave me gave me bits and pieces to sort of go in the right direction and that…and I think,

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I don't know, I went back to them about a year later…and got some more support from them for something else to do with the photography. I think they signed the paperwork so I could keep permitted work or something. Something like that…but yeah I mean basically, Shaw Trust didn't have that much, after we came away from the Condition Management." (Passage 81)

Irwin describes how he left work initially due to stress at work which was expressed through anxiety and avoidance. He improved significantly in mood and learned skills to manage symptoms but remained vulnerable to re-trauma and was thus avoidant and unable to follow job applications through. He indicates that returning would have been possible if he had been assisted more actively with job search and in making initial contact with employers. It cannot be said whether Irwin would have sustained long term re-employment if such interventions had been available but it appears that CMP and Pathways missed an opportunity to understand his needs fully and offer specific support.

HADS Initial	**HADS on completing CMP**
Anxiety – 15 (severe)	Anxiety – 6 (non)
Depression – 9 (mild)	Depression – 3 (non)

At his exit interview, the following summary was passed on to Shaw Trust:

Plan: Complete photography course and go self-employed as photographer. Irwin appears more positive and work focussed for future employment prospects. He is putting skills to use and seems more confident in himself.

Irwin undertook the 'original' CMP. At this time, Work Confidence Questionnaires and return to work timescales were not sought.

Biography – Post CMP

Irwin immediately set himself up as a self-employed photographer. He described it as a mixture of hobby, potential long term employment and as a way of 'treading water.' He said that he thought he would continue to claim incapacity benefit for another six months or so while the photography provided a form of ongoing therapy. The expression 'treading water' resonates with the concept of absence of a decision to act. In terms of its stated aim, CMP had been effective for Irwin but it did not prompt a decision to capitalise on improved health. This may have been because he accurately re-appraised his situation and decided to maintain his existing benefit status. Alternatively, the programme may not have offered sufficient opportunity to consider this possibility. Irwin attended the 'original' CMP in which the nature of non-employment was explored in less detail than

subsequent versions. Another possibility is that other factors (social and financial) inclined him against a decision to act in the short term.

Irwin admitted that, financially, his situation was rewarding. He could claim permitted work for his photography which supplemented his standard incapacity benefit income. Additionally, as he had obtained employment, he was able to claim the £40 return to work allowance which was part of the Pathways to Work incentive package. Irwin described the period after CMP as an opportunity to continue his 'recovery' without the stress of returning to 'normal' paid employment.

During this time, his personal circumstances worsened and his relationship faltered resulting in him looking after his children full time and putting the photography business on the 'back burner.' Having been in IB for six years, he described his current situation:

> "I tend not to think too much about where I'm headed or where I'm going cos I mean I
> still have a few…if I sit down and think about where I'm going, I tend to start dwelling on
> where I've been as well as where I'm going and I tend to start going down the route of
> my own mortality which is …and I sort of start to think to myself you know what's going
> to happen and how I'm gonna and what's going to happen with the kids and that…so I
> sort of tend to run through day to day like rather than sort of dwelling on the past"
> (Passage 30).

Irwin feels certain that he will not return to work and though his lifestyle is limited, he is able to cope financially. He has reduced his expectations to focus on his day to day demands of looking after his children and ensuring there is enough money for food and basic necessities. Irwin's current situation might have been avoided had he capitalised on improved health by the end of CMP. He asserted that the programme had failed to address deeper issues that impacted on his stress and anxiety in the workplace. It is also possible that social and financial factors reduced the likelihood of a decision to act after attending CMP. It is not possible to say if either of these explanations caused his drift into permanent incapacity. Irwin revealed that work remains theoretically possible for him but it is reasonable to say that he has currently decided that work is not something he will pursue.

The explicit CMP concept was relevant to Irwin in that the programme helped him to overcome anxiety in the short term. However, generalised anxiety was one of several factors that made him fearful of returning to work. The programme failed to address his traumatic experiences in previous employment and his consequent fear of the workplace. Irwin's need to avoid further traumatic, workplace stress was expressed in the theme of *control.* The structured and condition focused 'original' CMP did not provide a platform for him to express or challenge his specific fears. Irwin

stated that he had not intended to remain on incapacity benefits and that he would, in theory, be willing to consider returning to work. The CMP did not challenge his avoidant behaviour and, as such, could be said to have failed him.

Case Study 5 - Marianne

Biography – Pre CMP

Marianne is a mother of two in her mid-fifties who regained employment as a nursery assistant after her participation on CMP. Beforehand, Marianne trained then worked in nursery nursing for around thirty years. She had short breaks from this when she worked briefly as an assistant to a dental technician and when she had each of her two children. Marianne was diagnosed with ME after she developed fatigue related symptoms and a flu-like virus. This followed a period of intense stress in her personal and professional life. Her marriage failed after her husband relapsed into chronic alcoholism. She also held a demanding job as a nursery manager and had been undertaking significant professional training. In the period prior to CMP, Marianne lived partly in the UK and partly in Italy where she and her husband owned a second home. She described herself as an active and determined woman who had tried hard to find a solution to her ME. She presented for CMP with anxiety but her HAD Score worsened slightly between assessment and exit interview.

IPA Formulation

An IPA analysis of the interview transcript produced 41 sub themes, which were divided into five superordinate themes:

- **Autonomy**
- **Identity**
- **Stress**
- **Circumstances**
- **Threat**

The pairing of autonomy and identity refer to the concept of *who* Marianne is, how she values and protects her sense of herself. *Autonomy* describes how she approaches life with a sense of determination and agency. This included her decision to pursue professional training prior to becoming ill.

> "Yes because we were married for 23 years and 16 years were good but really... This was partly why I was studying…I thought I can't support these children. I didn't know what might happen with my husband. He could have just completely…I don't know…fallen apart…you know just gone completely downhill and not earned any money or anything and I couldn't see how to support myself because I just didn't earn enough money so that was why I started studying..." (Passage 24)

Marianne expresses her identity in terms of characteristics which she values, most notably as a positive thinking individual and a strong character. She experienced joy easily and could experience life with a child's sense of awe.

> "I think very outgoing, I do enjoy life and I think I was the same then. I think that when you work with children, everything is new and bright and amazing. You see all the magic in nature and everything really so you really appreciate life and I think now I'm back to that." (Passage 19)

Marianne regarded herself as a fit, capable person with a positive attitude to life.

> "I did actually start dancing again…it was it was a very good form of therapy because you go to a dance and you can dance as much or as little as you want. You can just do the slow numbers if you want but particularly I was feeling better because I was working those muscles and actually getting fit. So you can be ill and fit so you know physically fit." (Passage 35)

She was self-determining and adept at evaluating her situation and making decisions accordingly. Her ability to appraise her situation accurately can be seen as part of the decision-making process involved in either remaining on incapacity benefits or leaving them to seek employment. Marianne found her situations at home and work increasingly stressful but her sense of autonomy and independence led her to persevere despite this. Marianne became physically ill due to burnout.

The second cluster of superordinate themes are formed from circumstances around her, stress and threat. She tried to overcome her illness but discovered that her efforts made her worse. Realising she would be unable to work for some time, she commenced her claim for Incapacity Benefit. In a position of dependency, Marianne felt threatened by the ever-present risk of losing her benefits.

> "That was horrible…because every year you would get this letter to say that you were going…you've got to go and see the local adviser and that was always huge, hugely traumatic because at any point they can stop your money" (Passage 46).

She described a need to persuade others (in particularly the 'authorities') of her illness which may have contributed to a 'sickness identity.'

> "Yeah, and that was a major concern because you know you had to make out you were really that bad and you knew yourself, if you could work you would be working…because you know you don't want to be in that situation so you know you must know yourself that you can't do it so you've got to get through that first test and then you go for the

medical and, I mean, the questions they ask you…(sigh) I don't know…I always found it very difficult. I mean the one that I felt that I performed the best to keep the benefit…was when they chucked me off. Really strange…" (Passage 85)

Relief at securing ongoing benefit receipt re-enforced the cognition of threat whilst distracting from the need to focus on recovery.

"I think it is because, as we were saying, you have to say how ill you are to keep the benefits which is constantly reminding you that you are ill and you need to concentrate really, to get better you need to concentrate on the good things and the positive bits of your life and I think managing your illness, you know, working around it. What *can* you do? Not what *can't* you do all the time. So I think in that respect, it's bad for you" (Passage 97)

Marianne's insight describes how a component of her illness emerged as an effect of claiming. This highlights the complexity of the concept of illness and runs counter to explicit programme theory for CMP: that illness causes incapacity and ability to manage illness enables return to work. CMP offered the opportunity for participants to reconsider their claim in light of insights gained from course content and other participants.

Emphasising the need to influence benefit assessors, Marianne acknowledged that the period between medicals gave her the opportunity to manage her health. This illustrates the tension she experienced between the desire to be well and the need to maintain stability (by ensuring non-recovery from the health condition) through an ongoing claim.

"Usually you have a year between medicals and things so for the rest of that year you can be positive and do as much as you can to make yourself well so…and I think that's what you need to do and because yes it's just…I don't know how they get around it because obviously there are people who claim it that shouldn't be but for the people that need it…" (Passage 106)

Succumbing initially to stress and then experiencing additional pressure were threats to her sense of capability and independence. Illness became important as a means of maintaining identity and negating the risk of losing benefits. The initial illness (ME) improved. However, a secondary stress-related illness emerged from the tension between threat, autonomy and identity. This produced anxiety and, as the anxiety became sustained, resulted in depression. Anxiety and depression then sustained the conception of being ill.

Impact of Pathways and CMP

Marianne was unclear about how she came to attend CMP and was not favourable about Shaw Trust, though her recollections are limited.

> "I think basically they were trying to look at how I could get into work but as I said before...people have tried – I have tried thinking about what I could do...nobody ever came up with 'why don't we go down this route and try this!' I would have been by that point interested in doing some re-training thinking that I would never be able to work with children... but nobody ever really suggested anything" (Passage 76).

Marianne was more positive about CMP pointing out that it helped her to deal with the anxiety caused by uncertainty over the security of her benefit status.

> "They suggested it to me and I mean I was happy to do anything that might help because you know I was desperate to get better you know and it helped a lot with the anxiety... which basically had come about because of the claiming – being on benefits because it's just so stressful. It makes you ill being on benefits ...It's just awful, it really is" (Passage 78).

Marianne acknowledged that CMP had been helpful but principally for managing the anxiety brought about by being an IB claimant. Her original illness remained untouched:

> "It helped with the anxiety and things...but I think I remember at the interview at the end I think I remember saying to you that my problem *is* that...because I mean a lot of the time, I could cope – you know I could cope with stress and I managed to get rid of most of the depression as well so, although it was really aimed at helping those, my *physical* problem was still there...and that was really the problem so...yeah that hadn't really changed" (Passage 102)

In spite of Marianne's recollections, her clinical outcomes indicate worsened anxiety.

HADS Initial	HADS on completing CMP
Anxiety – 13 (moderate)	Anxiety – 16 (Severe)
Depression – 8 (mild)	Depression – 9 (mild)

At her exit interview, the following summary was provided to Shaw Trust:

Marianne has done well to attend all the sessions given her variable energy levels. She contributed well to the programme and engaged well with the course and with her colleagues.

She is confident and capable dealing with people. Marianne lacks confidence that her ME will not worsen and this is frightening for her. A gradual increase in activity is recommended. She remains susceptible to free floating anxiety.

Plans - Marianne is concerned about her energy levels - she found long days difficult. Her lack of confidence is based on whether she could manage 4 hours per day. She would like to try working to see how much she could do (up to 4 hours per day) e.g. a work trial 4 hrs x 3 days per week. Would like to do maternity nursing - would like to do seasonal work.

Most useful aspect of the course – Relaxation techniques, techniques to stop negative thinking (distraction). Meeting other people was helpful and the chance to reflect on life and self.

Overall - Marianne feels less depressed and anxious but needs to work on her ME and energy levels. She is nervous about her RTW but is willing to give it a try. I suggest in-work support.

It is noteworthy that Marianne was seen to have taken the opportunity reflect on her 'life and self.' This process is in keeping with the implied programme theory expressed by practitioners in Chapter 7. Though her anxiety worsened and she expressed less confidence about her ability to work, this may not mean that the programme failed for her. In her insight, she appeared satisfied that her best interests would be met by continuing her claim.

Work confidence questionnaire:

I am confident that I am able to work	2 (less confident)
I am confident that I will be able to find work	4 (more confident)
I am confident in my ability to manage my health	4 (more confident)
I am confident that work will not make my health worsen	3 (no change)
Work confidence total	13/20
Timescale for returning to work	3 -6 months

Biography – Post CMP

Marianne continued to live partly in the UK and partly in Italy. The frequent moves made it difficult for her to remember precise timescales but, at some point after completing CMP, she commenced permitted work as a cleaner which she found enjoyable. Her health began to improve but she lacked confidence in her recovery and feared her benefits being withdrawn. Marianne reflected that she had enjoyed her time on CMP but it had not been fundamental to her recovery. She attended (and paid with her own funds) the 'Lighting Process,' a brief residential course which aims to provide control over acute stress response (Parker, 2017). She noted that part of this process may have

been her own investment of money and energy and questioned whether it would have been so successful had it been funded by another organisation.

> "I did enjoy doing it and enjoyed being there and meeting those people so that was a positive always and learning some of the coping with anxiety was really useful – as I say it didn't get to the nitty gritty so yes it was very useful. Too short. After I'd done the lighting process which was even shorter, I did start thinking about you know really we need to set up a charity or something to pay for people to do this …but then I really got into thinking would that actually work? Had someone actually given it to me on a plate…would it have worked for me or would I have not gone into it as whole-heartedly as I did? You really do have to go in and trust that this is going to be the one that works." (Passage 113).

This insight raises the question of decision-making and ownership. Marianne was not placed on the Lighting Process, she chose to attend and invested her effort and money into it. This suggests a *decision* to act in response to her assessment of her situation. CMP was voluntary though some participants may have felt compelled to attend by their employment advisers (Corden and Nice, 2006a). Marianne's own experience and her opinion about other claimants suggest that people would only make use of a programme if they believed that it was in their best interests, made the decision to participate and were motivated to make the most of their investment. These factors did not form a part of the explicit programme concept or implementation theory.

On completing twelve months of permitted work, Marianne had to choose between ongoing employment and resuming her claim. She opted for the latter but, shortly after, her benefits were withdrawn. Before learning of this, she read a newspaper article about an ME sufferer who discovered she was Coeliac and whose health improved dramatically following diet change. Marianne tried the diet and became immediately confident that it would result in a cure. On discovering that her IB had been withdrawn, she sought employment confident that her new diet would help her to manage her health.

Five years and ten months after commencing her claim, Marianne resumed work at a nursery. Her health improved rapidly and she sought further opportunities to work in order to gain Working Tax Credit. Marianne continues to work with children and describes herself as being back both to full health and to her old self.

It is not possible to say whether Marianne's health would have improved so quickly had her benefit claim not been cancelled. What can be said is that the decisiveness of her subsequent actions

(finding work) were in keeping with her proactive character and her ability to assess her situation and act decisively. Marianne's initial illness was ME though she also suffered with anxiety. CMP was appropriate for anxiety (which she acknowledged) but offered no specific help for ME. As such the explicit programme concept was of limited relevance to her. However, the alternative programme theory inferred from practitioner accounts which suggests that the programme enabled rational re-appraisal of best interests may have been relevant in this case. Marianne's account demonstrates a keen awareness of her situation and decisive action in response to changes. Her belief that three to six months were required after course completion suggest a decision against an immediate return to work. It is possible that, having considered her health and circumstances, Marianne made a rational choice to maintain her incapacity claim.

Case Study 6 - Alistair

Biography – pre CMP

Alistair is a former financial services operative in his mid-fifties with a long history of fatigue related illness. He left school after A-Levels and remained with one employer for 32 years before taking ill-health retirement due to Chronic Fatigue Syndrome (CFS). His last attendance at work was five years prior to this. Between then and his retirement, Alistair was supported initially through sick pay and later through his employer's Long Term Disability Scheme (LTD) which paid 55% of his salary. This was, at different times, either reduced or enhanced by the sum he received in Incapacity Benefit. Throughout this period, Alistair periodically came into in dispute with his employers when the validity of his sickness was checked via independent assessment.

Following a review in 2009, Alistair's employers told that he was fit to work but did not have an appropriate position for him to return to. He remained absent from work claiming IB only. During this period, he was referred to Shaw Trust. Having already had some sessions of CBT through his GP surgery, Alistair was pleased to be accepted on to CMP.   At the time, he was appealing against his employer's decision to withdraw his LTD payment. When he began CMP, his symptoms were fatigue, physical weakness, headaches and low mood with frequent tearfulness.

IPA Formulation

Following the initial analysis of Alistair's transcript, 83 themes were originally identified. These were grouped into ten superordinate themes.

- **Assertion/Tenacity/ Determination**
- **Believed/judged/justice**
- **Identity**
- **Anger**
- **Control**
- **Perceptiveness**
- **Conflict**
- **Illness and health**
- **Narrative of victim and survivor**
- **Relationships and relating**

Alistair differed from the other case studies in that his financial relief was paid in part by his employers. He claimed IB only when his employer's policy demanded this to subsidise their payment.

By the end of his employment, the impasse between Alistair and his employers boiled down to whether Alistair's incapacity was to be believed. Alistair described becoming entrenched in conflict with his employers who, he believed, doubted his illness and sought to dismiss him.

> "I felt pressurised into agreeing with them that I was fit to work…that's what they
> wanted me to do but I was standing my ground…I wasn't going to be pushed. I wasn't
> going to be manipulated into a position where I knew that they could just dismiss me.
> I could see what they were trying to do. (Whispers) getting angry again now. (Laughs)
> I've got my arms folded, I'm getting angry." (Passage 62)

Alistair's identity is informed by his experience of ill health. Because his illness was questioned, it became closely tied in with a sense of moral righteousness; to disbelieve his illness was to attack his whole sense of himself (identity).

