Lone parents, health and work
Jo Casebourne and Liz Britton

A report of research carried out by Institute for Employment Studies and Centre for Economic and Social Inclusion on behalf of the Department for Work and Pensions
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The Authors

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The following is a glossary of certain terms used in the report.

**Child Support Agency**

The Child Support Agency is an executive agency of the Department for Work and Pensions and is responsible for assessing, collecting and paying child support maintenance, ensuring that parents who live apart meet their financial responsibilities to their children.

**Disability Living Allowance**

Disability Living Allowance (DLA) is a benefit for people who have an illness or disability. It provides extra money for people who need help with personal care (the care component) and/or help with walking (the mobility component). It is not means-tested and can be claimed both when in work, or when claiming other benefits.

**Health-related benefits**

The term health-related benefits is used in this report to cover both Incapacity Benefit and Income Support Disability Premium.

**Incapacity Benefit**

Incapacity Benefit (IB) is a contributory benefit for people with illnesses or disabilities who are unable to work, and who have made sufficient National Insurance (NI) contributions. There are three rates of Incapacity Benefit – short-term lower, short-term higher and long term rate. The rate received depends on how long the person has been on benefit for and whether they have also received Statutory Sick Pay from an employer for any prior period. At an early point in their claim recipients will need to satisfy a medical test called the Personal Capability Assessment (PCA). Before this they will need to submit GP sick notes. If a person meets the relevant medical test requirement but has not paid sufficient national insurance contributions then they will be eligible for IB ‘credits’ and, if they have a low household income, be also eligible for Income Support (with a disability premium also becoming payable after 52 weeks). The majority of
lone parents on IB will also be eligible for IS as they need an income supplement for their children.

**Income Support**

Income Support is a means-tested benefit available to certain groups of people on low incomes. Lone parents on low incomes are usually eligible to claim Income Support as are people with health conditions/disabilities.

**Income Support Disability Premium**

Income Support Disability Premium (ISDP) is for those on low incomes entitled to receive IB/IB Credits, after they have been incapacitated for 52 weeks. Those receiving the highest rate of DLA can get ISDP at an earlier stage, after 28 weeks. Lone parents who are incapacitated are likely to be in receipt of IB Credits and ISDP because they may not have made sufficient NI contributions to receive IB.

**New Deal for Disabled People**

The New Deal for Disabled People (NDDP) is a voluntary national programme to help people with an incapacity, illness or disability return to work. Participants must be in receipt of a qualifying benefit to join.

**New Deal for Lone Parents**

The New Deal for Lone Parents (NDLP) is a voluntary national programme to help lone parents into work. NDLP is open to all lone parents with a child under 16, working less than 16 hours a week, whether or not they are in receipt of benefits.

**Personal Adviser**

Staff who work with clients on an individual basis in a case management model.

**Personal Capability Assessment**

A medical assessment which is used to determine if a person is considered as meeting the threshold for incapacity, for benefit purposes. In certain parts of the country, this assessment is supplemented by an additional Capability Report which identifies the remaining work-related capabilities an individual has, and provides advice on possible workplace adjustments.

**Work Focused Interviews**

Work Focused Interviews (WFIs) are mandatory for lone parents making new and repeat claims to Income Support. They have been rolled out for existing (stock) claimants by the age of the lone parents' youngest child. The final stage of the roll out to stock claimants – those with a youngest child aged below five years and three months – began in April 2004 and will be completed by 2006. WFIs aim to encourage lone parents to join NDLP, by making lone parents aware of the support and help available to them, although participation in NDLP remains voluntary. WFIs are also applied to new claimants of IB in fully integrated Jobcentre Plus offices.
Working Tax Credit

The Working Tax Credit was introduced in April 2003, and replaces the Working Families’ Tax Credit and the Disabled Person’s Tax Credit. It is paid to those on low incomes working 16 hours a week or more. It includes a childcare element, that pays for up to 70% of the cost of registered childcare.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
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<td>BHPS</td>
<td>British Household Panel Survey</td>
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<tr>
<td>BUPA</td>
<td>British United Provident Association (private health care provider)</td>
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<tr>
<td>CAQDAS</td>
<td>Computer Assisted Qualitative Data Analysis Software</td>
</tr>
<tr>
<td>CSA</td>
<td>Child Support Agency</td>
</tr>
<tr>
<td>DDA</td>
<td>Disability Discrimination Act (1995)</td>
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<tr>
<td>DEA</td>
<td>Disability Employment Adviser</td>
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<tr>
<td>DLA</td>
<td>Disability Living Allowance</td>
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<tr>
<td>DWP</td>
<td>Department for Work and Pensions</td>
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<tr>
<td>ESOL</td>
<td>English as a Second or Other Language</td>
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<tr>
<td>GHQ12</td>
<td>General Health Questionnaire set of 12 questions</td>
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<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>IB</td>
<td>Incapacity Benefit</td>
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<tr>
<td>IES</td>
<td>Institute for Employment Studies</td>
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<tr>
<td>IS</td>
<td>Income Support</td>
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<tr>
<td>ISDP</td>
<td>Income Support with Disability Premium</td>
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<td>JSA</td>
<td>Jobseeker’s Allowance</td>
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<tr>
<td>NI</td>
<td>National Insurance</td>
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<tr>
<td>NDDP</td>
<td>New Deal for Disabled People</td>
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<td>NDLP</td>
<td>New Deal for Lone Parents</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<td>Abbreviation</td>
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<tr>
<td>PA</td>
<td>Personal Adviser</td>
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<tr>
<td>PCA</td>
<td>Personal Capability Assessment</td>
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<tr>
<td>SDA</td>
<td>Severe Disablement Allowance</td>
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<tr>
<td>WFI</td>
<td>Work Focused Interview</td>
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<td>WTC</td>
<td>Working Tax Credit</td>
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Summary

This report brings together two pieces of qualitative research examining the impact of health problems on lone parents’ decisions about work. In 2003 and 2004, 112 interviews and six focus groups were carried out with lone parents.

The research aims to help unpack the complex issue of the relationship between health and work for lone parents, and to determine whether there is more that can be done to support lone parents with health problems, and, in particular, to help them enter the labour market.

Methodology

In Part One, 58 in-depth interviews and three focus groups were carried out with lone parents with health problems on Income Support (IS), or in work having claimed IS in the past (see Chapter 2). Interviews were sampled according to type of health problem, including whether they had children with health problems or disabilities.

In Part Two, 54 in-depth interviews and three focus groups were carried out with lone parents claiming health-related benefits (see Chapter 12). Health-related benefits are defined as Incapacity Benefit and Income Support with Disability Premium. Interviews were sampled according to the type of health-related benefit claimed: IS with Incapacity Benefit (IS plus IB), IS with Disability Premium (ISDP), and those who start to make a claim for health-related benefits for the first time when their youngest child reaches 16 (defined as movers in this report).

In both Part One and Part Two, interviews were conducted with female lone parents in London, Newcastle, and Leeds/Bradford (not all of these areas had the rolled-out model of Jobcentre Plus).

Part One – Key findings

Part One examines lone parents on IS and lone parents in work having claimed IS.

GHQ12

The General Health Questionnaire set of 12 questions (GHQ12) was used to provide a snap-shot of the mental well-being of lone parents in the sample (see Chapter 3). GHQ12 scores range from zero (least distressed) to 36 (most distressed).
The average score for the British population, based on the British Household Panel Survey (BHPS), is 11. Lone parents in this sample had an average score of 17.5, suggesting that this sample have poorer mental well-being than the national average. Lone parents on IS scored higher than those in work, and lone parents who identified themselves as having mental health problems scored higher than those who did not (see Section 3.3).