> "I didn't feel pressurised or anything and I was fine to go along to the Shaw Trust to
> see how that could help…and the bloke that I saw at Shaw Trust, he was fine…Martin…
> yes Mr Martin, that's what we called him…I can't remember very much about the
> content of the meetings that we had but I just felt that he didn't judge me, that he
> listened to what I had to say…yeah I felt quite accepted by him." (Passage 47).

His narrative of victimhood and ultimate victory strengthen his sense of righteousness. To protect his identity, Alistair exerted control over his situation as best he could. The recurring theme of tenacity illustrates the ego strength required to defend his identity.

> "Oh yes, I think… the course actually confirmed probably…a lot… the type of person
> that I was anyway…both my wife and myself can be very stubborn when we know that
> we are right…[wife] said 'I wouldn't cross with you – I wouldn't mess with you!'"
> (Passage 65).

Anger was a means by which he exerted control over his situation and protected his identity. Tenacity describes the energy with which this dynamic was enacted. His intensely angry response to threat appears to justify his moral standpoint (I *am* enraged therefore I *am* being treated unjustly). At the heart of the formulation is control. Control and illness here are closely linked. Illness is not just an effect of living but also a means of asserting self and therefore remaining in control.

Impact of Pathways and CMP

HADS Initial	HADS on completing CMP
Anxiety – 5 (non-significant)	Anxiety – 2 (non-significant)
Depression – 1 (non-significant)	Depression – 1 (non-significant)

At his exit interview, the following summary was passed on to Shaw Trust:

Alistair found putting the skills into practice ok as he had some awareness of them previous to the programme. Since the end of the programme, he has been putting them into regular practice and is now reaping the rewards of this.

Work attitude - The client is still keen to work and would like to pursue work with people who have a similar condition so he can help them. Currently he is waiting for resolution from his current workplace which should occur in the next few weeks before moving forwards.

General attitude - Alastair is more positive and is taking time out for himself allowing himself to be less stressed as a result. He has been employing his assertiveness skills which has increased his skills in managing situations and reducing stress.

Alistair wrote:

Fears:

Would I be able to last the course? Will my physical symptoms get worse? Would I be able to share experiences of others and to learn from them? Will I be accepted for who I am by people who care and understand about my condition?

Skills - I have felt a great deal of encouragement and have high hopes for the future.

Work attitude - I feel better prepared to stand up for myself. I recognise that change is inevitable and feel more able to cope with it. A large proportion of my day will be spent at work so I need to ensure that it is right for me!

Alastair undertook the 'original' CMP. Work Confidence Questionnaires and proposed timescale for obtaining were not sought.

Alistair alluded to the benefit of the group and of skilful facilitation being important factors in the delivery of CMP which was advantageous over self-help. He suggested that both the content and the style of delivery (group facilitation) were important for successful delivery:

> "I think getting myself there and being with people wasn't a major problem…I was
> quite comfortable doing that but going through the course…the strategies and
> everything…the content, it was good to sit down and do it in a structured way. I think
> it always helps having somebody lead you through it as well and also to hear other
> peoples' experiences, their problems, their successes and you realise that actually,

you're not the only person to have ever felt like the way you felt…that's a massive

boost…and there were no right or wrong answers. There was no judgement. I felt

completely accepted for who I was…by certainly yourself and…was it [Sonia]? …We are

the way we are and that's the way we are and we're here to try and get better so…"

(Passage 75).

Alistair acknowledged that he had already learned some helpful psychological skills but he alluded to

relaxation skills being particularly helpful for dealing with his feelings of anger and resentment.

"I was doing them beforehand but…ah, there was one of the sessions that you started

off with a breathing exercise and there was just the two of us and I thought oh…cos I

normally would get into the day and then do some of these exercises late morning,

early afternoon or whatever and this was like an early morning session and I thought,

this is wonderful, I must do this more often – get up and do my breathing exercises

(laughs) and so…I knew it worked and it definitely helped get through that frustration

and anger and annoyance and rage with the [employers] because …that's what it was!"

(Passage 83)

This passage suggests that Alistair's primary motivation for using CMP was to learn skills to help him

deal with emotions related to his employers rather than to managing a condition for the purpose of

returning to work. He was aware of his needs and made CMP relevant to him.

Biography – Post CMP

Shortly after CMP, Alistair's appeal was upheld and his LTD pay was back dated. His employers, at

this point, omitted to deduct his IB payment from his ongoing pay so he could claim both his LTD pay

and IB. He ceased considering alternative employment at this point. It is impossible to predict

whether Alistair would have been able to overcome the functional impairment brought about by his

primary illness (CFS) and sustain employment if financial imperatives required it. Alistair stated that

this would have been his intention which suggests that his decision whether to seek employment

was a direct response to his circumstances rather than to the extent of his illness. This implies that

the programme concept was not appropriate to Alistair's needs.

However, the problem conception summarised by Smith (2002) did allude to IB being used for some

as a route into early retirement. At the beginning of 2011, Alistair was re-assessed and declared fit

for work again. A considerable portion of the interview was given over to his account of the conflict

with his employers over his fitness or otherwise to work. The matter was complicated by his length

of service and pension arrangements in the event of ill health retirement. Alistair employed a

solicitor and took out formal grievances against both his manager and human resources and was eventually granted retirement on health grounds with an extension to his LTD scheme to take him past the required length of employment required for a full pension.

Alistair's relationship with CMP was complex. The inferred programme theory expressed by some practitioners (Chapter 7) suggests that CMP did not just provide skills of health management but also enabled participants to harness the power of group process to help them to re-appraise their situation possibly with a view to returning to work. There is evidence that Alistair experienced these effects though it appears that he could assess his best interests independently of CMP.

At the time of his attendance, he was in receipt of Incapacity Benefit only and was appealing his employer's decision to withdraw his generous long-term disability pay. Had he lost the appeal, then he would have considered regaining employment. In this context, CMP was an appropriate intervention. However, the CMP modules he attended were related to conflict with his employers (communication and assertiveness) and the effect of the conflict on his mood (anxiety and depression) rather than his primary illness, CFS. This corresponds with his account of conflict with his employers that consumed his thoughts and energy at the time. With the possibility of losing his long term financial aid, he was faced with a decision to potentially return to work. When he won his appeal (proving his illness), he had a choice to either start work or remain employed (but not working) for long enough to reach early retirement. The latter option was the obvious choice but this should not conceal the fact that it was a *decision* based on Alistair's appraisal of his situation. Viewed in these terms, CMP might have been useful for Alistair had he *chosen* to use it in the fashion laid out in the explicit programme theory (removal or reduction of a health condition that acts as a barrier to employment).

Emergence of unique formulations of incapacity

This purposive sample of case studies demonstrates that it is possible to improve clinically but not obtain employment (Irwin) whilst it is possible to *not* improve clinically yet still regain work (Pete). This corresponds with overall HADS and return to work data (see chapter 8). The interviews subsequently demonstrated that it was also possible for individuals to improve clinically, not achieve employment within a year but then find work at a later point (Susanne). Conversely, another interviewee improved clinically, found employment within a year but then lost it again (Tami). These irregularities illustrate the difficulty in attributing returns return to work outcomes to the intervention. This calls into question the validity of the payment mechanisms for Pathways providers obtaining 'work outcomes.' It also implies that summative evaluations into such programmes can be problematic. Even where sophisticated measures tracked employment

outcomes over time and attributed them accurately, their veracity in regard to the effectiveness of programmes themselves would remain questionable due to the impact of other variables.

The case studies show the great complexities within each case. They had dissimilar employment histories, different family and social influences and significantly diverse psychological drivers influencing their relationships with the world of employment and with their illness. None were impeded from working only by their health. The complexity of their formulations call into question CMP's explicit programme concept and theory described in chapter 5.

In three cases, participants resumed work only when their incapacity claims were finally cancelled. This phenomenon was noted by the National Audit Office (NAO, 2010). It suggests a decision to maintain the status quo until the option to remain incapacitated was removed. These participants *may* have benefitted from CMP but their return was triggered by external circumstances rather than by improvement in their health status or ability to manage it. In two other cases, participants maintained incapacity claims whilst earning additional income from permitted work and claiming a further £173 per month through the Return to Work Allowance. One of these (Mick) was employed when his claim ended and could increase his hours of work to address the income shortfall. The other (Irwin) was *self*-employed and still fearful of returning to work. The period of increased financial security allowed for a return of his psychological insecurity resulting in a return to sickness rather than to work.

Two participants (Irwin and Tami) indicated that their mental health problem was the result of deeper psychological problems and that these, rather than anxiety or depression, impeded the decision and effort to regain employment. Neither of them achieved resolution to these issues though they both improved significantly in mood. Whilst Tami regained employment, this was triggered by the cancellation of ESA. As she lost her job in circumstances attributable to the psychological 'issues' she had described, it is reasonable to conclude that her underlying presentation did not match with explicit programme theory and was therefore not addressed.

The explicit programme theory assumed that most claimants wanted to return to work but were prevented from doing so by their health condition. Improved ability to manage the condition would reduce the impact of this impediment allowing claimants to seek and maintain employment. Chapters 6 and 7 suggest that an alternative, 'implied' programme theory emerged in the Norfolk CMP delivery in which the programme invited participants to consider seeking employment through the lens of self-interest. This acted as a precursor to using the health management skills it taught. The case studies suggest a greater level of complexity than either of these theories.

Mick saw that there was no financial imperative to obtain permanent employment whilst he received IB, additional income from permitted work and the return to work allowance. This, and the fact that his presentation and HAD scores indicated good mental health, suggest that CMP was superfluous other than as a means of maintaining the status quo. He did not required help to decide whether employment was in his best interests or assistance in managing his mood. Irwin faced a similar financial situation which impeded efforts to seek permanent employment. It was not anxiety or depression that prevented his employment but deeper personal issues which the programme failed to address. In this sense, the 'implied' theory was appropriate for Irwin but failed in its application. As discussed in Chapter 5, CMP in its original format followed the explicit theory much more closely and did not challenge participants to consider the appropriateness of employment to their unique situations.

Alistair's employment and income status meant that maintaining his current situation was in his best interests. In these circumstances, CMP was inert though Alistair demonstrated that he could use CMP effectively if the situation had changed. In her fear of losing the security of benefits, Marianne highlighted a disincentive to manage her condition better or to improve clinically and, in line with this, she did neither. It is impossible to say whether an earlier return to work would have been in her best interests (as opposed to her own evaluation of her best interests) but she managed to make the transition to work when circumstances dictated (her IB claim being cancelled). This factor alongside her account of focusing on enjoying life between health assessments, suggests that she decided that her best interests were served by remaining on benefits. If this were the case, improvement or otherwise in her health or her ability to manage it remained irrelevant to the eventual outcome.

Tami recognised that work was in her best interests and wrestled with her fears and insecurities during CMP and beyond. Like Irwin, her immediate level of functioning improved. CMP proved helpful in managing symptoms of anxiety and depression but not in addressing the root cause of disturbed mood.

At the point of entry to CMP, only Pete apparently matched with the explicit programme theory in that he was out of work and his problems with mood posed a potential barrier to employment. However, he was certain that he would have returned to work even without CMP and his short claim (six months) made returning more likely for him than for longer term claimants. This makes it difficult to attribute his successful outcome to CMP. The interview indicates that Pete could be better described as *unemployed whilst experiencing an episode of depression* (due to the distressing endings of employment and a relationship coupled with loss of status and a return to living with his

parents). Since he never stopped seeking employment, depression could not be described as a barrier to employment.

The case studies suggest that the implied programme theory (that condition management skills are necessary but *not* sufficient if unaccompanied by desire for change) was essentially true. However, application of this different theory might not lead to improved outcomes because other factors (especially financial imperatives) played a pivotal role in informing participants of their immediate best interests.

Chapter 9 - Conclusions

This thesis has provided a detailed evaluation of the Norfolk Condition Management Programme. The National Audit Office (2010) stated that Pathways to Work and CMP failed to achieve stated objectives. This evaluation has enabled greater understanding of the mechanisms of CMP explaining not just its drawbacks but its benefits. These are of use for the design of future programmes of support for incapacity claimants. This conclusion draws together findings related to the overall concept, programme theory, design and delivery. It has been possible to learn not just from the intervention itself but from the political context from which Pathways to Work and CMP emerged. Therefore, wider policy implications are also presented within these conclusions.

Key findings:

1. There was an identifiable chain of logic in the delivery of Norfolk CMP from problem conception to long term outcomes.

2. Explicit CMP design did not logically follow on from the problem conception as identified by policy makers prior to the launch of Pathways to Work.

3. Explicit programme concept and theory focused on a medical formulation of incapacity. Pathways to Work artificially divided the health and employment aspects of incapacity rather than treating it as a single, whole but multi-faceted problem.

4. Focusing on management of health conditions (rather than a holistic formulation of incapacity) enabled the *responsibilisation* of claimants, in keeping with the contemporary political agenda, by making them responsible for the management of their health condition.

5. Revision to programme concept and design was driven in response to informal feedback from participants. This represented a re-alignment of programme concept with the problem conception initially outlined by policy makers.

6. Practitioners reported adjusting programme delivery in response to participants' needs in favour of explicit programme theory as driven by programme commissioners.

7. Practitioners recognised the social components of incapacity and encouraged the dynamics of the group setting as primary implementation theory (rather than teaching psychoeducational course materials).

8. The objective for the group evolved into helping participants to re-evaluate their claimant status and to reconsider the appropriateness and possibility of returning to work.

9. Outputs related to explicit programme concept and design (health improvement) did not result in reliable return to work outcomes.

10. Soft measures were associated with return to work outcomes (self-efficacy, confidence in ability to find work and predicted return to work timescales).

11. Exit interview and case study data revealed explicit and inferred evidence that claimants' incapacity was formed of a combination of factors including (but not limited to) health. Participants were seen to appraise their own best interests in terms of seeking work or remaining on benefits.

12. The theory-driven, six stage, circular model of evaluation proved to be a useful framework for identifying chains of programme logic and deviations from them.

There are many reasons why social programmes may fall short of expectations. These include failure to address the key components of the social problem it aims to remedy, use of ineffective or inappropriate programme content and inconsistent implementation and delivery. Effective programmes require coherent, comprehensible structure if they can be expected to succeed (Rossi, 2004). Without an integrity of design that is comprehensible to all involved (including participants), it cannot be expected to be implemented with consistency or measured meaningfully.

This thesis has closely followed the development of the CMP intervention highlighting the strengths and weaknesses of its concept, design and delivery. Significant and minor changes in the programme's evolution are seen as efforts to maintain or reinstate the integrity of design. The resulting data have challenged the conceptual basis of CMP. Quantitative data indicated a weak relationship between improved health and return to work outcomes. However, the major contribution of this study is qualitative data which describes the actions and reactions of people involved in CMP. Aside from concepts and theories, social programmes involve *people* and only work if people, including participants, choose to make them work (Astbury, 2010). Using Interpretative Phenomenological Analysis, the qualitative data presented in this thesis reports opinions and reactions but also constructs *meanings* from them. This has enabled the emergence of a deeper appreciation of the problem of incapacity claiming and the effect that CMP had on it.

Pathways to Work and Welfare to Work policy

Prior to Pathways to Work, efforts had been made, without success, to address growing claimant numbers (Golsch, 2006). Increasingly, the government sought new ways of addressing this problem, and the wider issue of welfare provision, in the context of globalisation (Considine, 2001; Du Gay, 2007). Incapacity was seen not just as a problem for government but a problem *of* government; just as claimant numbers increased, so too did the machinery of welfare administration (Blair, 2010).

The answer was described as a revised balance of rights and responsibilities on both sides of the welfare state (provision and receipt). Both citizens and government agencies were required to change. Within central government a culture of governance, rather than direct service provision, was established (Carmel and Papadopoulos, 2003). The critical implication of this, for CMP, was to disperse welfare provision, firstly to government departments and agencies and subsequently to the private and third sectors (Carmel and Harlock, 2008).

For those in receipt of welfare payments, *responsibilisation* was summarised as help for those who could work and security for those who could not (Blair 1998a). This posed a problem for policy makers involved in the creation of Pathways to Work. How could the concept of responsibility (for incapacity claimants) be operationalised? How could ability to work be defined? What was meant by the term *help*? To suggest that an incapacity claimant was responsible for obtaining employment might be seen as ignoring the impact of their health condition (Bambra et al, 2005). However, proposing that the illness did not prevent work would imply that claimants could be more accurately described as *unemployed* rather than disabled (Beatty and Fothergill, 2002).

An alternative approach was presented through the biopsychosocial model of illness (Engel, 1977) which was revised, in relation to incapacity, by Mansell Aylward who was Chief Medical Officer for the Department of Work and Pensions from 1996 until 2005 (Waddell and Aylward, 2005). Rejecting a purely medical model of illness, it emphasised psychological and attitudinal factors of incapacity. This enabled the conceptual marriage of health and personal responsibility. An illness could prevent work if it was allowed free rein to affect a person's functioning. However, if it was *managed*, then its impacts could be reduced, making work possible. Thereby, incapacity claimants could be regarded as *responsible* for managing health conditions.

Applying this to Blair's mantra of help for those who needed it (Blair, 1998a), this reduced the number of people requiring state security and increased those who could be helped to secure their own income. Help to manage health conditions enabled the *responsibilisation* of incapacity claimants. The government estimated that one million people could obtain work by making use of this assistance (DWP, 2006). This thesis proposes that the fundamental concept of CMP was driven by the need to activate the claimant population in order to revise the relationship between the citizen and the state. Chapter 1 discussed how the government's requirement, and therefore decision, to run a programme preceded the needs analysis for CMP. The appropriateness of a programme designed to help individuals to self-manage their health conditions is examined later in this concluding chapter.

As stated above, Blair's envisioning of a new relationship between state and citizen also required modification of the apparatus of welfare. The DWP and NHS were made jointly responsible for the development of Pathways to Work. The DWP was responsible for what could be described as the *employment side* and the NHS took charge of the *health side*. In the context of the non-treatment philosophy (Ford, 2008), the latter was termed *condition management.* This thesis suggests that this division of responsibility represented an un-natural separation in the solution for incapacity claiming and that this affected the programme theory underpinning CMP. The case for Pathways to Work was presented by Andrew Smith, Secretary of State for Work and Pensions in *Pathways to work: Helping people into employment (DWP, 2002).* Smith set out four main areas of concern (to claimants) which impeded off-flow from incapacity benefits. These were financial and economic considerations, social and cultural factors, inadequate or failing healthcare and welfare management and, finally, health. The last component was presented in terms of an incorrect assumption that health conditions prevented all work and that physical or mental impairment could be worsened or caused by sustained periods of incapacity claiming. The paper did not cite *hidden unemployment* but referred to the mechanisms of it (low human capital resources) within its explanation of social and cultural factors. This problem conception, examined in detail in Chapter 4, was consistent with the testimony of CMP participants as documented in programme outputs (Chapter 8) and outcome case studies (Chapter 9) and resonated strongly with the reflections of programme practitioners (Chapter 7).

CMP Programme concept

The analysis of CMP design (concept, programme-theory and implementation-theory), presented in Chapter 5, sets out Smith's (2002) problem conception from the perspective of claimants and, from these, extrapolates the proposed solution (programme outputs). However, detailed analysis of CMP design reveals no evidence that Smith's (2002) problem conception was instrumental in driving programme theory. The theory that applying psychological skills for managing health conditions would reduce the impact of the conditions, enabling return to working, is plainly established in the composition of the programme. Whilst the solution for incapacity was shared between the DWP (via JobCentrePlus) and the NHS, the qualitative data gathered in this study demonstrate that claimants did *not* conceive separate health and employment aspects of their incapacity but, instead, these aspects were intimately linked. Whilst it may have appeared reasonable to treat financial and economic factors separately (via employment advisers), there is no immediately clear reason why CMP placed such a heavy emphasis on the health component of incapacity. The increasing standing and cost-effectiveness of cognitive behavioural therapy (Layard, 2006) and anecdotal testimony from a Pathways to Work provider manager suggest an inclination towards CBT. CBT is closely linked

to the biopsychosocial model of illness and had a strong evidence base for the treatment of common mental health conditions (Department of Health, 2001). Since common mental health conditions accounted for more than a million incapacity claims (Layard, 2006), it may be that the treatment evidence base influenced the programme theory. In plain terms, it is plausible that the division of health and employment resulted in each party proceeding to do what each did well. As such, the NHS sought an evidence based solution for the management of common mental health problems and incorporated them into CMP.

The split between *employment* and *health* that was apparent between DWP and NHS in the creation and initial delivery of CMP, was replicated in provider-led CMP in Norfolk. This study found no evidence of meaningful co-ordination between the two organisations from the point of view of programme participants. Conversely, the testimonies of practitioners (Chapter 7) describe how CMP was delivered in isolation from the Pathways to Work provider and with no training or discussion on a shared problem conception, programme theory or of outcomes that would assist the *employment side*. Chapter 5 describes how the programme content had to be interpreted and translated into a programme without oversight from the *employment side* (the Pathways provider). Chapter 6 describes how the programme was revised to provide focus on the workplace and to include a complete section on the social consequences of workless-ness (rather than health) component of incapacity. This incursion into the *employment side* was instigated by the CMP provider.

The original programme for Norfolk CMP was produced by the Pathways to Work provider. As described in Chapter 5, this replicated the programme theory from the preceding CMP pilot programmes and focused almost exclusively on health management rather than social and cultural difficulties facing incapacity claimants. Output data for the Norfolk CMP (presented in Chapter 8) indicate an unclear relationship between clinical improvement and return to work outcomes. This thesis does not find unequivocal evidence that CMP participants, who returned to work, were influenced by improvement in health or ability to manage their health conditions. Early CMP pilot evaluations described improved confidence, reduced anxiety and depression and ability to manage stress (Pittam et al, 2008; Ford, 2008; Dorsett, 2008; Bewley et al, 2008, Warrener et al, 2009; Ford and Plowright, 2009; Hudson et al, 2009). Functional improvements such as these are associated with ability to return to work (Ford and Plowright, 2009). However, return to work outcomes of the early CMP programmes were ambiguous.

This thesis found no compelling evidence that the CBT component of CMP was helpful for the specific purpose of encouraging return to work. Neither participant feedback, recorded exit interviews nor case-study interviews revealed evidence of CBT skills being used. This was consistent

with a meta-analysis of interventions designed at assisting people with common mental health problems into work which similarly found no specific evidence for their effectiveness (Dibben et al, 2012). There was also concern that an evidence base gathered for clinical purposes might not be useful for shaping policy (Bower and Gilbody, 2005). The biopsychosocial model of illness has been criticised in its application to incapacity claimants (Shakespeare et al, 2017). In addition to HADS outcome data, this study found that confidence in ability to work, to find work and to cope in the workplace was a stronger predictor of return to work outcomes. Greater sense of self-efficacy (occupational self-assessment data) and confidence in a shorter return-to-work timescale were also associated with returning to work. In this instance, the findings from this study *are* in keeping with the pilot evaluations which noted that increasing confidence could be the 'single-most important outcome' of the programme (Ford and Plowright, 2008 p. 98). There was evidence that the overt emphasis on condition management could increase the maladaptive belief that obtaining work necessarily required an improvement in health. This was exacerbated by the central role of the Work Capability Assessment (medical) in acting as the gateway to incapacity benefit which occurred frequently in the testimonies of some participants.

This thesis has demonstrated that the explicit programme concept for the CMP was not sound. The CMP concept was flawed because it attempted to remedy the causes of incapacity claims but failed to address key issues that prevented ending claims. Improving health or managing a health conditions more effectively were not shown to enable a return to work within the population of long-term claimants in either data from this study or in the literature (NAU, 2010). This does *not* mean that this concept cannot logically work in any circumstances. 77,960 people commenced Pathways to Work in the final year of its operation (DWP, 2011). It is possible that managing health conditions might have enabled rapid return to employment for many of these claimants where a health condition was their *only* barrier to work. The problem of increasing incapacity claimant numbers was based on the group who did *not* flow off the benefit rapidly. Once a claimant has been out of work for more than six to twelve months, the likelihood of them regaining employment begins to decline (Bambra et al 2005; Hutton, 2006). For this group, the problem can be conceptualised differently from those who leave incapacity claims early. Health conditions can be the reason why they cease work in the first instance or they may leave work for other reasons whilst *also* having a health condition. However, the literature provides ample evidence that *remaining* on incapacity was driven by social, psychological and financial factors that were quite different from those that *caused* it (Walker, 1998; Grewal et al, 2002; McKeever, 2000; Drake, 2000; Turton, 2001; Legard et al, 2002).

Programme theory and implementation theory

A review of CMP provision in Norfolk was driven by the Pathways provider on the basis of insufficient evidence of return to work outcomes. The resulting 'express' programme was a response from the CMP providers to remedy the conceptual mismatch between the problem conception and the programme concept. The 'express' concept focused strongly on the factors that prevented return to work. This is evidenced in the promotional literature and in the week 1 intervention on social and psychological effects of the cycle of incapacity claiming. Through its short, focused delivery involving day-long workshops, the implementation theory for 'express' also went some way to reflecting the conceptual focus on managing wellbeing to get *into* work. However, the programme theory, with the exception of the intervention described above, remained the same as the original programme. It addressed health conditions rather than what could be described as the *condition of being a claimant.*

Interpreting the testimony of participants and practitioners, this study has constructed a formulation for long-term claiming that is consistent with Smith's (2002) problem conception. This could be described as *alternative programme theory.* The barrier to employment-seeking can be described as: *the direct impacts of non-employment combining with the long-term effects of claiming to create a reliance on incapacity status*. The word *reliance* is used instead of *dependency* because the latter is frequently used to describe claimants' financial relationship with a benefit. Reliance on incapacity status may include, but extends beyond, financial considerations.

The direct impacts of losing employment include psychological distress, reduced income, feelings of failure, reduction in social and leisure opportunities and loss of status, identity and social contact and isolation. Long term effects appear when an individual does not promptly return to work. These may include development of social anxiety, low mood, poor health behaviour (diet, exercise and sleep pattern) and unresolved trauma. In addition, claimants lose currency in the workplace (out of date training and experience) and, by definition, develop a worsening sickness record. These factors reduce employability from the perspective of employers but also in the consciousness of claimants themselves. Data from this study have shown that claimants realise a new form of stability. Long term impacts of claiming entail an adjustment of personal and career expectations; a form of writing themselves off. They may re-assign their energies to different needs such as family. This leads to a new role identity (Charmaz, 1991). Like increase in weight or dependency on a substance, these long-term effects may grow slowly and imperceptibly at first.

The *barrier to employment* forms in response to the change in identity. The importance of maintaining the incapacity claim increases in order to guarantee stability. The perverse effect of

this, for welfare to work programmes, is that remaining ill is necessary to minimise risking the stability that incapacity benefits provide. As such, CMP had the potential to *discourage* efforts to return to work. Improved anxiety *raises* the likelihood of returning to work and, thus, improvements may be denied or described as insufficient. Practitioner accounts have shown evidence of both resistance to help and attachment to the sick role. Chapter 3 outlined the differences between programmes outputs and outcomes. In this instance, an improvement in anxiety as a programme output (observed frequently in the data from this study) would not result in an *outcome* of seeking work (observed in case studies). The effect of this on claimants is that maintenance of incapacity status provides relief in the first instance but guarantees further distress in the longer term. This point was explored in week 1 of the 'express' programme. The medicals (Work Capability Assessment) figured prominently in case study accounts as they provided an intense focal point for individuals whose *stability* relied on maintenance of claimant status. As with addiction or substance dependency, the solution to the problem and the problem itself are both caused by the same action; in effect any act related to maintaining the incapacity claim. Whilst fearing loss of security, the case studies consistently revealed that participants perceived harm in being an incapacity claimant.

This conception does *not* suggest that the distress experienced by claimants is not real. The impacts, seen in terms of emotional and physical states, may mirror organic health conditions. This could add to the confusion whether long term claimants present with clinical or social problems. To a GP, the symptomology and language of distress may be identical. Reconsideration of clinical diagnosis is worthy of further research.

A programme theory related to this alternative programme concept might be to help participants to re-evaluate their beliefs around the stability of benefits. Linehan (1993) uses a simple *pros and cons* exercise to establish to real effects of maladaptive coping strategies used by people in response to emotional distress. Figure 9.1 below presents factors that might be included in this analysis. These are amalgamated from participant data and not all would be appropriate for all claimants. Different factors may have different value according to circumstances. For example, a benefit of maintaining claimant status, such as spending more time with family members, may be an advantage to one person but not to another.

Change – Leave benefits and seek employment

Positive (A)	Negative (B)
A job would bring income (save for x or spend on y)	I might not be able to get a job/there aren't any jobs
Would be nice to hold head up/be like people I know	I could not compete with foreign workers
Work is good for health and self-esteem	Workplace might be unpleasant/remind me of past distress
I could make new friends	If I don't find work I may be put on JSA with little hope of work and even less money
I would have a sense of purpose	My health condition prevents me doing most jobs
It would be good to be contributing	Work might be harmful to my health
It will provide new experiences and opportunities	I might only get menial/low status/physically demanding work
	Work might not pay much more than my current income
	I do not want to meet new people/I don't get on with people
	I might not be capable of doing the job
	I don't have the skills/experience/personality for modern jobs
	I don't like interviews
	I previously applied for jobs but was never invited for interview
	I am frequently sick – employers may not tolerate that
	I could not cope with losing work again
	Change will require immediate effort
	Why seek work deliberately when I can wait until I have to

Positive (C)	Negative (D)
I don't need more money than Incapacity Benefit gives me	I will feel like my life has been written off
I can be useful/have purpose in other ways than working	I will feel increasingly unhappy
Not changing requires no effort – I can do that later if needed	I will be increasingly anxious/avoidant
I can make do with the money/income I have	I will be lonelier and isolated and see people less often
I can take each day at a time/distract myself from worries	Opportunities will remain closed to me as I have low income
	My lifestyle will deteriorate (no structure/poor sleep and diet)
	I will feel more useless/lack purpose
	I will be unable to spend/invest/save money for me or for others

Do not change: Remain on incapacity benefits

Change = Sum of A + D
Do not change = Sum of B + C
Figure 9.1 Hypothetical decision matrix based on Linehan (1993)

A similar approach can be undertaken in the treatment of addiction (Carr, 2008). The apparent benefits of a substance such as *feeling good* are, under scrutiny, seen as either illusory or non-existent. However, the consequences, under similar scrutiny, are always proven to be real. The reverse applies for beliefs about abstinence or sobriety in which the substance misuser recognises no disadvantages to *not* being addicted to drugs. Using this method, the 'addict' reappraises whether they really *want* to use a substance and can make their own decision accordingly. The success of this method lies in the fact that it is frequently obvious to the person that their best interests are met by stopping the drug. Establishing the factors relevant to the decision matrix requires accurate history-taking at assessment and ongoing attentiveness to factors unique to the individual throughout the treatment process. The formulations of incapacity generated in the case studies demonstrated that claimant behaviour and choices are influenced by various unique factors. These could be considered using the same framework for decision-making.

This alternative mechanism for change (programme theory), related to incapacity claimants, is worthy of further research. However, a challenge to this theory emerges immediately: what if it is *not* in a person's best interests to stop claiming incapacity benefit? The decision matrix in figure 9.1 might indicate that a person's needs are best met by *remaining* on benefits.

CMP outputs and outcomes

This study has found that the Norfolk CMP delivered respectful, empathic facilitation from practitioners as well as support, shared identification and encouragement from peers. These provided the psychological conditions necessary to enable participants to safely and calmly reflect on the nature of their incapacity situation (condition) and come to *their own decision* as to whether returning to work was a likely and beneficial outcome of leaving the security of incapacity benefits. This finding accords with literature which attests that incapacity claimants formed their own view of their health and its impact on their ability to work. This was known before CMP was launched (Lonsdale et al, 1993; Dorsett et al, 1998; Green et al, 2000; Davies and Johnson, 2001; Corden and Sainsbury, 2001; Hedges and Sykes, 2001; Davies et al, 2001; Kelleher et al, 2002). It was also noted in early CMP and Pathways evaluations (Corden and Nice, 2006; Barnes and Hudson, 2006; Ford, 2008; Dorsett, 2008; Warrener et al, 2009; Hudson et al, 2009; Hayllar et al, 2010). Whilst the Norfolk CMP was helpful in supporting individual self-reflection and decision-making, this impact may have been diluted by the programme's continuing focus on *condition management* which reflected a different programme concept.

This study found that the Norfolk CMP was not helpful in preparing participants for employment if they did not decide to return to work. This was irrespective of the effect of the programme on their health and ability to manage it. A significant factor influencing an individual's assessment of their best interests is *employability*. Incapacity claimants are frequently older than others with whom they may compete for jobs. They are known to possess lower and fewer qualifications, have less valuable work experience and are frequently pre-judged on the basis of their health (Lonsdale et al, 1993; Errens and Ghate, 1993; Rowlingson & Berthoud, 1996; Dorsett et al, 1998; Green et al, 2000; Bunt et al, 2001; Loumidis, 2001; Davies & Johnson, 2001; Ashworth et al, 2001; Hedges & Sykes, 2001; Davies et al, 2001). Case study and exit interview data revealed that participants possessed a keen awareness of whether becoming ready for employment would result in a job or in job-seeking. As such, this study has demonstrated that health-focused welfare to work programmes may succeed in as much as they impact on participants' beliefs and decisions rather than their health.

It should be borne in mind that, whilst the National Audit Office found no evidence for the effectiveness of Pathways to Work in assisting incapacity claimants back into employment, there is no indication of *any* nation-wide intervention succeeding in this objective. The National Audit Office (2014) reported that the Work Programme had performed comparably with previous programmes (including Pathways to work) but harder to reach groups such as ESA claimants had proved tougher to re-employ than in previous programmes. NAU (ibid) found that performance was below expected levels and was "broadly similar to that of previous comparable welfare-to-work initiatives" (p.29).

Critique of this study

This thesis uses the word *participant* to describe interviewees which is consistent with the university's ethics (and other) policies. However, whilst the research subjects took part in the sense of being interviewed, they did not actively *participate* in the research process or in shaping the thesis. Greater participation might have been achieved by re-engaging case study subjects by gathering their responses to the formulations presented in Chapter 8.

The study is limited by the data gathered. There is preliminary evidence that the *one to one* format of CMP resulted in considerably improved return to work outcomes. However, the paucity of complete data sets has made it impossible to infer statistical significance from these data.

This study is theory driven. As such, its findings are limited to the theory inferred in the specific geographical context of this study. Its conclusions may apply only to the population of incapacity

claimants in Norfolk. For example, the concept of a claimant's individual decision based on a rational appraisal of their best interests may be less relevant in areas of significant economic decline with greater competition for fewer jobs.

A specific limitation to the study is lack of detailed post-CMP data. Whilst it is known that 33% of those surveyed returned to employment within a year of completing CMP, there are no data on what prompted each individual to do so. Analysis of other outputs, such as work confidence questionnaires, has shown that the returner population differed from the non-returners. However, these differences cannot be proved to be causative. It is likely that a proportion of returners did so after having their incapacity claim cancelled following a Work Capability Assessment. NAU (2010) stated that 80% of those who ended incapacity claims across 2008-9 did so because of this rather than CMP.