These scores are not representative of lone parents more widely and do not show changes over time.

**Differences between those on IS and in work**

There were no major differences in the types of health problems that lone parents and their children had, between those on IS and those in work (see Section 4.2). Those on IS had more sustained periods of claiming benefits and less substantial work histories than those in work (see Section 4.3). Both groups had a negative attitude towards benefits (see Section 4.4).

**How health acts as a constraint**

Of those on IS, one group felt that they could not work because of their health problem, a second group felt that their health problem would make working more difficult, and a third group did not feel that health was a constraint to work for them (see Section 5.2).

Health was not the key constraint to work for most of those on IS, but it did add to, and interact with, other constraints common to lone parents without health problems (see Section 5.2). Childcare was a major constraint for these lone parents, and where lone parents had very young children it was often felt that it was better to wait until their child was older before moving into work.

For some of those in work, health impeded their ability to work, and some were concerned about sustaining work because of health problems (see Section 5.3). Work exacerbated health problems in some cases, whilst in other cases, health had been improved by working.

**Using medical support**

It was common for lone parents to have been diagnosed and to be receiving medication and/or treatment for their health problems (see Sections 6.2 and 6.3). There were links between health and wider circumstances (eg cases of child asthma and poor housing. See Section 6.2.2). Those with children with health problems often faced difficulties getting the support they needed for their child (see Section 6.2.3).

The main difference between those on IS and those in work was the ability of those in work to make choices about private medical support (see Section 6.4). Those in work had more financial resources to access treatment not available on the National Health Service and wider social networks through work to get advice about treatment. In contrast, it was difficult for some on IS to keep up with regular treatment due to transport and childcare problems. Not being able to access treatment could make it more difficult for them to work.

**Support needed and received**

A lot of additional support was needed that lone parents were not receiving, and that could not be provided by family or friends (see Section 7.2). This included: having more information and advice to enable them to better manage their health problems, immediate, fast access to counselling, and more access to practical support.
There were lone parents in the sample who felt that they did not need any support, either because of strong feelings of independence, or because the only thing that they felt would help was their health improving (see Section 7.2). For those that feel that they cannot work until their health improves, interventions such as condition management programmes may change attitudes on their ability to work despite health problems.

**What makes lone parents look for work**

There are a number of things that would attract those on IS into work: having affordable childcare, being better off in work, and finding jobs with training and career progression (see Section 8.2). There was little awareness of the broad package of financial help available if they moved into work.

Those in work said they had moved into work because of the identity, pride and satisfaction they got from working, as well as stressing the importance of setting an example for their children and being able to better provide for their children financially (see Section 8.3).

**What helps lone parents start and stay in work**

Lone parents on IS felt that a number of things would help them move into work: help with job search, a job matching service, help building skills and confidence, childcare information, and help with self-employment (see Section 9.2). These are all available through the New Deal for Lone Parents (NDLP), suggesting that lone parents (including those that have been on NDLP) need to be made aware of all the services that NDLP provides.

It was common for lone parents in work to have received help from NDLP (see Section 9.2). Some of those in work would benefit from help finding more suitable jobs: jobs that were less stressful, less physical, and with employers who understood their need to take time off because of health problems (see Section 9.3). This help could be provided through the NDLP in-work service, whether or not individuals had taken part in NDLP whilst on IS. Employers could also do more to support employees with health problems (see Section 9.3.3).

**How existing provision supports lone parents**

There was a lack of knowledge and confusion about health-related benefits amongst lone parents in the sample (see Section 10.2). Most had not had a Work Focused Interview (WFI) (see Section 10.3). Lone parents had generally heard of NDLP and many had taken part and had positive experiences (see Section 10.4). Those on IS suggested the need for more regular and proactive contact from Personal Advisers (PAs) to encourage them to continue to engage with NDLP.

It was suggested that group sessions with other lone parents would be helpful, particularly for those who were isolated or had little support (see Section 10.6). For others, one-to-one support may be more appropriate.

In most cases lone parents in the sample had not mentioned their health problem to anyone from Jobcentre Plus (see Section 10.7). This was because they did not want to discuss it, or because they did not know that they could discuss it. It was felt that discussing it could be helpful and that advisers should ask about health in interviews. When health was mentioned, PAs were understanding, but did not signpost lone parents to organisations that could provide support.

PAs may need training about different health problems and the organisations that can provide support, as well as training to encourage lone parents to work despite their health, rather than assuming that lone parents cannot work because of their health. Advisers could help lone parents to
find work that they were able to do despite their health problems. PAs could be incentivised to work with lone parents with health problems, who may be more difficult to move into work than other lone parents.

Part Two – Key findings

Part Two examines lone parents claiming health-related benefits.

Circumstances of lone parents

It was common for lone parents in the sample to have began their first benefit claim when they became a lone parent or had their first child (see Section 13.3). The sample had a negative attitude towards benefits and did not like being dependent on state support. From the onset of the claim, it was common for lone parents to have remained outside the labour market.

For the most part, the sample had worked at some point, although a few had never worked (see Section 13.3). Work histories were largely characterised by low-paid work. The ISDP plus IB group had longer work histories than those on ISDP or movers (this is unsurprising as they would have to have worked enough to make sufficient National Insurance contributions to be eligible for IB).

How health problems and/or disabilities affect decisions about work

Health problems and/or disabilities had a strong influence on lone parents’ ability to carry out normal day-to-day activities (see Section 14.2). Health and/or disability was considered to be the primary constraint to working (see Section 14.3). Even where respondents saw themselves first and foremost as lone parents, rather than as someone with a health problem and/or disability, the health problem and/or disability was the factor that resulted in economic inactivity. Other constraints were common to lone parents without health problems and/or disabilities, with the exception of the fear of unsympathetic employers.

In the main, the sample wanted to work, although many did not feel ready because of their health problem and/or disability (see Section 14.4). Lone parents felt that their health problems and/or disabilities would affect the type of work that they could do in a number of ways. For example, in terms of the work environment they would need, the tasks they could do, the hours they could work, and needing flexibility when their condition fluctuated.

There was concern about their ability to sustain work, and concern that coming off benefits and moving into work was quite risky, and uncertainty about whether they would be able to return to benefits if necessary.

Support needed and received

Lone parents in the sample were receiving a wide variety of medication and treatment to manage their health problem and/or disability (see Section 15.2). They also had support from a number of medical and social care professionals, and disability organisations (see Section 15.3). This was in addition to support from family, friends and lone parents’ children.

There was a need for a wide range of additional support, including more information and advice, as well as practical support that others in the sample were already receiving (see Section 15.5). The need for support to be flexible and available when it was needed was key. Fighting to keep support was felt to add unnecessary stress.
Helping lone parents start work

Other than an improvement in their health problem and/or disability, the help needed was similar to that needed by lone parents without health problems and/or disabilities (see Section 16.2). It included: help with childcare, training, the benefit-to-work transition, confidence building, and English as a Second or Other Language (ESOL) help.

Finding a supportive working environment was considered important, and it was suggested that it would be useful to build their skills or confidence whilst on benefits so that they are not too far removed from the labour market when they do feel ready to work. This could be done, for example, through work taster sessions or voluntary work.

The sample were not clear on where they would go to access the kinds of help they needed to move into work (see Section 16.4). The Jobcentre was suggested, but lone parents were unaware of the range of services that Jobcentre Plus could offer them.

How existing provision supports lone parents

There was confusion about what health-related benefits lone parents were claiming, reflecting the lack of strong branding of health-related benefits, and lone parents’ perception that there was a lack of information explaining differences between, and eligibility for, different types of health-related benefits (see Section 17.2). Lone parents found the system of health-related benefits confusing and hard to understand.