A detailed history-taking of participants including qualifications, and work history would have enhanced the study considerably and enabled a comparison between returner and non-returner populations. This would warrant further research.

The study is limited by the lack of an appropriate counterfactual. CMP may be regarded as a concept-driven programme and therefore a theory-driven approach that probes the concept in detail appears to be appropriate. However, this study would have been enhanced by comparison with similar individuals who did not participate in CMP. This could have been achieved by surveying health and return to work outcomes for individuals who attended CMP assessments but did not attend the programme. This was a considerable missed opportunity.

CMP *could* only help people with health conditions into employment who wanted to return to work and who were capable of being selected by employers. The findings from this study suggest that, considering employability factors, a significant proportion of claimants will continue to assess that their best interests are met by extending their status as long as possible.   However, a proportion of incapacity claimants may benefit from a focused programme whose concept, programme and implementation theory are based on a holistic problem conception.

The circular model of evaluation presented in Chapter 3 has served as a useful framework for judging the impact of the Norfolk CMP. It has been helpful in estimating the value of specific interventions, such as health management advice, as these can be interpreted in the context of anticipated benefits. This is made possible by identifying a coherent thread of logic that runs from problem conception through all stages of design and delivery and can be observed in programme effects. Identifying an overall programme theory, which distinguishes outputs from outcomes, has helped to explain why apparent success (clear improvements in participant's health and functioning)

did not result in more claimants returning to work. Identification of specific programme theory has helped to explain the reasons for this. Using this model of evaluation, alterations to programme delivery may be regarded as efforts to restore the integrity of design. Analysis of programme developments has promoted understanding of alternative programme theory. Each stage of design, delivery and measurement has provided further insight into the problem conception which can inform the design of future programmes.

Wider implications

A holistic appraisal of claimants' health status resulting in individual *formulations of incapacity* for programme participants might include social, psychological and employability factors (age, skills, qualification and experience) as well as level of functional impairment. This could have implications for the assessment of claims which are currently verified by the Work Capability Assessment (WCA). The findings of this study suggest that the concept of *work capability* might be extended to include likelihood of being offered employment (employability) and the psychological components of claiming such as harmful effects of non-employment on social identity.

Changes to medicals (WCA) have previously caused controversy (Wiggan, 2012). The impact of threat to benefit status in terms of personal income has highlighted the significance of the relationship between this factor and willingness to make use of the help available in programmes such as CMP (as attested by participants in case studies and exit interviews). Further research into the impact of revised assessment criteria may be beneficial. Measuring the effect of *removing* financial hazard on policy or programme changes (by safeguarding claimants' status) would also be worthy of further investigation.

A holistic assessment of a person's incapacity might reveal a less important role for functional impairment and allow more consideration of social, financial and psychological factors. In this case, programme design could allow participants to identify solutions to barriers to employment without causing anxiety about income. As was evidenced in this study, such anxiety can lead to the entrenchment of claimants in the sick role. A programme which provides the resources and structure to address personal barriers to employment such as those revealed in this study, may represent a direction for further research.

References

Acheson, D. (1998) *Independent inquiry into inequalities in health.* London: The Stationery Office.

Adam, S., Emmerson, C., Frayne, C. and Goodman, A. (2006) *Early Quantitative Evidence on the Impact of the Pathways to Work Pilots*. DWP Research Report 354. Norwich: HMSO

Adam, S., Bozio, A. and Emmerson, C. (2010) 'Reforming Disability Insurance in the UK: Evaluation of the Pathways to Work Programme', *Institute for Fiscal Studies*, pp.1-33. Available at: http://www.netspar.nl/files/Evenementen/2010-10-15%20TC/paper%20bozio.pdf. (Accessed: 22 January 2015)

Adedokun, O., Childress, A. and Burgess, W. (2011) 'Testing conceptual frameworks of nonexperimental program evaluation designs using structural equation modeling', *American Journal of Evaluation*, 32(4), pp. 480-493.

A.A. World Services (2001) *Alcoholics Anonymous the story of how many thousands of men and women have recovered from alcoholism fourth edition*. New York: A.A. World Services, Inc.

Ashworth, K., Hartfree, Y. and Stephenson, A. (2001) *Well enough to work?* DWP Research Report 145. Leeds: HMSO

Artazcoz, L., Benach, J., Borrell, C. and Cortes, I. (2004) 'Unemployment and mental health: understanding the interactions among gender, family roles and social class', *American Journal of Evaluation*, 31 (3), pp. 363-381.

Astbury, B., and Leeuw, F. (2010). Unpacking black boxes: Mechanisms and theory building in evaluation. *American Journal of Evaluation, 31*(3), 363-381.

Bambra, C. and Eikemo, C. (2009) 'Welfare state regimes, unemployment and health: a comparative study of the relationship between unemployment and self-reported health in 23 European countries', *Journal of Epidemiol Community Health,* 63, pp. 92–98.

Bambra, C., Whitehead, M., and Hamilton, V., (2005) 'Does "welfare-to-work" work? A systematic review of the effectiveness of the UK's welfare-to-work programmes for people with a disability or chronic illness', *Social Science & Medicine,* 60, pp. 1905–1918.

Bannister, P., Burman, E., Parker, I., Taylor, M. and Tindall, C. (1994) *Qualitative methods in psychology*, Buckingham: Pen University Press

Barnes, H. and Hudson, M. (2006) *Qualitative research on the Condition Management Programme*. DWP Research Report No 346, Norwich: HMSO

Battye, F. (2015) 'Payment by results in the UK: progress to date and future directions for evaluation', *Evaluation*, 21 (2), pp. 189-203.

Baum, A., Fleming, R. and Reddy, D.M. (1986) 'Unemployment stress: loss of control, reactance and learned helplessness', *Social Science and Medicine*, 22(5) pp. 509-516.

Beatty, C. and Fothergill, S. (1996) 'Labour market adjustment in areas of chronic industrial decline: the case of the UK coalfields', *Regional Studies* 30 (7) pp. 627-640.

Beatty, C. and Fothergill, S. (2002) 'Hidden unemployment amongst men: a case study', *Regional Studies*, 36(8), pp. 811-823.

Beatty, C. and Fothergill, S. (2004) 'The diversion from 'unemployment' to 'sickness' across British regions and districts', *Centre for Regional Economic and Social Research*, 39(7), pp. 837-854.

Beatty, C., Duncan, K., Fothergill, S. and McLean, S. (2013) 'The role of health interventions in reducing incapacity claimant numbers', *Centre for regional economic and social research, Sheffield Hallam University*

Benzies, K. M. and Allen, M. N. (2001), 'Symbolic interactionism as a theoretical perspective for multiple method research', *Journal of Advanced Nursing*, 33, pp.541–547.

Berthoud, R. (1998) 'Counting the cost of disability' *New Statesman* 127 (4368)

Berthoud, R. (1998) 'Small change: the benefits agenda for disabled people', *New Economy,* 1070 (6)

Berthoud, R. (2011) 'Trends in the employment of disabled people in Britain'*, Institute for Social and Economic Research*, No. 2011-03

Bewley, H., Dorsett, R., and Haille, G. (2007) *The impact of Pathways to work*, DWP Research Report 435, Norwich: HMSO

Bewley, H., Dorsett, R. and Ratto, M. (2008) *Evidence on the effect of Pathways to Work on existing claimants*. DWP Research Report 488, Leeds: HMSO

Black, C. (2008) *Working for a healthier tomorrow*. London: The Stationery Office

Blair, A. (1998a) *New ambitions for our country: A new contract for welfare*. Department for work and pensions, CM3805, Norwich: HMSO.

Blair, A. (1998b) *A new contract for welfare: Support for disabled people,* Department for Work and Pensions. CM 4103, Norwich: HMSO.

Blair, A. (2010) *A Journey: My political life*. London: Hutchinson.

Bower, P. and Gilbody, S. (2005) 'Managing common mental health disorders in primary care: conceptual models and evidence base', *British Medical Journal*, 330, pp.839-842.

Brouwers, E.P., Tiemens, B.G., Terluin, B. and Verhaak, P.F. (2006) 'Effectiveness of an intervention to reduce sickness absence in patients with emotional distress or minor mental disorders: a randomized controlled effectiveness trial', *General Hospital Psychiatry*, 28(3), pp. 223-229.

Bunt, K., Shury, J., Vivian, D. and Allard, F. (2001) *Recruiting benefit claimants: a survey of employers in ONE pilot areas*, DSS Research Report 139, Leeds: HMSO

Burchardt, T. (1999) 'The Evolution of Disability Benefits in the UK: Re-weighting the basket', *Centre for Analysis of Social Exclusion, London School of Economics*, Case Paper 26, pp.1-30.

Burke, P. and Stets, J. (2009) *Identity Theory*. Oxford: Oxford University Press

Burr, V. (2003) *Social Constructionism.* 2nd edn. Hove: Routledge

Burton, K. and Waddell, G. (2006) *Is work good for your health and well-being?* London: The stationery office

Campbell, D.T. (1969) 'Reforms as experiments', in Caro, F. G (ed.) *Readings in evaluation research.* New York: Russell Sage Foundation

Capelli, P., Bass, L., Katz, H., Knoke, D., Osterman, P. and Usee, M. (1997) *Change at Work.* New York: Oxford University Press

Carr, A. (2008) *The Nicotine Conspiracy.* London: Arcturus.

Carmel, E. and Harlock, J. (2008) 'Instituting the 'third sector' as a governable terrain: partnership, procurement and performance in the UK'**,** *Policy & Politics* 36(2), pp. 155–71.

Carmel, E. and Papadopoulos, T. (2003) 'The new governance of social security in Britain', in Millar, C (ed.) *Understanding social security*. Bristol: The Policy Press, pp. 1-17.

Casey, D. and Murphy, K. (2009) 'Issues in using methodological triangulation in research', *Nurse researcher,* 16 (4) pp.40-45.

Castles, F. (2004) *The future of the welfare state: crisis myths and crisis realities*. Oxford: Oxford University Press

Charmaz, K. (1991) *Good days, bad days: the self in chronic illness and time,* New Brunswick: Rutgers University Press

Christie, A. and Marshall, M. (2006) 'Pathways to Work? Narrative experiences of people claiming health-related benefits, National Programme for Improving Mental Health and Wellbeing - Small Projects Initiative 2006-7', *Scottish Government*. Available at: http://www.scie-socialcareonline.org.uk/profile.asp?guid=26852c1f-deb2-40b4-a995-917581ce1c42. (Accessed: 1 May 2012)

Clarke, A. and Dawson, R. (1999) *Evaluation research.* London: Sage.

Clayton, S., Bambra, C. Gosling, R. Povall, S. Misso, K. and Whitehead, M. (2011) 'Assembling the evidence jigsaw: insights from a systematic review of UK studies of individual return to work initiatives for disabled and long-term ill people'. Available at: www.biomedcentral.com/1471-2458/11/170 (Accessed 15 September 2012).

Conrad and Barker (2010) 'The social construction of illness: key insights and policy implications', *Journal of Health and Social Behaviour*, 51, pp. 67-79.

Corden, A. and Nice, K. (2006) *Pathways to Work: Findings from the final cohort in a qualitative longitudinal panel of incapacity benefits recipients. DWP Research Report No 398*, Norwich: HMSO.

Coleman, N., Sykes, W. & Groom, C. (2013) *What works for whom in helping disabled people into work? Working paper 120. Department for Work and Pensions*. Norwich: HMSO

Connexions (2014) *What employers want.* Available at: www.connexions-tw.co.uk/what-employers-want/ (Accessed 21.1.14)

Considine, M. (2001*) Enterprising States: the public management of welfare to work*. Cambridge: Cambridge University Press

Considine, M. and O'Sullivan, S. (2014) 'Markets and the new welfare: buying and selling the poor', *Social Policy and Administration*, 48(2), pp.119-126.

Cook, T. and Campbell, D. (1979) *Quasi-Experimentation – Design and analysis issues for field settings.* Boston: Houghton Mifflin

Coolican, H. (2006) *Introduction to Research Methods in Psychology*, London: Hodder Arnold

Cooper, M. (2008) *Essential Research Findings in Counselling and Psychotherapy*. London: Sage.

Corden, C. Nice, K. and Sainsbury, R. (2005) *Incapacity Benefit Reforms Pilot: Findings from a longitudinal panel of clients*. DWP Research Report 259, Norwich: HMSO.

Corden, C. and Nice, K. (2006) *Incapacity Benefit Reforms Pilot: Findings from the second cohort in a longitudinal panel of clients*, DWP Research Report 345. Norwich: HMSO.

Corden, C and Nice, K. (2006) *Pathways to Work: Findings from the final cohort in a qualitative longitudinal panel of incapacity benefits recipients*. DWP Research Report 398. Norwich: HMSO.

Corden. A, and Sainsbury, R. (2001) *Incapacity Benefits and Work Incentives.* DWP Research Report 141. Norwich: HMSO.

Coryn, C., Noakes, L., Westine, C. and Schroter, D. (2011) 'A Systematic Review of Theory-Driven Evaluation Practice From 1990 to 2009', *American Journal of Evaluation,* 32(2) pp. 199-226.

Côté, J. and Schwartz, S. (2010) 'Comparing psychological and sociological approaches to identity: Identity status, identity capital, and the individualization process', *Journal of Adolescence*, 25, pp. 571–586.

Cotton, D., Stone, V. and Thomas, A. (2000) *Why not ONE: Views of non-participants before full participation*. DSS Research Report 127, Norwich: HMSO.

Crabtree, B. and Miller, W. (Eds) (1999) *Doing Qualitative Research - Second Edition*, Los Angeles: Sage

Cronbach, L. J. (1980) *Towards reform of program evaluation.* San Francisco: Jossey Bass.

Dallos, R. and Vetere, A. (2005) *Researching Psychotherapy and Counselling*, Maidenhead: Open University Press-McGraw Hill

Davies, V. and Johnson, C. (2001) *Moving towards work: The short-term impact of ONE*, DSS Research Report 140. Norwich: HMSO.

Davis, S. (2003) *Handbook of research methods in Experimental Psychology*, Oxford: Blackwell Publishing

Daponte, B. O. (2008) *Evaluation Essentials: Methods for conducting sound research.* San Francisco: Jossey-Bass.

Davies. V, Sirett. L, and Taylor. J (2001) *ONE year on: clients' medium-term experiences of ONE: Qualitative research with ONE participants*. DWP Research Report 154: HMSO

Davies, V. and Johnson, C. (2001) *Moving towards work: the short-term impact of ONE*, DWP research report 140. London: HMSO.

Demou, A., Gibson, I. and Macdonald, W. (2012) 'Identification of the factors associated with outcomes in a Condition Management Programme', *BMC Public Health*. Available at: http://www.biomedcentral.com/1471-2458/12/927. (Accessed 20 January 2013).

Department for Education and Employment (1998) *A new contract for welfare: the gateway to work.* London: The stationery office

Department of Health (2001) *Treatment Choice in Psychological Therapies and Counselling: Evidence-Based Clinical Practice Guideline*. London: Stationery Office

Department of Social Security (1998a) 'New Ambitions for our Country: A new contract for welfare', London: The stationery office

Department of Social Security (1998b) 'A new contract for welfare: Support for disabled people', London: The stationery office

Department of Social Security (1999) *Opportunity For All: Tackling Poverty and Social Exclusion*, First Annual Report 1999, London: Department for Social Security.

Department of Work and Pensions (2006) *A new deal for welfare: Empowering people to work*, Norwich: Crown Press.

Department of Work and Pensions (May, 2013) *Quarterly Statistical Summary*. Available at: /www.gov.uk/government/uploads/system/uploads/attachment_data/file/204853/stats-summary-may13.pdf (Accessed 1 August 2013).

Department of Work and Pensions (2017) *Quarterly Benefit Summary*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/591734/dwp-quarterly-stats-summary-february-2017.pdf (Accessed 21 February 2017)

Department of Work and Pensions, Press Release, (July 8th 2013) 'Help for people on sickness benefits to address barriers to work', https://www.gov.uk/government/news/help-for-people-on-sickness-benefits-to-address-barriers-to-work *(Accessed 30 January 2015)*

Department of Work and Pensions (2011) Parovider-led Pathways to Work: Official statistics. October 2011. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/200533/pl_pathways1011.pdf (Accessed 29 March 2017)

Dibben. P, Wood. G, Nicolson. R and O'Hara. R, (2012) *Quantifying the effectiveness of interventions for people with common health conditions in enabling them to stay in or return to work: A rapid evidence assessment,* DWP Research report 812, Norwich: HMSO

Donaldson, S. (2007) *Program Theory-Driven Evaluation Science,* New York: Taylor & Francis

Dorsett, R. (2008) *Pathways to Work for new and repeat incapacity benefits claimants: Evaluation synthesis report*. DWP Research Report 525, Norwich: HMSO

Dorsett. R, Finlayson. L, Ford. R, Marsh. A, White. M, and Zarb. G (1998) *Leaving Incapacity Benefit*. DWP Research Report 86, Norwich: HMSO

Drake, R. (2000) 'Disabled people, New Labour, benefits and work', *Critical Social Policy,* 20 (4) pp. 421-439.

Du Gay, P. (2007) *Organising Identity*, London: Sage

Durand, R., Decker, P. and Kirkman, D. (2014) 'Evaluation methodologies for estimating the likelihood of program implementation failure', *American Journal of Evaluation*, 35, 3, pp. 404-418.

Elder-Vass, D. (2010) 'Realist critique without ethical naturalism and moral realism'. *Journal of Critical Realism* 9, (1) pp. 33-58.

Elhorst, P. (2003) 'The mystery of regional unemployment differentials: Theoretical and Empirical Explanations', Journal of Economic Surveys, 17, (5) pp. 709–748.

Engel. G, (1977) 'The Need for a New Medical Model: A Challenge for Biomedicine', *Science* 196, pp.129–136.

Erens, B. and Ghate, D. (1993) *Invalidity Benefit: A longitudinal survey of new recipients*. DSS Research Report 20, Norwich: HMSO

Ezzy, D. (1993) 'Unemployment and mental health: a critical review', *Social Science and Medicine,* 37(1), pp. 41-52.

Fisher, J. (2012) *The process of transition.* Available at: https://www.csu.edu.au/__data/assets/pdf_file/0006/949533/fisher-transition-curve-2012.pdf (Accessed: 27 March 2017).

Ford, F. and Plowright, C. (2009) 'Realistic evaluation of the impact and outcomes of the condition management pilots', University of Central Lancashire School of Health and Postgraduate Medicine. Available at: www.nliah.com/Portal/microsites/Uploads/Resources (Accessed: 25 May 2012).

Ford. F, Expert Paper (undated) *Analysis of health and employment outcomes of the seven pilot CMPs/* Available at: *https://www.nice.org.uk/guidance/ph19/evidence/expert-paper-2-371292302* (Accessed: 25 May 2012).

Ford, F. (2008) 'Evaluation of Lancashire Condition Management Programme', IASO, University of Central Lancashire. Available at: *www.nliah.com/Portal/microsites/Uploads/Resources*(Accessed: 20 April 2012).

Forsyth, K. and Keilhofner. (2006) 'The Model of Human Occupation: Integrating theory into practice', in Duncan, E.A.S. (ed). *Foundations for practice in occupational Therapy, 4th Edition*. London: Elsevier

Fothergill, S. and Wilson, I. (2007) 'A million off Incapacity Benefit: how achievable is Labour's target?', *Cambridge Journal of Economics*, 31, pp. 1007–1023.

Franche, R. and Krause, N. (2002) 'Readiness for return to work following injury or illness: conceptualizing the interpersonal impact of health care, workplace and insurance factors' *Journal of Occupational Rehabilitation,* 12 (4) pp. 233-256.

Freud, D. (2007) *Reducing dependency, increasing opportunity: options for the future of welfare to work: An independent report to the department for Work and Pensions*. Leeds: Crown Press: HMSO

Garthwaite, K. (2014) 'Fear of the brown envelope: exploring welfare reform with long-term sickness benefits recipients', *Social Policy and Administration.* 48(7), pp. 782-798.

Golsch, K. (2006) 'Men's labour market mobility in Britain: globalization, labour market flexibility and job insecurity', in Blossfeld, H., Mills, M. and Bernardi, F. (Eds.) *Globalization, uncertainty and men's careers: an international comparison*. Cheltenham: Edward Elgar Publishing

Grant, A. (2010) *The Condition Management Programme: early findings from qualitative research in Wales*. [Lecture presented at the *Social Policy Association Annual Conference,* University of Lincoln] 5-7 June.

Grant. A, (2012) 'Barriers to Work for Incapacity Benefit Claimants in Wales', *Contemporary Wales*: 25: pp. 173-190. Available at: aimeegrant.weebly.com/uploads/6/3/1/2/6312343/aimee_grant_final.pdf. (Accessed: 20 April 2012)

Green, H., Smith, A., Lilly, R., Marsh, A., Johnson, C. and Fielding, S. (2000) *First Effects of ONE: Findings from Survey and Qualitative Research with Clients*. DSS Research Report 126, Norwich: HMSO

Green, H., Marsh, A. and Connolly, H. (2001) *Short term effects of compulsory participation in ONE. Survey of clients: Cohort Two Wave One*. DWP Research Report 156, Norwich: HMSO

Greenberg, D. and Morris, S. (2005) 'Large-scale social experimentation in Britain', *Evaluation,* 11 (2), pp. 223-242.

Greenberger, D. and Padesky, C. (1995) *Mind over mood.* New York: Guildford Press

Grewal, I., Joy, S., Lewis, J., Swales, K. and Woodfield, K. (2002) *Disabled for life? Attitudes towards, and experiences of disability in Britain*. *DWP research report 173*, Norwich: HMSO

Grimm, P. (2010) Social Desirability Bias. *Wiley International Encyclopedia of Marketing*. Available at: http://onlinelibrary.wiley.com/doi/10.1002/9781444316568.wiem02057/abstract (Accessed March 2017)

Grover, C. and Piggott, L. (2010) 'From Incapacity Benefit to Employment and Support Allowance: social sorting, sickness and impairment, and social security', *Policy Studies*, 31 (2), pp.265-282.

Hacking, I. (1999) *The social construction of what.* London: Harvard University Press

Handler, J. and Hasenfeld, Y. (2007) *Blame Welfare, Ignore Poverty and Inequality*. New York: Cambridge University Press.

Hansen, H. (2005) 'Choosing evaluation models', *Evaluation*, 11 (4), pp. 447-562.

Harvey, S.B., Henderson, M., Lelliott, P. and Hotopf, M. (2009) 'Mental health and employment: much work still to be done', *British Journal of Psychiatry*, 194(3), pp. 201–3.

Hayllar, O., Sejersen, T. and Wood, M. (2010) *Pathways to Work: The experiences of new and repeat customers in Jobcentre Plus expansion areas*. DWP Research Report 627, Norwich: HMSO

Hayllar, O. and Wood, M. (2011) *Provider-led Pathways to Work: the experiences of new and repeat customers in phase one areas*. DWP Research Report 723, Norwich: HMSO

Hedges, A. and Sykes, W. (2001) *Moving between sickness and work*. DWP Research Report 151, Norwich: HMSO

Heideggar, M. (1962) *Being and time.* New York: Harper and Row

Hills, D., Child, C., Blackburn, V. and Youll, P. (2001) *Evaluation of the New Deal for disabled people innovative schemes pilots*. DWP research report 143, Norwich: HMSO

Hirsch, D. and Goulden, C. (2006) *Response to the Government consultation on the Green Paper: A new deal for welfare: Empowering people to work.* York: Joseph Rowntree Foundation

Høgelund, J., Holm, A. and McIntosh, J. (2010) 'Does graded return-to-work improve sick-listed workers' chance of returning to regular working hours'? *Journal of Health Economics*, 29(1), pp.158-169.

Homan, R. (1991) *The Ethics of Social Science Research. London: Longman*

Hudson. M, Ray. K, Vegeris. S, and Brooks. S (2009) *People with mental health conditions and Pathways to Work*. DWP Research Report 159, Norwich: HMSO

Hutton, J. (2006) *A new deal for welfare: Empowering people to work*, Norwich: Crown Press

Institute for social and economic research (2011) *Number of working age claimants of benefits on grounds of incapacity for work, 1972-2010* [illus]. Available at: https://www.econstor.eu/bitstream/10419/65931/1/655003177.pdf (Accessed 20 January 2013)

Jakobsen, K. (2001) 'Employment and the reconstruction of self: a model of space for maintenance of identity by occupation'*, Scandinavian journal of occupational therapy,* 8 (40), pp. 40-48.

Joyce, K., Smith, K., Henderson, G., Brieg, G. and Bambra, C. (2010) 'Patient perspectives of Condition Management Programmes as a route to better health, well-being and employability', *Family Practice*, 27, pp. 101-109, Oxford University Press [Online] Available at: http://www.ncl.ac.uk/ihs/research/publications/2010. (Accessed: 29 November 2012).

Judkins-Cohn, T., Kielwasser-Withrow, K., Owen, M. and Ward, J. (2014) 'Ethical Principles of Informed Consent: Exploring Nurses' Dual Role of Care Provider and Researcher', *Journal of Continuing Education in Nursing*, 45 (1), pp.35-42

Keilhofner, G. and Burke, J. (1980) 'A model of human occupation, part 1: conceptual framework and content', *American journal of occupational therapy*, 34 (9), pp. 572-581.

Kelleher, J., Youll, P., Nelson, A., Hadjivassiliou, K., Lyons, C. and Hills, J. (2002) *Delivering a work-focused service: Final findings from ONE case studies and staff research*. DWP Research Report 166, Norwich: HMSO

Kellet, S. Bickerstaffe, D., Purdie, F., Dyke, A., Filer, S., Lomax, V. and Tomlinson, H. (2011) 'The clinical and occupational effectiveness of condition management for Incapacity Benefit recipients', *British Journal of Clinical Psychology*, 50, pp. 164-177.

Larkin, M., Watts, S. and Clifton, E. (2006) 'Giving voice and making sense in interpretative phenomenological analysis', *Qualitative research in psychology,* 3, pp.102-120.

Layard, R. (2006) 'The Depression Report – A New Deal for Depression and Anxiety Disorders', *London School of Economics and Political Science. Centre for Economic Performance. Mental Health Policy Group*. Available at: http://eprints.lse.ac.uk/818/1/DEPRESSION_REPORT_LAYARD.pdf (Accessed 9 May 2012).

Lechmann, D. and Schnabel, C. (2013) Absence from Work of the Self-Employed: A Comparison with Paid Employees*, Institute for the study of labor,* Discussion Paper No. 7756, pp. 1-28.

Lehmann, E. (2015) 'What if 'what works' doesn't?' *Evaluation*, 21 (2), pp. 167-172.

Legard, R., Lewis, J., Hiscock, J. and Scott, J. (2002) *Evaluation of the Capability Report: Identifying the work-related capabilities of incapacity benefits claimants*. DWP research report 162*,* Norwich: HMSO

Le Grand, J. and Bartlett, W. (1993) *Quasi-markets and social policy*. London: Macmillan

Lindbeck, A. (2004) 'An essay on Welfare State Dynamics' in Sodersten, B. (ed.) *Globalization and the welfare state*, New York: Palgrave Macmillan

Lindsay, C. and Dutton, M. (2009) 'Employability through health? Partnership-based governance and the delivery of Pathways to Work condition management services', *Employment Research Institute*, 31, pp. 245-264.

Linehan. M, (1993) *Skills training manual for treating borderline personality disorder.* London: Guilford Press

Lonsdale. S, Lessof. C, and Ferris, G. (1993) *Invalidity Benefit: A Survey of recipients*. DWP Research report 19, Norwich: HMSO

Loumidis. J, Youngs. R, Lessof. C, and Stafford, B. (2001) *New Deal for Disabled People: National Survey of incapacity benefits claimants*. DWP Research Report 160, Norwich: HMSO

Macfarlane, B. (2009) *Researching with Integrity*, Abingdon: Routledge

Malim, T. Birch, A. and Wadely, A. (1992) *Perspectives in psychology. First edition.* Hampshire: Macmillan

McFadyen, R.G. (1995) 'Coping with threatened identities: unemployed peoples' self-categorizations', *Current Psychology*, 14 (3), pp.233-257.

McInnes, R. (2012) *ESA and incapacity benefit statistics*. Standard Note SNO1421, House of Commons Library

Mead, L. (1997) *From Welfare to Work: Lessons from America*. London: IEA Welfare Unit

Mertens, D and Ginsberg, P. (2009) *Handbook of Social Research Ethics,* Los Angeles: Sage

Millward, L. J., Lutte, A. and Purvis, R. G. (2005) 'Depression and the perpetuation of an incapacitated identity as an inhibitor of return to work', *Journal of psychiatric and mental health nursing,* 12 (5) pp. 565–573.

Mitchell, M. and Woodfield, K. (2008) *Qualitative research exploring the Pathways to Work sanctions regime*. DWP Research Report No 475. Norwich: HMSO

Moran, D. (2000) *Introduction to phenomenology*. London: Routledge

Morrell, J. (2005) 'Why are there unintended consequences of program action and what are the implications for doing evaluation?' *American Journal of Evaluation,* 26 (4), pp. 444-463.

National Audit Office, (2010) *Department for Work and Pensions Support to incapacity benefit claimants through Pathways to Work*, *Report by the controller and auditor general, HG21, Session 2010-2011*. Norwich: HMSO

National Audit Office, (2014) *The work programme, HC 266, Session 2014-15*: NAO

National Audit Office, (2016) *Contracted-out health and disability assessments, HC 609, Session 2015-16*: NAO

Newton, B., Meager, N., Bertram, C., Corden, A., George, A., Lalani, M., Metcalf, H., Rolfe, H., Sainsbury, R. and Weston, K. (2011) *Work Programme evaluation: Findings from the first phase of qualitative research on programme delivery.* DWP Research Report 821, Norwich: HMSO

Newton, B., Meager, N., Corden, A., Irvine, A. and Sainsbury, R. (2014) *Work Programme evaluation: the participant experience report*. DWP Research Report 892, Norwich: HMSO

NHS North West (2011) *Greater Merseyside NHS Condition Management Programme*. Available at: www.ewin.northwest.nhs.uk/ (Accessed 20 March 2012)

Nice, K. and Davidson, J. (2010) *Provider-led Pathways: experiences and views of Condition Management Programmes*. DWP Research Report No 644. Norwich: HMSO

Nice, K. Davidson, J. and Sainsbury, R. (2009) *Provider-led Pathways to Work: Experiences and views of early implementation*. DWP Research Report 595, Norwich: HMSO

Nolan, A. and Wong, G. (2004) *Evaluating local economic and employment development.* Paris: OECD.

Noordik, E., van Dijk, F.J., Nieuwenhuijsen, K. and van der Klink, J.J. (2009) 'Effectiveness and cost-effectiveness of an exposure-based return-to-work programme for patients on sick leave due to common mental disorders: design of a cluster-randomized controlled trial', *BMC Public Health*, 9 (140), pp. 1-11.

Norris, N. (2015) 'Democratic evaluation: The work and ideas of Barry MacDonald', *Evaluation,* 21 (2) pp.135-142.

Nystuen, P. and Hagen, K. B. (2006) 'Solution-focused intervention for sick listed employees with psychological problems or muscle skeletal pain: a randomised controlled trial', *BMC Public Health*, 6(1), 69.

Osgood, J., Stone, V. and Thomas, A. (2002) *Delivering a work-focused service: views and experiences of clients*. DWP research report 167*,* Norwich: HMSO

Ostrey, A. and Spiegel, J. (2004) 'Labour Markets and Employment Insecurity: Impacts of globalization on service and healthcare-sector *workforces', International Journal of Occupational and Environmental Health*, 10 (4) pp. 368-374.

Parker, P. (2017) 'The lightning process: using neuroscience to rebuild health'. Available at: http://lightningprocess.com/phil-parker/ (Accessed: 27 March 2017)

Pawson, R. and Tilley, N. (1997) Realistic Evaluation. London: Sage.

Pawson, R. (2005) 'The ABC of evaluation', *American Journal of Evaluation*, 26 (4), pp. 582-583.

Peck, J. and Theodore, N. (2000) 'Work first: workfare and the regulation of contingent labour markets'. *Cambridge Journal of Economics,* 24, pp. 119-138.

Pittam, G., Secker, J., Plowright, C. and Ford, F. (2008) 'Qualitative evaluation of the Impact of the Pathways to Work Condition Management Programme', Anglia Ruskin University

Portes, J. (2012), 'Welfare and work: continuity and change', *National Institute Economic Review* No. 221

Pringle, J., Drummond, J., McLafferty, E. and Hendry, C. (2011) 'Interpretative phenomenological Analysis: a discussion and critique', *Nurse researcher*, 18 (3), pp. 20-24.

Prochaska, J. and DiClemente, C. (1983) Stages and processes of self-change in smoking: toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, 5, pp. 390–395.

Purdie, F. and Kellett, S. (2015) 'The influence of presenting health condition on eventual return to work for individuals receiving health-related welfare benefits', *Social Policy Administration*, 49(2), pp. 236–253.

Reagon, C. (2011) 'The changing role of occupational therapy in vocational rehabilitation: reflections on an evaluation of Condition Management Programmes' *British Journal of Occupational Therapy*, 74(6), pp. 309-311.

Reid, K., Flowers, P. and Larkin, M. (2005) 'Exploring the lived experience', *The Psychologist*, 18, pp. 20–23.

Riley, R., Bewley, H., Kirby, S., Rincon-Aznar, A. and George, A. (2011) *The Introduction of JobCentre Plus: An evaluation of labour market impacts*. Department for Work and Pensions Research Report No 781, Norwich: HMSO

Riach, K. and W. Loretto (2009) 'Identity work and the 'unemployed' worker: Age, disability and the lived experience of the older unemployed', *Work Employment and Society* ,23(1), pp. 102-119.

Rogers, C. (1951) *Client-centred therapy.* London: Constable

Rogers, C. (1961) *On becoming a person: a therapist's view of psychotherapy*, London: Constable

Rossi, P., Lipsey, M. and Freeman, H. (2004) *Evaluation: a systematic approach.* London: Sage.

Rowlingson, K. and Berthoud, T. (1996) *DISABILITY, BENEFITS AND EMPLOYMENT: An evaluation of Disability Working Allowance*. DSS Research Report 54, Norwich: HMSO

SALUS (2010) Condition Management Evaluation Lanarkshire. Available at: www.southlanarkshire.gov.uk/.../salus_condition_management_survey. (Accessed 25 May 2012).

Shakespeare, T. Watson, N. and Abu Alghaib, O. (2017) 'Blaming the victim, all over again: Waddell and Aylward's biopsychosocial (BPS) model of Disability', *Critical Social Policy*, 37(1), pp. 22–41.

Smith, J.A., Flowers, P. and Larkin, M. (2009) *Interpretative phenomenological Analysis: theory and research.* London: Sage

Scriven, M. (1994) 'The fine line between evaluation and explanation', Evaluation Practice, 15 (1) pp. 75-77.

Scriven, M. (1998) 'Minimalist theory: The least theory that practice requires', American Journal of evaluation, 19 (1) pp. 57-70.

Shadish, W. R., Cook, T.D. and Leviton, L. C. (1991) *Foundations of Programme evaluation*. London: Sage

Shinebourne, P. (2011) *The Theoretical Underpinnings of Interpretative Phenomenological Analysis (IPA),* Existential Analysis 22, (1) pp. 16-31.