It was uncommon for lone parents in the sample to have had a WFI, with the exception of movers who had one as their youngest child approached 16 (see Section 17.3). NDLP was widely known about, although participation was low amongst lone parents in the sample (see Section 17.4.1). There was much less awareness of NDDP, which may reflect the fact that NDDP is not marketed as a strongly branded programme (see Section 17.4.2). It was common for lone parents to want to see a Disability Employment Adviser (DEA) rather than a lone parent adviser if they wanted help in moving into work (see Section 17.4.3).

Jobcentre Plus could do more to signpost lone parents to support when they first make a claim for health-related benefits (see Section 17.5). Lone parents could automatically see a DEA at this time, who could ensure they were aware of the support available to move into work, including through NDDP.

It was suggested that more proactive contact from Jobcentre Plus would be helpful, at times that were appropriate to each lone parent, and for some, delivered through home visits. Permitted work rules could also be used to enable lone parents to work.

Moving from IS onto health-related benefits when the youngest child reaches 16

Benefit transitions for movers began when they were informed by Jobcentre Plus that their benefit status would change, and ended with a claim for health-related benefits (see Section 18.2). Having been informed that their benefit status was changing, lone parents first heard about health-related benefits from doctors, family and friends, advice centres, and when they were advised to claim by Jobcentre Plus staff.

Transitions described by movers were not always straightforward. There were movements into work or onto Jobseeker’s Allowance (JSA) before moving onto health-related benefits, and gaps between claims for IS and claims for health-related benefits.
Movers would have liked more help at the point of making the transition: particularly, more information about what was going to happen, more preparation for their change in benefit status, and more information about DEAs and NDDP (see Section 18.3). All those making a claim for health-related benefits when their youngest child turned 16 could see a DEA.

The main reason for not claiming health-related benefits before, was that health problems and/or disabilities had got worse in the period leading up to the youngest child turning 16 (see Section 18.4). Other reasons for not claiming before included: it being the first time they had been required to work, being unaware of health-related benefits whilst on IS, or being unaware of the financial incentive for claiming health-related benefits rather than IS.

Comparative Conclusions

Presented below are the overall findings in terms of the key research themes that cut across both pieces of research (see Chapter 20).

Health problems and/or disabilities

Across all three groups (lone parents on IS, in work, and on health-related benefits) there was a high incidence of multiple health problems, which for the most part, included both a mental and physical health problem and/or disability.

Lone parents with health problems, in some cases also had children with health problems and/or disabilities. This included children with mobility problems, asthma, eczema, and behavioural problems. The relationship between poor housing and health was an issue for some. In some cases lone parents may need support to find more suitable housing, before they are able to think about work.

Benefit and work histories

The three different groups of lone parents within the two pieces of research differed in terms of the length of time they had been on benefits and whether they had any previous history of working.

Lone parents in work tended to have spent less time claiming IS, overall, than those currently on IS. It was more common for the ‘in work’ group to have worked before having children, and to have used IS for short periods of time, between jobs, or after the birth of children. In contrast, lone parents on IS had more sustained periods of claiming and included some who had never worked.

Lone parents on health-related benefits differed between those claiming ISDP plus IB, who had spent less time on benefits and had longer work histories, those on ISDP with less work histories, and movers who had the least work history and had often not worked since having children.

Having worked at some point in the past (mainly in low-paid work) was common. However, facing a lack of work history, or recent work history may act as a constraint to work in some instances.

Attitudes to benefits and work

Lone parents in all three groups expressed their dislike of claiming benefits. This was due to the struggle to ‘make ends meet’ on benefits, as well as finding claiming benefits to be stigmatising, humiliating and demoralising. Being on benefits was described as leading to boredom, isolation and exclusion from ‘normal life’. Claiming benefits was considered to be a ‘necessary evil’. 
Those in work had strong ‘work ethics’ and described getting a sense of identity, pride, and self-respect from work. Lone parents on IS and on health-related benefits did, in the main, want to work. They described work as leading to financial independence, as providing social contact with other adults, and to enable them to build their confidence.

**How health is a constraint to work**

The biggest difference between Part One and Part Two of this research was not the type of health problem or disability that lone parents had, but the impact that it had on their day-to-day activities and ability to work, and the prominence of the health problem and/or disability compared with other constraints to work.

Amongst those on IS, health or disability was not felt to be the key constraint to moving into work. Some thought it would prevent them from working, whilst others thought it would make work more difficult, or would not have an impact. Other constraints, such as childcare or the age of their children, were often more important.

In contrast, for the sample claiming health-related benefits, health or disability was the key constraint to moving into work. Health problems and/or disabilities had a significant impact on their ability to carry out normal day-to-day activities. Even where respondents saw themselves first and foremost as lone parents, rather than as someone with a health problem and/or disability, the health problem and/or disability was the factor that resulted in economic inactivity.

Other constraints that these lone parents faced were similar to those faced by lone parents without health problems and/or disabilities, except for the perceived lack of employers who would be supportive to those with health problems and/or disabilities.

The fact that these lone parents did not like claiming benefits and wanted to work, shows that there is a great deal of potential to develop services to enable them to move into work. Attitudes that lone parents have to their health problem, and the extent to which they feel it impacts on their ability to work, influence whether they feel able or ready to work. Services such as condition management programmes could change the way that lone parents perceive the impact of their health problem on their ability to work.

**Health support**

It was common for the lone parents in the three groups to have received a diagnosis and to be receiving treatment. A wide range of support was received. This included practical and emotional support from family, friends and their children, as well as external support. However, in a few cases lone parents were not receiving any support.

The main difference between those on IS and those in work related to their ability to make choices, often financial, about the type and frequency of support they needed. Lone parents on health-related benefits had access to a wider range of support from medical and social care professionals than the other two groups.

More support was needed across all three groups. This included more information and advice about the health problem/disability, and about support, as well as practical help and extra financial help. Support needed to be flexible and timely so that lone parents could access it when they needed it. Jobcentre Plus could provide a signposting role in directing lone parents to support, which could help rehabilitation, and make the period out of the labour market shorter for some.
Help to start work

The help needed by those on IS and on health-related benefits was similar to what lone parents without health problems and/or disabilities would need to start work. Lone parents expressed a need for help with job search and interview preparation, as well as help with confidence, training, information on childcare options, help with self-employment and ESOL help. They also needed help with finding supportive employers.

There was a lack of awareness of services already available to them that could provide this kind of support. Lone parents were often unaware of the changes to services provided through Jobcentre Plus. There was a need for activities to keep them close to the labour market until they were ready to work. This could include wider use of the permitted work rules. Condition management programmes could help individuals move into work despite their health problem and/or disability.

Help to sustain work

There was concern amongst some of those in work that the work they were doing was unsustainable. The NDLP in-work service could be used to provide help to these lone parents to find more suitable jobs.

There was a reluctance to discuss their health with employers, for fear of ‘putting them off’ at recruitment, or embarrassment of discussing mental health problems. Those with supportive employers felt that they could be more open and honest about their health problem and/or disability.

The negative perceptions of employers, amongst some of those on benefits in the sample may, in some cases, be outdated. PAs could have a role in giving lone parents examples of supportive employers and in updating this image. Employers have an important role to play in developing good practice for employees with health problems and/or disabilities.

Existing provision

There was a lack of awareness and confusion about health-related benefits amongst lone parents on IS and in work, and confusion amongst those claiming health-related benefits about what benefits they were actually claiming. This suggests a need for clearer branding of health-related benefits.