Simons, H. (2015) 'Interpret in context: generalizing from the single case in evaluation', *Evaluation*, 21 (2), pp. 173-188.

Smith, A. (2002) *Pathways to work: Helping people into employment. Department of work and pensions CM5690*, Norwich: The stationery office

Smith, A. (2003) *Pathways to work: Helping people into employment. The Government's response and action plan. Department of Work and Pensions CM 5830*, Norwich: The stationery office

Smith, J.A. and Osborn, M. (2004) 'Interpretative phenomenological analysis', in Smith, J.A. (ed.) *Qualitative psychology: a practical guide to research methods, Second edition*, London: Sage

Smith, J. A. (2004) 'Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology', *Qualitative research in psychology,* 1, pp.39-54.

Snaith, R.P. (2003) The hospital anxiety and depression scale, *Health and Quality of Life Outcomes*, 1 (29), pp.1-4.

Stafford, B. (2003) 'Beyond lone parents: extending welfare to work to disabled people and the young unemployed', in Walker, R. and Wiseman, M. (eds) *The welfare we want: the British challenge for American Reform*, Bristol: Policy Press

Sridharan, S. and Nakaima, A. (2012) 'Towards an evidence base of theory-driven evaluations: some questions for proponents of theory-driven evaluation', *Evaluation*, 18 (3), pp. 378-395.

Stanley, K. (2004) *Fit for purpose: the reform of incapacity benefit.* London: Institute for public policy research

Stoker, S. (2000) 'Urban political science and the challenge of urban governance' in Pierre, J. (ed) *Debating Governance*, Oxford: Oxford University Press

Tennant, R., Kotecha, M. and Rahim, N. (2010) *Provider-led Pathways: experiences and views of implementation in phase 2 districts*. DWP Research Report 643, Norwich: HMSO

Thorslund, K.W. (2007) 'Solution-focused group therapy for patients on long-term sick leave: A comparative outcome study', *Journal of Family Psychotherapy*, 18(3), pp. 11–24.

Turton, N. (2001) 'Welfare benefits and work disincentives', *Journal of Mental Health,* 10 (3), pp.285-300.

Waddell, G. and Aylward, M. (2010) *Models of sickness and disability applied to common health problems*, Cardiff: Royal Society of Medicine Press Ltd

Waddell, G. and Aylward, M. (2005) *The scientific and conceptual basis of incapacity benefits.* London: The stationery office

Walker, R. (1998) 'Promoting positive welfare', *New Economy,* 1070 (6)

Walker, R. and Wiseman, M. (2003) 'Making welfare work: UK activation policies under New Labour', *International Social Security Review*, 56 (1), pp. 3-29.

Warren, J., Bambra, C., Kasim, A., Garthwaite, K., Mason, J. and Booth, M. (2013) 'Prospective pilot evaluation of the effectiveness and cost-utility of a 'health first' case management service for long term Incapacity Benefit recipients', *Journal of Public Health,* 36, pp. 117-125

Warrener, M., Graham, J. and Arthur, S. (2009) *A qualitative study of customer views and experiences of the Condition Management Programme in Jobcentre Plus Pathways to Work*. DWP research report 582, Norwich: HMSO

Welfare Reform Act (2007) Available at: www.legislation.gov.uk/ukpga/2007/5/pdfs/ukpga_20070005_en.pdf. (Accessed: 9 May 2012).

Weiss. C. E, (1997) 'How can theory based evaluation make greater headway?', Evaluation Review, 21 (4) pp. 501-524.

Wiggan, J. (2012) Telling stories of 21st century welfare: The UK coalition government and the neo-liberal discourse of worklessness and dependency*, Critical Social Policy,* 32 (3) pp. 383-405.

World Health Organisation (1993) *The ICD-1- Classification of mental and behavioural disorders: diagnostic criteria for research.* Geneva: World Health Organisation

Appendices

Appendix 1 – Summary of themes from welfare to work evaluation literature 1993 – 2014

Long term incapacity claimants are characteristically detached from the labour market (Lonsdale et al, 1993; Erens and Ghate, 1993; Loumidis et al, 2001; Newton et al, 2014)

Long term incapacity claimants possess lower human capital resources (Lonsdale et al, 1993; Erens and Ghate, 1993; Rowlingson and Berthoud, 1996; Dorsett et al, 1998; Bunt et al, 2001; Davies and Johnson, 2001; Ashworth et al,2001; Hedges and Sykes, 2001; Davies et al, 2001; Kelleher et al, 2002; Fylan et al, 2011; Newton et al, 2014)

Those most detached from labour market face other barriers to work which health based programmes struggle to address (Green et al, 2000; et al, 2001; Loumidis et al, 2001; Kelleher et al, 2002; Corden and Nice, 2006a; Blank et al, 2008; Hayllar et al, 2010; Hayllar and Wood, 2011; Fylan et al, 2011; Newton et al, 2011; Dibben et al, 2012; Newton et al, 2014)

Programmes report improved functioning but this is not reflected in return to work outcomes (Rowlingson and Berthoud, 1996; Green et al, 2000; Corden et al 2005; Pittam et al, 2008; Ford, 2008; Dorsett ,2008; Bewley et al, 2008; Warrener et al, 2009; Ford and Plowright, 2009; Hudson et al, 2009; Nice and Davidson, 2010; Kellet et al, 2010; Hayllar et al, 2010; Hayllar and Wood, 2011; Newton et al, 2014)

Claimants own views on health and employment prospects impact strongly on likelihood of obtaining work (Lonsdale et al, 1993; Dorsett et al, 1998; Green et al, 2000; Davies and Johnson, 2001; Corden and Sainsbury, 2001; Hedges and Sykes, 2001; Davies et al, 2002; Brouwers et al, 2006; Corden and Nice, 2006a; Corden and Nice, 2006; Barnes and Hudson, 2006; Ford, 2008; Dorsett, 2008; Warrener et al, 2009; Hudson et al, 2009; Hayllar et al, 2010; Newton et al, 2011; Newton et al, 2014)

The link between illness and unemployment was unclear (Erens and Ghate, 1993; Ashworth et al, 2001; Loumidis et al, 2001; Adam et al, 2006; Corden and Nice, 2006a; Corden and Nice, 2006; Bewley et al, 2007; Blank et al, 2008; Ford, 2008; Dorsett, 2008; Ford and Plowright, 2009; Høgelund et al, 2010; Hayllar and Wood, 2011; Newton et al, 2011; Dibben et al, 2012)

Interventions faced difficulties reducing their effectiveness (Cotton et al, 2000; Hedges and Sykes, 2001; Green et al, 2001; Kelleher et al, 2002; Corden et al, 2005; Brouwers et al, 2006; Corden and Nice, 2006a; Corden and Nice, 2006; Barnes and Hudson, 2006; Nystuen et al, 2006; Dorsett, 2008; Nice et al, 2009; Noordik et al, 2009; Hudson et al; Nice and Davidson, 2010; Tennant et al, 2010; Newton et al, 2011; Newton et al, 2014)

Knowledge of participants' unique circumstances was seen as a necessary requirement to inspire change (Davies and Johnson, 2001; Corden and Sainsbury, 2001; Hedges and Sykes, 2001; Davies et al, 2001; Green et al, 2001; Kelleher et al, 2002; Corden et al, 2005; Brouwers et al, 2006; Corden and Nice, 2006a; Corden and Nice, 2006; Barnes and Hudson, 2006; Thorslund, 2007; Pittam et al, 2008; Ford, 2008; Ford and Plowright, 2009; Hudson et al, 2009; Nice and Davidson, 2010; Tennant et al, 2010; Newton et al, 2014)

Appendix 2 - Ethical approval (2010) for initial data collection: Participant information sheet and consent form.

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Participant Information Sheet

Purpose of the Research Project

</div>

Significant investment of time, resources and money are routinely allocated to programmes like the Condition Management Programme. Programmes are usually designed to incorporate the most up to date practices e.g. NICE Guidelines. However, some observers have highlighted that the attitude of the participant is the most significant factor in regard to the eventual outcome. This research project seeks to establish what other factors make a programmes like this successful.

<div align="center">

What will participation involve?

</div>

Psychological Questionnaires:
Psychological questionnaires are designed to be helpful. They assist in making the programme relevant to you and they also help to measure changes is psychological wellbeing. If you take part in the Research Project, you will be asked to undertake an additional questionnaire before you start the programme, at the end of the programme and again three months later.

Semi-structured Interviews:
You will be invited to attend an interview with the researcher upon completion of your Condition Management Programme. This will last approximately one hour. You will be asked questions about what you found useful and helpful in the programme. The purpose of the interview is to provide qualitative information (opinions and beliefs) to complement the qualitative data (facts and numbers) which are generated by the questionnaires.

Observation:
The researcher wants to know what happens during therapeutic change programmes to help participants to achieve their goals. For this purpose, they will make notes of their own observations during sessions. In addition, some sessions may be taped using video or audio equipment. All participants whether participating in the research project or not, will be required to give their consent to be recorded.

Some important points to consider:
Participation is absolutely voluntary.
You can withdraw at any point without giving any reason.
Your participation in the Condition Management Programme will not be affected in any way.
Your name will not be published.
All data collected is anonymised.

The Researcher
The primary researcher is **Steve Roberts**.
Steve works for Priory Healthcare and is a Counsellor/Therapist. He is qualified in counseling to Masters Degree level. His primary training is in the Person Centred Approach and he has subsequently gained further training qualifications in Cognitive Behavioural Therapy. Steve has worked in one to one therapy and has also provided group therapy in primary health settings and also at a drug and alcohol rehabilitation centre. Steve has also provided psycho educational group programmes (such as Condition Management Programme) in healthcare and commercial settings.

<div align="center">

If you would to participate then please indicate this to the researcher. You will be asked to sign an Informed Consent Form which the researcher will explain to you.

</div>

</div>

Appendix 2 (continued)

Research Participation - Informed Consent Form

Thank you for agreeing to participate in this research project. Please read the following contract carefully before signing below to indicate that you have fully understood the implications and requirements of both yourself and the research author in this research project.

You:-

Are willing to donate approximately three hours of time in addition to the standard programme length.
Will not be provided with any financial or material compensation in return for participation.
May withdraw from the research at any stage without giving reasons.
Are willing to share biographical data obtained through interview.
Are willing to allow data from questionnaires to be gathered for research purposes.
Are willing for research findings (but not personal information) to be shared with university research staff and interested parties within Shaw Trust and Priory Healthcare.
Are willing for research findings to be published in the public domain.
Are able to obtain all information that is kept on you under provision of the Data Protection Act, 1998
May advise a Priory Healthcare representative if you believe that your involvement in the research project has been handled incorrectly. You will not have to speak with the research author directly.
May contact the researcher upon completion of the study to talk through the results of the overall study.
Fully understand that individual feedback on the results of any research data specific to yourself cannot be provided by the researcher.

The research author:-

Will ensure your data remains anonymised. (A number/letter code will be used in place of your name)
Will store electronic data securely.
Will not disclose your identity or participation with any other person.
Will ensure that data provided by yourself will be included in data analysis.
Will advise you immediately if your participation in the research project is no longer required for any reason and will either return data gathered up to that point to you or destroy it as you wish.
Will ensure that your participation in the research project will not affect or prejudice in any way your participation in the Condition Management Programme.
Will apply standard risk assessment procedures as used throughout the CMP if it is believed that you are at risk of physical, mental or emotional harm.
Will advise therapeutic staff within Priory CMP and/or Employment Advisors at Shaw Trust if, during a research interview throughout the course of the CMP, it is established that you are at risk of harm. This will be done in accordance with standard operating procedures for CMP.
Will not discuss or reveal any information you provide outside of the standard CMP with any other person (except in the case of your personal safety being compromised).

Please confirm the items below	Name	Signature
This information has been provided in a format that I can understand.		
I have had any queries fully explained to me.		
I fully understand the requirements of myself and the researcher		
I am willing and able to participate in this research programme		

Appendix 3 – Ethical approval (2013) for Case Study interviews: Participant letter, information sheet and consent forms.

Can incapacity be reduced to medical criteria and return to work be enabled by evidence-based therapies in the Condition Management Programme?

I am writing to you about the research I am conducting as part of my PhD qualification at the University of East Anglia (UEA).

I am interested in investigating barriers to employment that are experienced by incapacity benefit claimants. In particular, I am looking at changes in how people see themselves, the impact of organisations such as the Benefits Agency, National Health Service and Job Centre and the effect these have on health. The information will be useful in finding out how psychological therapy could be used more effectively to assist people back into employment.

It would be very helpful if you could take part in my research. Please read the information sheet attached to this letter and, if you are willing to take part in this study, please sign and return the consent form enclosed.

If you have any further questions about the research, please contact me on s.roberts1@uea.ac.uk. If you have any concerns about the research please contact my supervisor: Professor Anne Cockburn at A.Cockburn@uea.ac.uk.

Yours sincerely,

Steve Roberts

INFORMATION SHEET

Can incapacity be reduced to medical criteria and return to work be enabled by evidence-based therapies in interventions such as the Condition Management Programme?

Researcher: Steve Roberts

Supervisor: Professor Anne Cockburn

I would like to invite you to take part in my research and I need your signed consent if you agree to participate. Before you decide, you need to know why I am doing this research and what it will involve. Please take time to read this information carefully to help you decide whether or not to take part. Please contact me if there is anything that is not clear or if you would like more information. Thank you for reading this.

What is this study about?

I am trying to find out what factors, in addition to illness, make it hard for incapacity benefit claimants to seek and find employment.

How will you be involved?

I will interview you for between 1 and 2 hours, at a time and place that is agreeable to you. It is anticipated that one interview will be sufficient. However, if it is important to spend longer on any aspect of the interview than is possible in one interview then I may ask if you would be willing to attend a second meeting. The interview will be recorded.

Who will have the access to the research information (data)?

Data management will follow the 1988 Data Protection Act. I will not keep information about you that could identify you to someone else. All the names of the individuals taking part in the research will be anonymised to preserve confidentiality. The data will be stored safely and will be destroyed when my project is completed.

The data will only be used for my work and will only be seen by myself, my supervisor, and those who mark my work. Once the project is written up, the PhD thesis will be available to be read at the UEA library.

Who has reviewed the study?

The research study has been approved under the regulations of the University of East Anglia's School of Education and Lifelong Learning Research Ethics Committee.

How will findings from this study be published (other than in the PhD)?

Separate academic papers, books or presentations at conferences may be written and delivered by the researcher before or after submission of the PhD which may make use of the data you provide. The same guidelines will apply to protect your anonymity and to secure confidentiality as per the PhD study.

Who do I speak to if problems arise?

If there is a problem please let me know. You can contact me via the University at the following address:

Steve Roberts

School of Education and Lifelong Learning
University of East Anglia
Appendix 3 (continued)

If you would like to speak to someone else you can contact my supervisor:

Professor Anne Cockburn,

School of Education and Lifelong Learning

University of East Anglia

NORWICH NR4 7TJ

A.Cockburn@uea.ac.uk

If you have any complaints about the research, please contact the Head of the School of Education and Lifelong Learning, Dr Nalini Boodhoo, at n.boodhoo@uea.ac.uk.

Sometimes, talking about difficult times in our lives can be upsetting. If you find that participation in this project causes you distress then I will be pleased to signpost you to suitable providers of counselling or you may wish to contact one of the following counselling agencies:

The Norwich Centre:- 01603 617709

St Barnabas Counselling Service:- 01603 625222

Off the Record:- 01603 626650

OK, I want to take part – what do I do next?

You need to fill in one copy of each consent form ('Consent to participate' form and 'Use of data' consent form) and return them in the prepaid envelope provided. Please keep the letter, information sheet and the second copy of each consent form for your information.

Can you change your mind?

Yes. You have the right to withdraw from the research at any time without giving any reason up to the date of PhD submission (planned for 30th September 2015)

Thank you very much for your time.

Appendix 3 (continued)

CONSENT FORM

(1ST COPY FOR RETURN TO RESEARCHER)

Can incapacity be reduced to medical criteria and return to work be enabled by evidence-based therapies in interventions such as the Condition Management Programme?

I have read the information about the study and:

Please tick the relevant box.

I am willing to take part in the study.

I am not willing to take part in the study.

Your Name: ……………………………………

Your Signature: …………………………………………………………….

Date: ……………………………………………..

Appendix 3 (continued)

USE OF DATA CONSENT FORM

(1ST COPY FOR RETURN TO RESEARCHER)

Can incapacity be reduced to medical criteria and return to work be enabled by evidence-based therapies in interventions such as the Condition Management Programme?

Please tick the relevant boxes.

I have read the information about the study and understand that I may, if I wish, review the data that I provide (written interview transcript) and make amendments or omissions to this data. I understand that I may review written

findings that are taken from my data but may not request that they be changed or re-worded.

I wish to review my data (interview transcript) before it is used for writing up.

I wish to review findings that are directly attributable to my data alone prior to submission of the PhD.

I understand that any subsequent request to remove or alter data or withdraw consent to use data must be made prior to submission of the PhD thesis which is planned for September 30th 2015.

Your Name: …………………………………

Your Signature: ……………………………..

Date: ………………………………………..

Appendix 4 – Ethical approval (2015) for practitioner interviews: Latter, information sheet and consent forms.

Steve Roberts

Post Graduate Research Student

16th October 2015

University of East Anglia

Norwich Research Park

Norwich NR4 7TJ

United Kingdom

Email:xxxxxxxxxxx@uea.ac.uk

Tel: +44 (0) 1603 59xxxx

Fax: +44 (0) 1603 59xxxx

Evaluation of the Norfolk Condition Management
PARTICIPANT INFORMATION STATEMENT

(1)   What is this study about?