It was rare for lone parents in all three groups to have had a Work-Focused Interview (WFI), reflecting the ongoing roll-out of WFIs, as well as the possible granting of waivers and deferrals.

Awareness of NDLP was high, with many of those on IS and in work having been on NDLP in the past and having had positive experiences. Lone parents on IS felt that PAs needed to be more proactive in keeping them engaged in NDLP. PAs could be incentivised to work with lone parents with health problems who may be more difficult to move into work than those without health problems.

For lone parents on health-related benefits, it was common to have heard of NDLP, but rare to have taken part. There was a lack of knowledge of what NDLP consisted of, suggesting the need for more information detailing all the services NDLP provides.

It was rare for those on health-related benefits to have heard of NDDP and none had taken part. When asked whether they would rather see a lone parent adviser or a DEA, lone parents said that they would rather see a DEA, reflecting the fact that health or disability was their biggest constraint to work. This suggests that all those making a new claim for health-related benefits could be seen by a DEA.
Rather than advising lone parents on IS or health-related benefits to stay on benefits because of their health problem, PAs could signpost them to support and help them find jobs they could do despite their health problems. In some cases, this might change lone parents’ perceptions of whether they are ready to work.

To tackle the isolation experienced by certain groups of lone parents, lone parents may benefit from group support sessions with other lone parents. This was suggested by lone parents who attended focus groups. For others who have restricted mobility or who are not able to cope in group situations, for example, home visits or one-to-one meetings at the Jobcentre may be more appropriate.

It was suggested that the Jobcentre environment could be improved, for example, by having toilets, areas for children to play and areas where health issues could be discussed in private. As well as different types of provision being needed for different groups, provision also needs to be delivered at stages appropriate to the individual lone parent.

Conclusions
Lone parents on IS with health problems were different from other lone parents on IS who do not have health problems. Health problems often acted as an additional constraint to entering work, and these lone parents need additional support to the mainstream support available to all lone parents on IS.

Lone parents on health-related benefits had health/disability as their main constraint to entering work but also face constraints common to those lone parents not on health-related benefits. These lone parents needed support to ensure that they can move into work if, and when, it is appropriate for them to do so.

It is clear that there are opportunities for better marketing of existing services and increasing referrals to existing provision. However, it is also clear that there are gaps in provision and support for lone parents on IS and those on health-related benefits.

Condition management programmes may be a helpful tool to help lone parents manage their health problems and to think about the types of work they could do despite their health problems. We look forward to the ‘Job Retention and Rehabilitation Pilots’ and the ‘Incapacity Benefit Reform Pilots’ developing an evidence base on the effectiveness of this approach. The permitted work rules could also be used to encourage lone parents to build up work slowly over time.

The lone parent PA role could be broadened to include some knowledge about health and health-related benefits. There is a need for lone parents to be encouraged to discuss their health with PAs, and for training of PAs so that they are able to broach the subject sensitively and are able to refer lone parents to support for their health problems. PAs could also discuss suitable work with lone parents, rather than assuming that their health problem means that they cannot work.
1 Introduction

The Institute for Employment Studies, and the Centre for Economic & Social Inclusion, have prepared this report for the Department for Work and Pensions. This is a report of two qualitative studies to explore the impact of health problems on lone parents’ decisions about work. The research was designed to focus on female lone parents, as lone mothers make up 94 per cent of lone parents on Income Support.

The first study (Part One) examines lone parents who have health problems, but are not claiming health-related benefits (lone parents who were claiming only Income Support, and lone parents who had moved into work after claiming only Income Support). The second study (Part Two) examines lone parents on health-related benefits: those claiming Income Support with a Disability Premium and/or Incapacity Benefit, and those who stopped claiming Income Support and started claiming Incapacity Benefit after their youngest child turned 16 years old (referred to in this report as ‘movers’). These two studies were commissioned separately and used different methodologies.

The findings from Part One and Part Two draw on in-depth interviews and focus groups with lone parents in three areas: Newcastle, Leeds/Bradford, and London. The findings of Part One draw on 58 in-depth interviews and three focus groups. The findings of Part Two draw on 54 in-depth interviews and three focus groups.

Both pieces of research aim to help unpack the complex issue of the relationship between health and work for lone parents, and to determine whether there is more that can be done to support lone parent families with health problems, in particular, to help them enter the labour market.

1.1 Background to the research

1.1.1 What are health-related benefits?

In this report, ‘health-related benefits’ are defined as Incapacity Benefit and Income Support with Disability Premium.

Incapacity Benefit (IB) is a contributory benefit for people with illnesses or disabilities who are unable to work, and who have made sufficient National Insurance (NI) contributions. There are three rates of Incapacity Benefit – short-term lower, short-term higher and long term rate. The rate received depends on how long the person has been on benefit for and whether they have also received Statutory Sick Pay from an employer for any prior period. At an early point in their claim, recipients will need to satisfy a medical test called the Personal Capability Assessment (PCA). Before this they will
need to submit GP sick notes. If a person meets the relevant medical test requirement but has not paid sufficient national insurance contributions then they will be eligible for IB ‘credits’ and, if they have a low household income, also be eligible for Income Support (with a disability premium also becoming payable after 52 weeks).

Income Support Disability Premium (ISDP) is for those on low incomes entitled to receive IB/IB ‘Credits’, after they have been incapacitated for 52 weeks. Those receiving the highest rate of DLA can get ISDP at an earlier stage, after 28 weeks. Lone parents who are incapacitated are likely to be in receipt of IB Credits and ISDP because they may not have made sufficient NI contributions to receive IB.

The majority of lone parents on IB will also be eligible for IS, as they need an income supplement for their children. These lone parents may, therefore, be receiving IB and ISDP. Many lone parents who have passed a PCA will receive ISDP, rather than IB, because they have not made sufficient NI contributions to receive IB.

1.1.2 Lone parents and health-related benefits

There are an estimated 1.75 million lone parent families in Britain, a quarter of all families (One Parent Families, 2003). 958,000 lone parents claimed Income Support in February 2003, and of these, 123,900 lone parents claimed ISDP (13 per cent of all lone parents claiming Income Support).

Administrative data are not reliable for counting the total number of lone parents receiving Incapacity Benefit without Income Support, because, on the Incapacity Benefit database, it is not compulsory to include information about dependants. Administrative data for February 2003, show that just 57,800 lone parents claim IB without IS. However, this is likely to be an underestimate.

It is possible to ascertain the numbers claiming Incapacity Benefit, as well as ISDP, because the Income Support database holds information about other benefits. 27,500 lone parents were claiming IB, as well as ISDP, in February 2003.

1.1.3 Lone parents, health/disability and work

Research evidence indicates that lone parents experience a higher incidence of health problems than partnered mothers (Holtermann et al., 1999, Marsh and Rowlingson, 2002, Millar and Ridge, 2001, Shouls et al., 1999). Compared with couples, lone parents have worse general health: in 2000, 61 per cent of partnered mothers said that their health was good, compared to 54 per cent for lone parents (Marsh and Rowlingson, 2002). Data from the Labour Force Survey from Spring 2003, show that only 77 per cent of lone parents reported having no disability, compared to 86 per cent of married mothers.

Lone parents who are not working are also more likely to experience health problems than lone parents in work. Twenty-eight per cent of lone parents in 2000 said that they had a long-term illness or disability, rising to 33 per cent amongst non-working lone parents. Two-thirds of these non-working lone parents said that health affected their ability to work (Marsh and Rowlingson, 2002). Data from the Labour Force Survey from Spring 2003, show that 60 per cent of employed lone parents

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1 Since the introduction of Tax Credits in April 2003, new claimants would claim Child Tax Credit on top of IB to supplement their income but existing claimants are more likely to be subject to the system as outlined here.

2 The data on Income Support are from the 5 per cent Income Support scan for the quarter ending February 2003, and the data on those claiming IB without IS are from the 5 per cent Incapacity Benefit scan for the quarter ending February 2003.
report having no disability, compared to only 40 per cent of lone parents who are not employed. In addition, the children of lone parents also experience higher levels of poor health than other children, placing an extra burden on lone parents, and further limiting their ability to work (Marsh et al., 2001).

The types of health problems predominantly described by lone parents, in the Family and Children’s Survey, are musculoskeletal problems (affecting mobility), respiratory problems, and mental health problems (mainly depression). Many lone parents also report having more than one health problem or disability (Marsh et al., 2001). As well as having health problems of their own, 23 per cent of lone parents have one child with a long-standing illness or disability, while another five per cent have two or more children in this situation (Marsh and Rowlingson, 2002). Low/moderate income couples are equally as likely to have children with long-standing illnesses or disabilities: 22 per cent have one child with a long-standing illness or disability, while another seven per cent have two or more children in this situation (Marsh and Rowlingson, 2002).

Fifty-four per cent of lone parents are currently in work in the UK, some way below the Government’s target of 70 per cent of lone parents in employment by 2010 (Evans et al., 2003). Whilst the New Deal for Lone Parents (NDLP) has been a popular initiative amongst lone parents, and has succeeded in moving many into employment, many other lone parents choose not to move into work, often because they face significant constraints to employment. Having health problems and/or disabilities is one of these constraints (Finlayson et al., 2000, Marsh et al., 2001).

A recent synthesis of research on the national evaluation of the New Deal for Lone Parents (Evans et al., 2003), has brought together a number of interesting findings on how lone parents are affected by health problems. Having ill-health or disabilities limits the likelihood of participants getting a job. Those furthest away from work are more likely to report health problems – 23 per cent of all lone parents report health problems as a perceived barrier to work, and this rises to 35 per cent among lone parents who do not want to work within the next three years. There are also important differences between existing (stock) and new (flow) Income Support claimants. Existing claimants are more likely to have health problems and/or disabilities.

Research has also found that ill-health and disability are factors that lower the probability of participation in NDLP. Lone parents limited by a health condition in the amount, or type, of work they can undertake, were less likely to participate. Half as many participants (11 per cent) reported having such a limiting condition as did non-participants (22 per cent). Additionally, having caring responsibilities for someone who was ill or disabled made participation less likely (Evans et al., 2003).

Overall, the research to date has shown that lone parents experience a higher incidence of health problems than other mothers, that more non-working lone parents experience health problems than those in work, and that health problems affect lone parents participation in the New Deal for Lone Parents, and the labour market. However, more research is needed to examine how health problems affect lone parents ability, propensity and likelihood to enter the labour market, their attitudes to work, and their welfare.

1.2 Part One – Aims and objectives

Whilst some lone parents with health problems are claiming health-related benefits, there is also a significant group of lone parents on Income Support who report having health problems, but are not claiming health-related benefits. It is this group that Part One of this research focuses on. Part One is concerned with both the health problems of lone parents on IS (who are not claiming health-related benefits) and of lone parents who have moved into work having claimed IS without health-related benefits, and the health problems of their children.
The objectives of Part One of the research are to:

- Identify differences (health, access to support, attitudes, circumstances etc.) between those lone parents with health problems (or children of lone parents with health problems) who are in work, and those who are on IS.
- Ascertain how, and to what extent, health problems impede lone parents’ prospects of starting and staying in work.
- Document the circumstances of lone parents with health problems, and determine what they are doing (with medical support) to overcome the problems.
- Determine whether the support needs of lone parents with health problems are being met.
- Identify any ‘triggers’ that made those in work, look for work, or that would facilitate those out of work, to look for work.
- Identify and explore what would help lone parents with health problems start work, and stay in work.
- Identify whether existing provision, such as Work-Focused Interviews (WFIs), New Deal for Lone Parents, and health-related benefits do/could deliver support to lone parents with health problems, wishing to enter/remain in work.

1.3 Part Two – Aims and objectives

Part Two of this research is concerned with the health problems and/or disabilities of lone parents who are claiming health-related benefits.

The objectives of Part Two are similar to those of Part One, although they are focused on starting work rather than both starting and staying in work, as Part Two does not include those already in work. Part Two does not, therefore, have as an objective, comparing lone parents on benefits to those in work. In Part Two, examining existing provision also includes the New Deal for Disabled People (NDDP), as lone parents on health-related benefits are eligible for NDDP. Part Two does not focus on triggers into work, but does have an additional objective of examining why some lone parents start claiming health-related benefits when their youngest child reaches 16.

The objectives of Part Two of the research are to:

- Ascertain how, and to what extent, health problems affect lone parents’ decisions about work now, and aspirations to work in the future.
- Document the circumstances of lone parents with health problems, and determine what they are doing (with medical support) to overcome the problems.
- Determine whether the support needs of lone parents with health problems are being met.
- Identify and explore what would help lone parents with health problems start work.
- Identify whether existing provision, such as Work-Focused Interviews, New Deal for Lone Parents, New Deal for Disabled People, and health-related benefits do/could deliver support to lone parents with health problems wishing to enter work.
- Ascertain why a large group of lone parents who were on Income Support with no health-related benefits, start to claim health-related benefits for the first time when their youngest child reaches 16.
1.4 Methodology

Methodological details about sampling criteria, recruiting the samples, descriptions of the samples, and conducting the interviews and focus groups differed between the two studies. These details can be found at the beginning of the sections of the report that refer to Part One and Part Two of the research respectively. The general methodological approach that was relevant to both studies is discussed here.

1.4.1 A qualitative approach

A qualitative approach was chosen for this research to provide detail about, and insight into, lone parents’ experiences of health problems and/or disabilities. Whilst the results are not representative of the lone parent population, they aim to go beyond survey data that have shown that health is a constraint to work for lone parents, and to provide rich information on, for example, why health problems and/or disabilities act as a constraint to some lone parents and not to others, and how health problems and/or disabilities interact with other constraints to work.

1.4.2 Sampling criteria

The research focused on three conurbations in England which had large proportions of lone parents on Income Support: London, Newcastle, and Leeds/Bradford. Additionally, London was chosen because lone parents experience lower employment rates in London than elsewhere (O’Connor and Boreham, 2002), even after controlling for variations in characteristics. Of the three areas, the ‘Jobcentre Plus’ model had only been rolled out in Newcastle at the time of the research (the rollout of Jobcentre Plus areas will be completed in 2006)3. Wards were selected within each city that broadly reflected the make up of lone parents in the wider area, and ensured that the sample was not concentrated in a particular locality, such as a major housing estate.

The research was also designed to focus on female lone parents, as lone mothers make up 94 per cent of lone parents on Income Support.

Additional sampling criteria relevant to Part One or Part Two, and details of how the samples were recruited, can be found in Chapter 1 and Chapter 12 respectively.

1.4.3 Interview topic guides

In both Part One and Part Two of this research, topic guides were developed and then piloted in London. In Part One, three pilot interviews were conducted with lone parents who had opted-in to the research (see Chapter 1 for details of the opt-in process) and in Part Two, two pilot interviews were conducted with lone parents who had not opted-out of the research (see Chapter 12 for details of the opt-out process). These interviews were not analysed, and are additional to the interviews conducted with lone parents in the main stages of this research. The topic guides were then modified in the light of the pilot findings before the main-stage interviews were conducted. The final topic guides are shown in the Appendices.