You are invited to take part in a research study about the Condition Management Programme. The Condition Management Programme was offered to claimants of Incapacity Benefit in order to help them to overcome, or improve their management of, a health condition which stood as a barrier to re-employment. The overarching purpose of this was to reduce the number of individuals claiming Incapacity Benefit as well as to improve the quality of life for people who wanted to work but faced challenges in attaining it. This research project aims to evaluate the effectiveness of CMP in achieving its aims.

You have been invited to participate in this study because of insights you may be able to offer as a result in your involvement in CMP as a mental health professional. This Participant Information Statement tells you about the research study. Knowing what is involved will help you decide if you want to take part in the research. Please read this sheet carefully and ask questions about anything that you don't understand or want to know more about.

Participation in this research study is voluntary. By giving your consent to take part in this study you are telling us that you:

✓   Understand what you have read.
✓   Agree to take part in the research study as outlined below.
✓   Agree to the use of your personal information as described.

(2)   Who is running the study?

The study is being carried out by the following researcher: Steve Roberts, Post-graduate PhD research student.

Steve Roberts is conducting this study as the basis for the degree of PhD at The University of East Anglia. This will take place under the supervision of Professor Nigel Norris.

(3)   What will the study involve for me?

Appendix 4 (continued)

This study is based on evaluating the continuity of CMP through its stages of design and delivery. These stages are:

1. Problem evaluation - Foundations of the social problem (of increased numbers of IB claimants) from the perspective of policy makers.

2. Programme concept (proposed overall solution to the problem), Programme theory (specific solutions to specific problems) and Implementation Theory (method and plausibility of the change process).

3. Programme design (building a programme in line with the principles above)

4. Programme delivery.

5. Outputs (immediate and measurable clinical outcomes/observable health/work-related behaviour changes)

6. Outcomes (medium/longer term health/work related behaviour change and return to work outcomes)

This section of research is focused on stage 4 – programme delivery - with a view to examining elements of continuity (and possibly discontinuity) of the content and method of delivery with the programme's stated aims and anticipated outcomes.

I will interview you for around one hour, at a time and place that is agreeable to you. It is anticipated that one interview will be sufficient. However, if it is important to spend longer on any aspect of the interview than is possible in one interview then I may ask if you would be willing to attend a second meeting. The interview will be recorded. The purpose of the interview is to gain your insights and experiences of delivering the CMP.

(4) How much of my time will the study take?

I will interview you for around one hour, at a time and place that is agreeable to you. It is anticipated that one interview will be sufficient. However, if it is important to spend longer on any aspect of the interview than is possible in one interview then I may ask if you would be willing to attend a second meeting. The interview will be recorded. The total time commitment should be between one and two hours.

(5) Do I have to be in the study? Can I withdraw from the study once I've started?

Being in this study is completely voluntary and you do not have to take part. Your decision whether to participate will not affect your current or future relationship with the researchers or anyone else at the University of East Anglia or place of work.

If you decide to take part in the study and then change your mind later, you are free to withdraw at any time. You can do this by advising me personally or, if easier, by emailing my supervisor: A.cockburn@uea.ac.uk

You are free to stop the interview at any time. Unless you say that you want us to keep them, any recordings will be erased and the information you have provided will not be included in the study results. You may also refuse to answer any questions that you do not wish to answer during the interview. If you decide at a later time to withdraw from the study your information will be remove from our study records and will not be included in the study results, up to the point that we have analysed and published the results and this would include the submission of the dissertation for assessment purposes.

Appendix 4 (continued)

Transcripts of interviews will be made available to you if you request. You will be offered the opportunity to review the transcript of the interview and you are invited to contact me with any amendments you wish to make or if you wish for any sections of the transcript to be omitted.

may ask to review your transcript at any time up to the submission of the thesis (September 30th 2016).

(6)   Are there any risks or costs associated with being in the study?

You will not be required to discuss personal or professional practice so there is no risk of disclosure which could be harmful either professionally or personally. During the process of discussing the CMP, it is possible that recollections of former programme participants who were at that time in crisis could, in turn, lead to some distressing memories. In the event of this, please be reminded that you are not required to continue participating and I will advise you on how to access de-briefing or counselling.

Aside from the points mentioned above, we do not expect that there will be any risks or costs associated with taking part in this study.

(7)   Are there any benefits associated with being in the study?

It is hoped that the study will add to the body of knowledge on CMP and similar social programmes which may be of benefit to policy makers, programme designers and to participants of future programmes of a similar nature.

(8)   What will happen to information about me that is collected during the study?

Personal information about you is not required for this study and therefore none will be collected for use in this study.

An audio recording will be made of the interview. This will be transcribed either by the research student or via a transcription service. Your real name will be changed in the transcript. As there were only a small number of clinicians involved in the CMP, there remains a risk that you could be identified. As the data are unlikely to be sensitive, this is not regarded as being a significant risk. The transcript and original recording will be kept securely for a period of ten years following publication of my thesis after which they will be destroyed. An electronic version of the transcript will only be stored on UEA data storage.

You may request to see or make amendments to the transcript up to the date of submission (September 30th 2016). You may also request to destroy the original recording up to the date of submission. The transcript and specific passages from it will be published in the PhD thesis. It is also possible that they may be published in subsequent publications or public presentations. The data generated from the interview will not be used in research projects undertaken by third party researchers.

By providing your consent, you are agreeing to us collecting personal information about you for the purposes of this research study. Your information will only be used for the purposes outlined in this Participant Information Statement, unless you consent otherwise. Data management will follow the 1998 Data Protection Act and the University of East Anglia Research Data Management Policy (2013).

Your information will be stored securely and your identity/information will be kept strictly confidential, except as required by law. Study findings may be published. Although every effort will be made to protect

Appendix 4 (continued)

your identity, there is a risk that you might be identifiable in publications due to the nature of the study and/or the results. In this instance, data will be stored for a period of 10 years and then destroyed.

We will keep the information we collect for this study, and we may use it in future projects. By providing your consent you are allowing us to use your information in future projects. We don't know at this stage what these other projects will involve. We will seek ethical approval before using the information in these future projects.

(9)   What if I would like further information about the study?

When you have read this information, *Steve Roberts* will be available to discuss it with you further and answer any questions you may have. If you would like to know more at any stage during the study, please feel free to contact me by email at steve.roberts2005@yahoo.co.uk or by phone on 07941 298229 or Professor Nigel Norris, Supervisor by email at N.Norris@uea.ac.uk or by phone on 01603 456161: ext 2620

(10)   Will I be told the results of the study?

You have a right to receive feedback about the overall results of this study. You can tell us that you wish to receive feedback by *ticking the relevant box on the consent form.* This feedback will be in the form of *a one page summary.* You will receive this feedback after the study is finished.

(11)   **What if I have a complaint or any concerns about the study?**

Research involving humans in UK is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this study have been approved under the regulations of the University of East Anglia's School of Education and Lifelong Learning Research Ethics Committee.

If there is a problem please let me know. You can contact me via the University at the following address:

   Steve Roberts

   School of Education and Lifelong Learning

   University of East Anglia

   NORWICH NR4 7TJ

   [S.Roberts1@uea.ac.uk]

   If you would like to speak to someone else you can contact my supervisor:

   [Professor Nigel Norris, N.Norris@uea.ac.uk, 01603 456161: ext 7231

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact please contact the Head of the School of Education and Lifelong Learning, Dr Nalini Boodhoo, at n.boodhoo@uea.ac.uk.

(12)   OK, I want to take part – what do I do next?

Appendix 4 (continued)

You need to fill in one copy of the consent form and return it to me in the pre-paid envelope. Please keep the letter, information sheet and the 2nd copy of the consent form for your information.

This information sheet is for you to keep

PARTICIPANT CONSENT FORM (1st Copy to Researcher)

I, ...[PRINT NAME], agree to take part in this research study.

In giving my consent I state that:

✓   I understand the purpose of the study, what I will be asked to do, and any risks/benefits involved.

✓   I have read the Participant Information Statement and have been able to discuss my involvement in the study with the researchers if I wished to do so.

✓   The researchers have answered any questions that I had about the study and I am happy with the answers.

✓   I understand that being in this study is completely voluntary and I do not have to take part. My decision whether to be in the study will not affect my relationship with the researchers or anyone else at the University of East Anglia now or in the future.

✓   I understand that I can withdraw from the study at any time.

✓   I understand that I may stop the interview at any time if I do not wish to continue, and that unless I indicate otherwise any recordings will then be erased and the information provided will not be included in the study. I also understand that I may refuse to answer any questions I don't wish to answer.

✓   I understand that personal information about me that is collected over the course of this project will be stored securely and will only be used for purposes that I have agreed to. I understand that information about me will only be told to others with my permission, except as required by law.

✓   I understand that the results of this study may be published. Although every effort will be made to protect my identity, I may be identifiable in these publications due to the nature of the study or results.

☐   Yes, I am happy to be identified.
☐   No, I don't want to be identified. Please keep my identity anonymous.

Appendix 4 (continued)

I consent to:

- **Audio-recording**   YES ☐   NO ☐

- **Reviewing transcripts**   YES ☐   NO ☐

- **Would you like to receive feedback about the overall results of this study?**

    YES ☐   NO ☐

If you answered **YES**, please indicate your preferred form of feedback and address:

☐ Postal: _____

_____

☐ Email: _____

....

Signature

....

PRINT name

....

Date

Appendix 5 – Practitioner interview question guide

CMP Practitioner interview

The interview will be semi-structured. A selection of questions from the following list will be asked in order to stimulate memories and recollections of the CMP.

What was your initial understanding of the purpose of CMP? Did this develop over time?

What was your understanding of the rationale behind CMP? (How was it intended to work?) Did this develop over time?

Can you describe specific desired outputs from the programme? (Describe difference between outputs and outcomes)?

How did you gain your understanding of CMP, its purpose and its rationale?

Are you/were you aware of any specific or general theories which underpinned CMP?

Are/were you aware of any consistencies or inconsistencies between the identified problems (experienced by participants), the desired outputs of the programme and the means (interventions) devised to deliver these outputs?

How did your understanding of CMP and its participants evolve over time?

What was your understanding of the problems faced by CMP participants?

In what ways did CMP address these problems?

What was your understanding of the then government's political agenda regarding IB claimants?

In your view, what were the strengths and weaknesses of the CMP? (How could it have been improved?)

Final question: (Describe evaluation theory behind the study). Do you have any thoughts on the implementation of CMP in light of this?

Appendix 6 – Sonia: IPA themes from practitioner interview

Comprehensive programme works best	Faith in programme	Problems with delivery	Challenging clients	Anger/alienation/disenfranchisement	Health focus at home and in workplace	Fear v comfort	Finance/Benefits Trap/Response to system	Claimant presentation	Relationships
(No longer) comprehensive prog	Programme theory – improve wellbeing	Appropriateness of referral	Disruption/derailing/challenging/resistance	Alienation/ disenfranchised	General drive for health at work	Fear of workplace	Better off on benefits (financial)	Claim trajectory	Importance of rapport/ trust/ relationship/ engagement.
Comprehensive – technical	(Faith in programme)	Programme dilution	Feeling put down – parent/child	Anger	(Lack of) drive for health in workplace	Comfort zone – no pressure / predictable finances	Financial – benefits trap	Employability	Relationship – impact
Comprehensive prog - flexibility	(Need for) funding	Programme fit (severity)	Group dynamic	Denial/resistance	Express less clinical – original more clinical	Stages of change / progression model	Needing to/ having to prove illness	Psychological / social presentation	Relationship with practitioner
Express was diluted	Belief in the programme.	Suitability of referral	Group dynamic – energy	Disillusioned – disenfranchised / given up	Condition focus	Catch 22 – need social interaction but feared it	Risk of RTW – better off on benefits	Motivation / engagement	Relationship with referrers
Programme length/intensity	Cuts in funding	Referrers – uncertainty / lack of understanding	Reluctance / resistance / ambivalence	Rejection of programme (don't want to buy it)	Getting well enough	Fear of leaving comfort zone	Resistance mainly financial	Non-health factors	Relationship with therapist
Flexibility/comprehensive (or lack of)	Evidence base	Logistics – meeting clients' needs	Perfect prog v resistance	Resentment	Health at work	Tackling anxiety/fear			Teacher/pupil dynamic
Implementation focus	Faith in programme (programme-first thinking)	Time pressure		Loss of confidence/hope	Health condition as gateway to referral	Wanting to work			Human factor – group needs
	Funding cut	Uncertainty amongst referrers		Familiarity with past RTW programmes	External factors (financial crisis) re non-success	Willingness to try			Authority - relationship
	Lack of funding	Severity of illness/problems			Impairment v incapacity	Increasing focus on work outcomes as time progressed			Balancing needs
					Lack of drive for health in workplace	Initial reticence about work.			Aim at majority
					Variable focus on clinical v social	Variable motivation/ readiness			

Appendix 7 – Clare: IPA themes from practitioner interview

Problem conception	Problem spec - Risk: fear v agency	Problem spec - Isolation and disenfranchisement	Problem spec - individual factors	Contexts	How course worked	How course worked (contd)	Improvers	Dual role (therapy v RTW agent)	Value of group	Prog theory	Autonomy
A 'social condition'/ social state	Ambivalence – risk	Clients are isolated / disenfranchised	Character traits	Context out of our scope	Acceptance / empathy	Good resources	1:1 would improve it	Balancing – individual v commissioners needs	Group – bonding/ identification	Empowerment/resourcing/ agency-creating	Delivery scope (to design/deliver as we saw fit)/ locally driven
Complex condition	Health = only part of problem – social trap too.	Isolated/disenfranchised/ stigma	Stress thresholds	Interaction of issues and context	Anchoring in reality/ orientation right from outset	How versus what of delivery	Need for greater work / connection with referrers	Conflict of interest (political v personal agenda)	Group = powerful tool	Gain confidence/ self-efficacy in managing symptoms	Primarily a psycho-social course (self and work)
Complexity of factors / problem	Catch 22/ rational risk of losing benefits	Isolation v security/comfort		Toxic workplaces	Assistance from isolation/ disenfranchisement	Personal development v skills/health management	Need for individual input (making personal relevance)	Conflict of interests – best interests of state v client.	Group disadvantage re specific presentations	Increase resources	Making personal sense of the programme
Traumatic experience of work	Agency and motivation	Judgement/ stigma		Stress at work	Assistance rather than pressure	Focus on work - explicit in programme	Presentations – biographies	Difficulty (therapist) – lack of jobs	Group process (over content)	Increase self-interpretation of situation (either way re RTW)	Manager set tone
More than choice/decision	Avoidance/ Fear/ fear of recovery	Helplessness			Demonstrating understanding of the problem	Prog = mixture of benefits	Varying complexity – challenging presentations	Dilemma – therapist (ethics)	Content less important than process (group)	Outcome – self-efficacy/agency /choice	Not invested in their work status (therapist)
More than condition	Impacts of recovery/ impacts of recovery	Identity			Benefits trap – open/honest session	Prizing the individual	Express misses unique presentations	Dual role – therapist v agent of state		Outcome = increasing choice	Not trained but prior experience of groups
Multifactorial trap.	Need to remain ill/ investment in illness	Condition = inherently distressing			Broad range of interventions	Understanding problem = key to programme	Resistance/ambivalence - Is the 'solution' desirable?	Rationale v personal motivation (RTW v helping)		Outcome may be leave work (better self-care and decision making)	Personal interest in the programme – increase wellbeing and manage lives better
Problem – failure in coping	Stuckness / trap/ impact of time/length of claim	Social meaning of workless-ness			Core conditions (Rogers)	Social impacts – pivotal		Wellbeing v RTW		Outputs – better scores	Evolving concept of the problem
Problem – loss of vision / self/status interpretation	Spectre – the workplace				Course benefit – pause button to reflect	Grounding it in participants' experience		Social assumptions on value e.g. of work			Pride in package (therapist)
loss of vision/ understanding/interpretation	Proving illness – fear losing benefits				Delivery – allowing voice on key problems	Working on the person not the situation					RTW may not be best outcome

Appendix 8 – Hilary: IPA themes from practitioner interview

Autonomy in delivery	Programme theory	Problem concept	Dual purpose RTW and Therapy	Client agency	Context	Difficulties/challenges	Programme strengths	Value of group	Work	Facilitation skills
Ethics + competence (therapist)	Driven by clients	Getting stuck!	Accepts RTW agenda (therapist)	Agency	Circumstances / environment/context	Disruption	Effective/useful materials	Group (atmosphere)	Employers culture	Facilitation skills (value of)
Weak training – learned on job	Positive effect of course	Impacts of loss of employment (psycho social)	Agenda v needs	Agenda (RTW) v their needs	Context – trap/struck	Difficult to measure effectiveness (multi-variate)	Clients understanding/accepting of workplace	Group dynamics	Inconsistency of condition (inconsistent health)	Engagement v disengagement
Role of manager – set the tone	Purpose/theory – develop resilience/resources	Medical v social models	Formulaic v client centred	Being pulled back	Context (home)	Other variables e.g. context	Structure	Power of groups	Mental health prejudice (workplace)	Engagement v turn-off
Self-trained/understood.		Money (lack of)	Client centred	Choice / decision / agency	Context (unsupportive environment)	Compulsion	Good materials	Power of the group	Toxic workplaces	Facilitation skills (value and importance of)
Therapist making own sense		Money struggle – stress/trap	Culture of helping and valuing (care)	Individual decision making/expectations	Impact of context	Unpredictable outcomes	Good materials	Value of group (debate)	Value of work/activity	
Creating the programme (ourselves)		Workplace unable to accommodate	Discursive	Ownership/engagement	Negative environments	Variables – job availability		Value of group energy		
			Do no harm					Value of groups (identification, ideas, interaction, info-sharing)		
			Dual approach – structure v non-formulaic							
			Ethics – abuse (RTW only)							