Details of how the interviews and focus groups were conducted in Part One and Part Two can be found in Chapter 1 and Chapter 12 respectively.

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3 In this report we use the term ‘Jobcentre’ when referring to the local Jobcentre office, and the term ‘Jobcentre Plus’ when referring to the services offered by the new organisation which has replaced the Benefits Agency and the Employment Service.
1.4.4 Analysis

To ensure the rigorous use of qualitative data, analysis of interviews and focus groups was conducted using Computer Assisted Qualitative Data Analysis Software (CAQDAS), in the form of the programme ‘Atlas.ti’.

All transcripts were read and each was fully coded using Atlas.ti. Atlas.ti allows the user to organise qualitative information and to code qualitative data under relevant thematic headings. For example, a code was ‘benefit history’. Any reference to this theme in all transcripts is then attached to this code, and then all information about benefit history can be easily extracted at the stage of detailed analysis.

Transcripts in Atlas.ti can also be grouped into any number of ‘Families’. For example, each transcript can be placed in one ‘family’ according to benefit type, and one according to geographical area. This makes it easy to retrieve information relating to a particular group, for example, only for those lone parents who left IS for IB, when their youngest child reached 16.

Analysis in Atlas.ti was done by the three main interviewers, who analysed each others, as well as their own, transcripts. A code list was developed, with each code being carefully defined to ensure consistency of coding between the interviewers. The analysis involved further teamwork to develop interpretations and implications. Extracts of this coded data were then used to write reports. This ensures that all rich information is captured, and that findings are thoroughly evidence-based.

In this report, quotes from interviews and focus groups are used to illustrate points made in the text. They are used to show both comments made by many of those who took part in the research, as well as comments that were more unusual, but important in terms of the objectives of the research. All the names of lone parents and their children have been changed. In Part One, each quote indicates whether a lone parent was in work or on Income Support, and what health problems they, or their children had. In Part Two, each quote indicates what type of health-related benefit the lone parent received.

Where the analysis has shown key differences between those in work or on Income Support in Part One, or between the three health-related benefit groups in Part Two, we have outlined them. Where there are no key differences, all the lone parents within Part One or within Part Two are discussed together.
Part One – Lone parents on Income Support and lone parents in work
2 Methodology

2.1 Sampling criteria

In addition to the sampling criteria of female lone parents in London, Newcastle and Leeds/Bradford (see Introduction), the main sampling criteria for Part One was to interview both lone parents in work, and lone parents claiming Income Support (and not claiming health-related benefits). This enabled us to see what leads some people to work, despite their health problems, and leads others to remain on benefits. For those employed, only those who are working over 16 hours a week and not claiming benefits were sampled. This enables those on Income Support to be compared with a group of lone parents who have moved into work, after a period claiming Income Support, who are working enough hours to be eligible for Working Tax Credit (WTC).

Following from the research evidence, which shows the type of health problems that lone parents face (as discussed in the Introduction), this research was designed to focus on lone parents who reported having musculoskeletal, respiratory or mental health problems, and lone parents whose children had health problems, or were disabled. Within the sample, the aim was to interview 45 lone parents who had a health problem themselves, and 15 lone parents whose child had a health problem.

2.2 Recruiting the sample

To recruit lone parents for this research, the Income Support Customer Database was used. Contact details for all female lone parents in selected wards were requested, excluding all those in receipt of health-related benefits, but including those in receipt of Disabled Child Premium. Details of both lone parents still claiming Income Support, and lone parents who had left Income Support within the last year, without making a new claim, were requested, to enable us to capture lone parents who had moved into work.

As there is no information on the Income Support database on health issues, it was necessary to ask lone parents who had health problems to opt-in to the research, by completing a pro-forma that was attached to an opt-in letter (both the opt-in letter and pro-forma can be found in the Appendices). The pro-forma asked lone parents if they, or their children, had health problems that had lasted for over a year, and what these health problems were. It also asked whether they were currently claiming Income Support, or working over 16 hours a week. Incentives were offered to encourage recipients to participate in the research.
From the Income Support database, records for 12,724 lone parents currently in receipt of Income Support were received, and 2,365 lone parents who had stopped claiming Income Support between 1 May 2002, and 1 May 2003, and had not returned to Income Support, or had returned to Income Support and left again.

A mail-out to 2,000 lone parents (chosen at random from the Income Support records received) was conducted, inviting respondents to opt-in to the research. Of the 2,000 lone parents invited to participate, 194 responded (9.7 per cent). According to the information provided on the pro-formas, 108 of these lone parents were broadly eligible for the research, representing 5.4 per cent of the total group invited to participate.

2.3 Description of the sample

From those lone parents who opted-in to the study, 60 were recruited for interview. However, two of the lone parents were discovered, on arriving at interviews, not to have health problems, although they had mistakenly indicated that they did have a health problem on the pro-forma, so they were not interviewed. Consequently, the sample was reduced to 58 lone parents with health problems.

2.3.1 Area, ethnicity and age

In terms of geographical breakdown, this included:

- 20 lone parents in Leeds/Bradford;
- 19 lone parents in Newcastle; and
- 19 lone parents in London.

A diverse range of ethnic groups were represented within the sample. There were:

- 40 White lone parents;
- 11 Black lone parents;
- four Pakistani lone parents;
- two Bangladeshi lone parents; and
- one Indian lone parent.

The ages of lone parents interviewed varied, with:

- 24 lone parents being aged 16 to 35; and
- 34 lone parents being aged 36 years old and above.

2.3.2 Employment status

In terms of their employment status, 31 lone parents in the sample were on Income Support, and 27 were in work, for 16 hours or more, having previously been on Income Support.

Lengths of time that lone parents on Income Support had been claiming, varied. According to the Income Support Customer Database, at the time that lone parents were contacted:

- seven had claimed IS for less than six months;
- one had claimed IS for between one and two years;
• one had claimed IS for between two and three years;
• one had claimed IS for between three and four years;
• one had claimed IS for between four and five years;
• six had claimed IS for between five and six years;
• one had claimed IS for between seven and eight years;
• two had claimed IS for between eight and nine years;
• four had claimed IS for between nine and ten years;
• four had claimed IS for between 11 and 12 years; and
• three had claimed IS for between 12 and 13 years.

Lengths of time that lone parents in work, had been working, also varied. According to the pro-forma completed by lone parents, on opting-in to the research:
• ten had been in work for less than six months;
• 12 had been in work for between six and 12 months; and
• five had been employed for over a year.

Lone parents in work were employed in a wide range of sectors, including the private sector (call centres and retail), the public sector (health, education and local government), and the voluntary and charitable sector. Many lone parents were working in low paid and low-skilled occupations, including administrative and clerical roles (receptionists and switchboard operators), bar workers, shop assistants, caterers, and healthcare assistants. Some lone parents were working part-time (more than 16 hours a week) and some had more than one job, to ‘make ends meet’.

There were many lone parents working at the minimum wage, or for not much more. However, there were some lone parents in management roles, and some who were professionally qualified, who were currently earning over £20,000 a year. These included teachers (primary school) and nurses (including dentist nurses and general practice nurses).

### 2.3.3 Type of health problem

Many lone parents reported more than one health problem, including both physical and mental conditions. Of the 58 lone parents interviewed:

• Twenty-eight lone parents had a single health problem themselves, of which, 18 had a physical health problem only, and ten had a mental health problem only.

• Twenty had multiple health problems themselves, of which, 11 had both mental and physical health problems, and nine had multiple physical health problems but no mental health problems.

• Of those lone parents with health problems themselves (whether one or more), 11 also had children with health problems.

• Ten lone parents, without health problems themselves, had children with health problems, of which, two had a disabled child.
The flow chart in Figure 2.1 identifies the main distinctions between the different types of health problems found within the sample.

**Figure 2.1: Different types of health problems**

- **Fifty-eight lone parents interviewed**
  - Twenty-eight lone parents have a single health problem themselves
    - Of which, 18 have a physical health problem only
    - Of which, four also have children with health problems
  - Twenty lone parents have multiple health problems themselves
    - Of which, ten have a mental health problem only
    - Of which, two also have children with health problems
  - Ten lone parents have a child health problem only
    - Of which, eleven have both physical and mental health problems
    - Of which, three also have children with health problems
    - Of which, two are disabled

Source: IES/CESI, 2003

The more common health problems found amongst children of lone parents, within the sample, include asthma and eczema, although there were a number of children with behavioural problems.

Health problems experienced by parents were more diverse. The main mental health problem amongst lone parents was depression, while physical conditions included: skeletal and muscular problems, heart and lung conditions, arthritis, allergies (e.g., asthma) and diseases (e.g., diabetes, cancer).

### 2.4 Conducting the interviews

After the interview topic guides were piloted (see Introduction), the main-stage interviews were completed. Interviews were conducted in lone parents’ homes, to make it easier for lone parents to take part in the research. Interviews were recorded and transcribed in full.
In a few cases, family members of lone parents were used to translate, in interviews where a lone parent had English as a Second or Other Language (ESOL). Lone parents chose to have family members translate, and in most cases this worked well, although questions may have been re-phrased by interpreters, and researchers were reliant on interpreters to translate respondents’ answers accurately.

In some interviews, lone parents became upset when talking about their health problems, or described themselves as suicidal. In these cases, researchers ensured that respondents were happy to continue with the interview. In all cases, researchers asked questions sensitively and made it clear that respondents did not have to answer any questions they did not feel comfortable with.

2.5 Focus groups

Participants for focus groups were recruited from both those lone parents who had been interviewed, and also from those who had returned the pro-forma and who were broadly eligible for the research, but that had not been interviewed.

It was decided to conduct separate groups for those in work and those on Income Support because the discussions could then have a slightly different focus. For example, lone parents in work could discuss the role of employers in helping them remain in work, and how they manage their health problems at work, whilst lone parents on Income Support could focus on how health acts as a constraint to moving into work and what they feel would help them move into work. There was also a concern that lone parents on Income Support (particularly those with mental health issues) might feel that they were being unfairly compared to lone parents in work who had managed to move into work despite their health issues.

The aim was to recruit one group in work and one group on Income Support in each area: London, Newcastle and Leeds/Bradford. In Bradford and Leeds it was decided to conduct one focus group in each city so that lone parents did not have to travel between cities. It was therefore decided to recruit one group on Income Support in Bradford and one group in work in Leeds, which meant having half the number of lone parents that both lived in the correct city and had the correct working/not working status to recruit from than there were in Newcastle and London. This made these groups difficult to recruit.

In Leeds it proved impossible to find a time that fitted with people’s different work schedules, and in Bradford, some lone parents on Income Support did not want to attend focus groups. In some cases, lone parents had issues with travelling to attend groups (situated in the city centre), and some lone parents would have required interpreters, but whilst these were offered, as was having lone parents bring a family member or friend to translate, they decided that they did not want to attend. In these cases, where attending a focus group proved too difficult, moving into work will, presumably, be harder still.

The focus groups in Leeds and Bradford did not, therefore, take place, and two groups were recruited in London and two in Newcastle. In the event, only one group in Newcastle went ahead, due to non-attendance. Of the three groups that took place, there was one group in London of three lone parents who were in work, one group of four lone parents in Newcastle who were on Income Support, and one group of six lone parents in London who were on Income Support.
The topic guide was developed based on the interview topic guide and feedback from the interim presentation given at DWP, and focused on issues such as constraints to moving into work, support, what Jobcentre Plus could do and ‘in work’ issues. The focus group topic guides are shown in the Appendices. All focus groups were taped and fully transcribed.

2.6 Analysis

Analysis of the interviews and focus groups was then conducted using the software Atlas.ti (see Introduction for details).
3 Results of the General Health Questionnaire

3.1 Introduction

The General Health Questionnaire set of 12 questions (GHQ12) is used in the English Health Survey, commissioned by the Department of Health, and is used in the British Household Panel Survey, to assess mental well-being. The GHQ12 was included in the interview topic guides in this research, to explore the mental well-being of lone parents with health problems.

The aim of using this measure in this research is to provide an assessment of mental well-being of lone parents in this study, which is independent of self-described mental health, or a medical diagnosis. The GHQ12 is not, however, sufficient to make a diagnosis that a particular lone parent has mental health problems.

Results from our administration of the GHQ12, with the interview sample, have been scored and compared with results from other research, to assess whether the mental well-being of lone parents, participating in this study, is better or worse than the mental well-being of the general population.

3.2 GHQ12

During interviews, lone parents were asked the 12 questions, which are:

Have you recently:
1. been able to concentrate on whatever you’re doing?
2. lost much sleep over worry?
3. felt that you were playing a useful part in things?
4. felt capable of making decisions about things?
5. felt constantly under strain?
6. felt you couldn’t overcome your difficulties?
7. been able to enjoy your normal day-to-day activities?
8. been able to face up to problems?
9. been feeling unhappy or depressed?
10. been losing confidence in yourself?
11. been thinking of yourself as a worthless person?
12. been feeling reasonably happy, all things considered?

Interviewees responded by choosing an answer from a standard set of responses for each question, which included replies such as:

- more than usual;
- same as usual;
- less so than usual;
- much less than usual.

These individual responses were coded and scored, to provide a score on a scale running from zero (the least distressed) to 36 (the most distressed) (Cox et al., 1987).

### 3.3 GHQ12 scores

Of the 58 lone parents that were interviewed, 53 completed the GHQ12 as part of the interview. The remaining five lone parents were too upset to complete the GHQ12 or did not want to complete it. The average (mean) score of the 53 lone parents that completed the GHQ12 was 17.5. This compares with an average score of 11 for the British population, based on the British Household Panel Survey (BHPS). The mental well-being of lone parents that were interviewed was, therefore, below the British average – these lone parents were worse off in terms of mental well-being than the general population. However, it must be stressed that the BHPS is based on the response of approximately 10,000 people, whilst these findings are based on 53 lone parents. This comparison is, therefore, limited.

Data can be acquired, at cost, from the BHPS to produce analysis at sub-level, eg gender, working and non-working mothers, and benefit recipients. Such data has not been sourced and analysed as part of this research. However, a recent study on the effectiveness of out-of-home day care for disadvantaged families in Hackney, London (some of whom were in work and some of whom were on benefits) provides a useful comparison (Toroyan et al., 2003). The GHQ12 scores of mothers, randomly selected for this study, were 11.9 (for the 49 respondents in action areas) and 12.7 (for the 61 respondents in control areas). Both groups in the research on day care scored in line with the national average, and had lower scores (indicating better mental well-being) than the lone parents with health problems that were interviewed in this research.

In this research:

- seven lone parents scored between one and nine;
- 24 scored between 10 to 18;
- 17 scored between 19 to 27; and
- five scored between 28 to 36.
Whilst some lone parents in our sample showed high levels of mental well-being, and scored below the national average of 11, there were a group of lone parents who had high scores, indicating low levels of mental well-being.