Appendix 9 - Mick: Summary of themes from IPA analysis

Identity	Value of work/employment	Health	Relationships – Interaction with others	Optimism V Painful emotions/memories	Agency and control	Risk	Insight, awareness and evaluation (weighing up)	Organismic needs
Identity – Worker	Money – relationship with (success, freedom/liberty)	Health – impacts (Shock/loss)	Reaction to pressure (contrary)	Optimism	Self-activation v health	Stuck in rut	Choice (awareness of)	Belonging
Identity – striver v sciver	Money – Social and personal effects (opportunity/power)	Health – effects	Reaction to external agencies	Opportunity	Choice	Comfort of benefits	Comparison and contrast (experiences)	Need for love
Identity – useless/failure	Belonging	Health – diagnosis	Passive recipient of health care	Seizing moment	Acceptance – self	Temptation	Awareness/insightful	Need to be noticed
Identity and judgment/classification	Teamwork	Health – relationship/meaning	Health – GP relationship	Focus on positives	Acceptance – situation/circumstances	Avoidance	Sense of self in world – narrative –(written off)	Need for recognition
Identity (joker)	Social aspect of work	Illness – disinterest	Adversarial with gov't agencies	Hide pain/be strong attitude	Agency	Safety/caution v opportunity	Self-interest (enlightened)	Social connections/contact
Pride in work – pride in self	Work – habit		Demoralising effect of claiming	Personal pain	Decision making	Avoid wallowing	Self-reflection	
Roles (work, claimant, home)			Passive recipient of CMP/PtW	Glossing over negatives	Responsibility (personal)	Risk	Financially astute	
Work role – pride in			Sensitivity – argumentativeness	Denial, distortion, distraction	Self-determining	Fear of loss of benefit money	Nice/pleasing v not nice/displeasing	
Morals and values			Relationships – please v displease	Fresh start	Desire to work/opportunity of work	Protecting benefits	Aversion to being out of work	
Pride – in self			Mutual respect	Positive attitude	Independence	Fortune good/bad	Contentment/satisfaction/acceptance	
Pride in appearance			Sensitivity/negative reaction to criticism	Achievements (awareness of/focus)	Confidence	Financial security v insecurity	Options/negative alternatives	
Self-worth – v shame			Emulate others	Willingness	Story telling	Regret	safety/avoidance v written off	
Self-criticism			Criticism of government					
Shame of self/denial/blame			Victim of JobCentre/benefits agency					
Blame of outsiders			Own agenda v authorities					
Allying with victim groups			Narrative of unfairness					
			Victim story					
			Rough treatment					
			Pleasing self					

Appendix 10 - Irwin: Summary of themes from IPA analysis

Identity (who I am in relation to others and in the world)	Stress	Health/Capacity	Capability and function	Safety versus Fear (the experience of the problem)	Avoidance	Control	Superficiality v depth (reflection)
Judged/judgement	External demands	Illness	Deferring responsibility	Safety	Escape/run	Being 'left alone'	Superficiality of CMP
Self-judgement/doubt/questioning	Unmanageable situation	Sick behaviour	Coping v cease coping	Safety v fear/insecurity	Exit/escape	Goal – be left alone	Help/lift
Sick role	Problems (multiple)	Illness lifestyle	Unmanageability	Frightened child	Avoidance/withdrawal	Tactical avoidance	Internal v external
Illness identity	Bad luck/misfortune	Illness or life?	Cease functioning	Fear/insecurity	Avoidance/fear of change	Solitary	Support v no proper support
Old me v new me	Powerless/loss of control	Sickness knowledge	Unmanageable life	Terror/terrified	Avoidance	Reclusive	Illness or life?
Old sociable person	Loss of control	Diagnosis	Tipping point	Comfort/safety v discomfort	Fear of work/work environment	Achievement (of sick status)	Visible v invisible
Believed/believable	Work stress (intrinsic)	What is mental illness?	Abdication of responsibility	Emotional/psychological security v financial security	Difficulty with people	Sickness career	Introspection v outward looking
Pulling a fast one	Work stress (interpersonal)	Function/ability to work	Diminished responsibility	Protecting self	Denial/distortion/omission	Benefits career	Inner v outer
Genuine v non-genuine	Stress – scarring	Illness or life?	Agency/responsibility	Irritability	Fear/aggression	Being 'in the system'	Appearance v insides
Justifying sick role	Choice – loss of	Nature of illness/depression	Loss of agency		Criticism	Non work/sickness career	Superficial v deep
Victim		Origins of illness – biology or life?	Support – help with claims		Fear of people	Withdrawing	Inner world
Illness story/narrative		Incapacity/illness	Normal v non-functioning		Relaxation seeking	Sickness planning	Underlying problems
Story telling/alibi/persuasion		Readiness for work	Victim		Feelings (avoidance of)	Achieving 'enhanced support'	Deep v surface
Unfairness/injustice		Pain/health problems	Support v lack of support		Present moment (staying in – avoidance of 'future')		Deeper problems
Blame			Going down		Flitting		
Resentment			Curling up		Walking out v commitment		
Respect v belittled			Loss of goals		Moving around		
Criticism/critical (of incompetence)			Change/loss				
Treated well v treated badly							
Anger/annoyance							
Criticism of others							
Understood v not understood							
Acceptance (of status quo)							

Appendix 11 - Marianne: Summary of themes from IPA analysis

Autonomy	Identity / Self-concept / Ego	Stress	Threat	Environment / Circumstances
Independence	Social comparison	Overwhelm	Fear and anxiety	Nurturing
Opportunity, development, entrepreneurialism	Positive (mental attitude/approach to life/Self-image)	Multiple demands/stressors (including self)	Risk and danger/threat	Unfavourable / critical
Decision making (decisiveness/action/agency)	Self-esteem (lowered/threatened)	Trauma	Powerlessness (stuck)	Unpredictability / untrustworthiness
Choice	Appearances and impressions	Denial (blind-spot / distortion / minimisation)	Helpless and hopeless	Change/transition and loss
Personal investment / goal setting	Capability	Avoidance / walking away	Security	People (influence / impact of)
Influencing and persuading	Respectability / judgement / real person/normal	Recovery / recuperation	Loss	Beginnings and endings (transition)
Self-reliance / determination	Resources (personal)			Luck (good and bad) / good fortune / timing
Control (of situation and loss of)	Conflict (internal)			Health and symptoms
Fulfilment	Self-protection			
Sense of future (vision)	Dealing with failure			
	Privacy			

Appendix 12 - Tami: Themes from IPA analysis

Movement – Away/Backwards	Movement – Towards/Forwards	Stuck-ness/Tension	Health	Threat/Fear	Personal Difficulties	Needs
Negative thinking	Ambition/goals	Drifting	Timeout	Bullying	Hurt	Meaning/purpose
Protection (of self)	Commitment (of self)	Hating being on benefits	Relief	Distrust	Damaged	Belonging
Withdrawal (of self)	Confidence (former)	Wanting to push through	Rest	Rejection	Healing	Acceptability
Avoidance	Career identity	Confidence (waiting for it to return)	Health conditions (effect of)	Pressure	Self-esteem	Being loved/liked
Safety	Shame/embarrassment	Guilt	Health awareness/preoccupation	Bad world	Failure	Self-esteem/worth
Security	Positive thinking	Doubting self	Struggling – multiple stressors	Bad people	Disappointment (in self)	Fitting in
Confidence (lack of)		Going nowhere feeling	Link to situations	Selfish people	Confidence (lack of)	Making the right impression
		Agitation		Judgement/scrutiny/surveillance	Victim	
		Comparison (self to others)		Criticism	Naivety/fragility	
		Faking/putting on a face		Vulnerability	Life-skills (lack of)	
		Pressure			Unworthy (feeling)	
		Timeout				

Appendix 13 - Alastair: Themes from IPA analysis

Assertion/Tenacity/ Determination/ Resourcefulness	Being believed / judged / justice	Identity / conviction in self	Anger	Control	Perceptiveness	Conflict	Illness / Health	Victim / Survivor narrative	Relationships/Relating
Asserting self	Believed v not believed	Belief/trust/acceptance	Anger/angry	Control v loss of control	Perceptiveness / being canny/wise	Criticism (of others)	Illness narrative	Victim	Transaction: Care – loyalty
Asserting self – my way	Fit or unfit (believed/not believed)	Righteousness	Anger (felt during interview)	Control (of agenda)	Astute/financially astute	Agreement v disagreement	Understanding own illness	Breakdown (verge of)	I'm ok – you're ok (not ok)
Tenacity	Doubt – legitimacy	Vindication (right/wrong)	Anger and rage	Setting life agenda	Opportunity/luck	Compliance / compliance v commitment	Recognising symptoms and signs of illness	Lack of support (work)	Survival
Battle	Agreement = being believed	Identity/self-concept	Outrage	Setting pace	Entitlement (awareness of)	Commitment v compulsion	Family depression (history) / family illness narrative	Threat/victim	Relationships
Fight back/willing to fight	Justification - Accepted/not judged/believed = justified	Self-reassurance		Control v compulsion		Blame	Inability to cope	Narrative (of suffering)	Support
Fit for battle	Judged v not judged	Indignation		Control and stability			Self and fatigue	Pressure	Sympathy
Energy	Scrutiny			Influencing people			Emotions (as illness)	Stress	Passive recipient (of good/bad fortune)
Independence	Validation			Intimidation				Narrative/story telling	Tearfulness / emotions
Determined/self-reliant/self-sufficient	Acceptance/acceptability			Powerful v powerless					
Robust/active/thorough	Morality			Playing game					
Weak v strong	Genuine or fake (sickness)			Goals					
Stubborn	Righteousness			Doing what is required					
Defensive/defending self/defending family				Strategy/tactics					
Reactive/proactive				Secrecy					
Determination to not be beaten									

Appendix 14 - Pete: exit interview themes

Trauma	Identity/capability	Relationship	Transaction	Drives towards/away
Break in life (life trauma	Identity (crash survivor)	IP conflict	Contribution	Loved
Life trauma / break	Identity – rebel	Difficult relationship	Good' attitude	Belonging
Break/life trauma	Identity – working man	Confrontation	Reliance / dependency	Incapacity / dependence
TRAUMA	Pride – special/chosen – feel good	Unloved/rejection	Hard work/graft	Child v man/coping v not coping
Break/life trauma (risk of)	Identity (I am what I can DO)	Difficult relationship – falling out	Right v wrong – morality/justice	Sense of place - belonging
Loss	Identity – tough/survivor	Conflict	Work-ethic	Finding a place to be loved
Traumatic events	Identity (group) with the unlucky/downtrodden	Relationship – appreciation and recognition	Justice (right v wrong/just deserts)	Assertion/reassertion of belief structure
Trauma / bewilderment	Identity (being challenged)	Impulsive/hot-headed	Deserving v undeserving	Belonging (loss of) / rejection
	Identity - fighter	OK/not ok with others	Judged/victimised	Judgement (cautious)
	Identity – righteous poor	Conflict/difficult relationship	Generous/righteous	(Work is WHERE I belong) - recognition
	Team identity	Relationship/relating	Justice – just deserts	OWNED v self-reliance
	Capability / reliance		Exchange – money for something	Owned = utter/complete loss of self
	Identity (protection of)		Deserving v undeserving (justice)	Safety v fight (for self
	Confidence / self-belief		Sense of Exchange – I do therefore I receive	Drive (to and from)
	Identity - group		Attitude – earn it/prove it	Dread (aversion)
	Decision/choice/self-activation		Exchange (have more to offer)	Fear
	Attitude – provider/self-reliance			Fear – of rejection

Appendix 15 - Hospital Anxiety and Depression Scale (HADS)

Instructions: Doctors are aware that emotions play an important part in most illnesses. This questionnaire is designed to help your doctor know how you feel. Read each item and circle the reply which comes closest to how you have been feeling in the past week. Don't take too long over your replies: your immediate reaction to each item will probably be more accurate than a long thought out response.

I feel tense or 'wound up':	A	I feel as if I am slowed down:	D
Most of the time	3	Nearly all of the time	3
A lot of the time	2	Very often	2
Time to time, occasionally	1	Sometimes	1
Not at all	0	Not at all	0
I still enjoy the things I used to enjoy:	**D**	**I get a sort of frightened feeling like 'butterflies in the stomach':**	**A**
Definitely as much	0	Not at all	0
Not quite so much	1	Occasionally	1
Only a little	2	Quite often	2
Not at all	3	Very often	3
I get a sort of frightened feeling like something awful is about to happen:	**A**	**I have lost interest in my appearance:**	**D**
Very definitely and quite badly	3	Definitely	3
Yes, but not too badly	2	I don't take as much care as I should	2
A little, but it doesn't worry me	1	I may not take quite as much care	1
Not at all	0	I take just as much care as ever	0
I can laugh and see the funny side of things:	**D**	**I feel restless as if I have to be on the move:**	**A**
As much as I always could	0	Very much indeed	3
Not quite so much now	1	Quite a lot	2
Definitely not so much now	2	Not very much	1
Not at all	3	Not at all	0
Worrying thoughts go through my mind:	**A**	**I look forward with enjoyment to things:**	**D**
A great deal of the time	3	A much as I ever did	0
A lot of the time	2	Rather less than I used to	1
From time to time but not too often	1	Definitely less than I used to	3
Only occasionally	0	Hardly at all	2
I feel cheerful:	**D**	**I get sudden feelings of panic:**	**A**
Not at all	3	Very often indeed	3
Not often	2	Quite often	2
Sometimes	1	Not very often	1
Most of the time	0	Not at all	0
I can sit at ease and feel relaxed:	**A**	**I can enjoy a good book or radio or TV programme:**	**D**
Definitely	0	Often	0
Usually	1	Sometimes	1
Not often	2	Not often	2
Not at all	3	Very seldom	3

Appendix 16 - Occupational Self-Assessment (OSA) survey items

1. Concentrating on my tasks
2. Physically doing what I need to do
3. Taking care of the place where I live
4. Taking care of myself
5. Taking care of others for whom I am responsible
6. Getting where I need to go
7. Managing my finances
8. Managing my basic needs
9. Expressing myself to others
10. Getting along with others
11. Identifying and solving problems
12. Relaxing and enjoying myself
13. Getting done what I need to do
14. Having a satisfying routine
15. Handling my responsibilities
16. Being involved as a student, worker, volunteer, and/or family member
17. Doing activities I like
18. Working towards my goals
19. Making decisions based on what I think is important
20. Accomplishing what I set out to do
21. Effectively using my abilities

Appendix 17 – Questions and ranking of responses from One – One feedback sheets

Rank	Category	Item	Mean
1	Core Condition	Being listened to by the therapist	4.73
2	Core Condition	Being or feeling understood by the therapist	4.72
3	Personal impact	The therapist was helpful	4.67
4	Core Condition	Being or feeling accepted by the therapist	4.65
5	Personal impact	I am glad I attended today	4.65
6	Facilitation	The things that the therapist said in response to me	4.64
7	Environment	The overall welcome and atmosphere was helpful	4.64
8	Core Condition	Being welcomed and generally looked after	4.63
9	Facilitation	Being helped to explore my thoughts and feelings	4.59
10	Core Condition	Feeling connected to the therapist	4.58
11	Facilitation	The advice or skills explained to me by the therapist	4.55
12	Facilitation	Being helped to feel safe and secure	4.54
13	Personal impact	The session was enjoyable	4.51
14	Change	I feel better now than when I arrived	4.51
15	Personal impact	I found the course interesting	4.51
16	Facilitation	The time and space provided to think about myself	4.45
17	Usefulness	The session was helpful for me to manage my mood generally	4.45
18	Environment	The building, rooms and facilities were helpful	4.44
19	Environment	The administration was helpful	4.31
20	Usefulness	I have learned new skills that I will use	4.29
21	Change	I feel more able to face the challenges in the world	4.12
22	Change	The session has made me think that work might be more possible for me	4.01
23	Usefulness	The session will be helpful for me to manage my mood at work	3.97

Appendix 18 - Response to request for information from Rt Hon Andrew Smith MP

HOUSE OF COMMONS

LONDON SW1A 0AA

Mr Steve Roberts
9 Central Close
Hethersett
Norwich
NR9 3ER

Our Ref: DE/ZA50649

3 December 2015

Dear Steve Roberts

Further to our previous correspondence regarding Pathways to Work, I am attaching a copy of a letter I have received from the Department of Work and Pensions, the contents of which are self-explanatory.

If I can be of any further assistance in relation to this, or indeed any other matter, please do not hesitate to get in touch.

With best wishes,

Yours sincerely

Rt Hon Andrew Smith MP

Appendix 19 – Response to request for information from Robert Devereux, Department for Work and Pensions

Department for Work & Pensions

Permanent Secretary
Caxton House
Tothill Street
LONDON
SW1H 9DA

0207 340 4000

www.gov.uk

ministers@dwp.gsi.gov.uk

Rt Hon Andrew Smith MP

Your ref: DE/ZA50649

Our ref: POS(44)10487/1027

30 November 2015

Dear Andrew,

Thank you for your letter of 9 October on behalf of Mr Steve Roberts of 9 Central Close, Hethersett regarding his research into the Condition Management Programmes.

Originally introduced in pilot areas in October 2003, the Pathways to Work programme aimed to assist incapacity benefits claimants into, and towards, paid work. The programme provided our work coaches with discretion to decide if a referral to a Condition Management Programme would support the claimant's health condition and as a result their return to work.

The Condition Management Programmes were procured under contract. In assessing their value and content, the Department was supported by a health professional from the Department of Health. The content of the programmes varied across the country. They included provision for help to stop smoking and assist entry to healthy activities, such as swimming, and Cognitive Behavioural Therapy.

Full details of the Condition Management Programmes are no longer held by this Department. However, Mr Roberts can obtain further information from the Government website at:
www.gov.uk/government/uploads/system/uploads/attachment_data/file/214423/rrep653.pdf; and at:
www.gov.uk/government/uploads/system/uploads/attachment_data/file/221223/WP113.pdf.

I hope he finds these useful.

Yours sincerely,

Robert Devereux