The average score of lone parents who described themselves as having mental health issues was 23.9, whilst the average score of lone parents who described themselves as having other health issues was lower, at 14.0. Those lone parents who said that they had mental health problems, therefore, had worse mental well-being, according to the GHQ12, whilst both lone parents with mental health problems, and lone parents with physical health problems, had lower mental well-being than the national average.

Lone parents on Income Support also scored higher than those in work, with lone parents on Income Support having an average score of 19.3, compared with an average score of 15.8 for those in work. While those in work would appear to have better mental well-being than those out of work, the average score is, nevertheless, higher than the national average for both groups.

### 3.4 Summary

GHQ12 is a quantitative tool, which is commonly used to provide analysis of mental well-being across large populations, and over time. However, it also allows a snapshot, or assessment, of current mental well-being, independent of identification of mental health problems by the respondent. While the results would suggest that lone parents, interviewed as part of this sample, have poorer mental well-being than the national average, it must be stressed that these results are not representative of all lone parents. They only show the mental well-being of the small group of 53 lone parents who completed the GHQ12 as part of this research.

The administration of GHQ12 has given us another tool for examining the mental well-being of lone parents in this research, at the time they were interviewed. However, whilst it has proved a useful indicator in this sense, using it in qualitative research amongst a small group of lone parents does not demonstrate mental well-being among the lone parent population more generally, and using it as a snapshot cannot demonstrate how mental well-being changes over time, for example, as individual lone parents move from benefits into work.
4 Differences between those lone parents with health problems who are in work and those who are on IS

4.1 Introduction

This chapter examines the circumstances of those who took part in the research. It documents the details of the health problems reported, work and benefit histories, the types of jobs that lone parents in work have, and attitudes to work and benefits. The differences between those currently claiming Income Support, and those in work, are stated where they exist.

4.2 Health problems

In Part One of this research the term ‘health problems’ is used. The term ‘health problem’ is used as a shorthand for having a health condition or impairment, as it is the term used by DWP both in commissioning the research, and in the research objectives. Within the sample are lone parents with health conditions or impairments, who may, or may not, regard themselves as disabled. The lone parents in the sample opted-in to this research by identifying that they had a ‘health problem that had been present for a year or more’.

4.2.1 Type of health problems

A key feature of the sample is the range of health problems described. It is worth noting that the details of the health problems presented here are as they were expressed by lone parents themselves. As such, not all of the health problems described have a name or a correct medical term. For the purpose of illustration, health problems reported included:

- pleurisy;
- carpal tunnel syndrome;
- high blood pressure;
• depression, anxiety and ‘nerves’;
• back problems;
• various cancers; and
• pains in limbs.

It is worth noting, at this stage, that there is an obvious distinction between having a health problem and being ill. The pro-forma used to get lone parents to opt-in to the research (see Appendix B) asked lone parents if they had been feeling ‘generally unwell’ this year, as well as asking about specific health problems. Many indicated that they had been unwell, whilst others, despite indicating having a debilitating health problem, did not indicate that they had been feeling ‘generally unwell’.

There was considerably less heterogeneity in child health problems reported. Whilst there were a few cases of serious physical disability, in the main, child health problems reported were asthma, eczema, and behavioural problems, such as Attention Deficit Hyperactivity Disorder (ADHD).

There was a high incidence of mental health issues conveyed. Without exception, mental health cases related to the parent, rather than the child. Generally, mental health problems described were depression, anxiety and ‘nerves’, with only a few exceptions, which included schizophrenia and agoraphobia.

Many reported having multiple health problems, in some cases as many as five health problems were reported. For the most part, multiple health problems included physical and mental health issues. In some cases, more health problems were mentioned in interviews than were initially declared in the opt-in pro-forma.

Instances of both a child health problem, and a lone parent health problem, were not uncommon. Furthermore, in some of these cases, both the parent and the child had more than one health problem.

4.2.2 Duration of health problems

In terms of the length of time that health problems have been present, there was a wide range of durations reported. It is difficult to say anything conclusive in terms of the duration of the health problems, as many of the sample have multiple health problems. Also, some health problems were not necessarily diagnosed as soon as symptoms were apparent. Some of the health problems have transformed over the years from one thing to another, for example, where pleurisy had developed into pneumonia. The minimum duration of health problems reported was one year. In the main, though, health problems were described as being present for much longer. Child health problems tended to have been present since birth, or early childhood.

A number of lone parents reported that their health problem had been present prior to them becoming a lone parent, and, in some cases, prior to them becoming a parent. In other cases, the circumstances relating to becoming a lone parent had had an impact on their health.

Some health problems were said to ‘come and go’. This was particularly the case with asthma amongst children. The on/off nature of asthmatic symptoms was often related to external circumstances, such as the weather.

There is no obvious relationship between the duration of the health problem and the type of health problem, with the exception of depression and anxiety, where the problem persists, on an ‘on/off’ basis, over a period of years.
4.2.3 How circumstances of lone parents relate to health problems

Naturally, it is not possible to discuss the causes of health problems from a medical perspective. However, there are some interesting social and circumstantial dimensions, which relate to some of the health problems reported.

Cases of depression were often triggered by an event, or events, that change circumstances. Bereavement, for example, seemed to have had the effect of triggering depression, in some lone parents in the sample. Chapter 4 looks in detail at how health problems, such as depression, impact on lone parents ability to work. However, it is worth noting here that some health problems, such as depression, started, or got worse, towards the end of Income Support entitlement. If the triggering event, such as bereavement, had not occurred, some of the sample might have otherwise been in a more work-ready position when their youngest child reached 16, and they were no longer entitled to Income Support. The example below illustrates how one lone parent was affected by bereavement.

Deborah has claimed Income Support since she became a lone parent due to a marriage break-up. She has mental health problems, high blood pressure and asthma. Becoming a lone parent unexpectedly, resulted in Deborah relying heavily on her parents, for both emotional and practical support. Eventually, her parents both grew older and they became ill. She adopted the position of carer and claimed Carer’s Allowance for a few years. Last year, suddenly, both of Deborah’s parents died, leading to her depression. She now finds it hard to face everyday life without them as they were, for many years, the most integral part of her day-to-day existence. Deborah now takes anti-depressants and cries most of the time. She has also begun comfort eating and has gained a lot of weight. She feels she is unable to face the outside world.

In the case of child health problems, environment was reported to have had a part to play. An example, cited a number of times, was the relationship between asthma and poor housing conditions, like damp, or being located next to a busy road. The example below shows the impact that housing can have on health:

‘The house that we lived in was a terribly damp place in the winter. I think it made it worse at the time there.’

(Lone parent with mental health problems and a child with asthma and eczema. On Income Support)

Mental health issues dominated many of the stories of the lone parents in the sample, and rarely was mental health reported as a singular health problem. There seemed to be links between mental and physical health problems for some lone parents. For example, in one case, where both a physical and mental health problem was reported, an injury at work was cited as the cause. The injury resulted in the physical health problem, which had an impact on mobility. As a result of not working, and not being physically able to carry on as previously, depression occurred. In this instance, it appears that there is a link between the physical and mental health problem.

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4 The lone parent took up a case against her employer but her public sector employer denied liability for the injury and her ‘no win no fee’ solicitor dropped the case.
There is also some evidence to facilitate an exploration of how mental health issues can contribute to poor physical health, and the prevalence of psychosomatic health problems. Panic attacks, for example, where the symptoms experienced are physical, but the cause is mental, were not uncommon in the sample. There are cases described by lone parents where it appears that the prognosis of the physical health problem is less positive due to the presence of a mental health issue. One lone parent described how she felt that her mental health affected her physical health:

‘I had pneumonia, problems with my gullet. I’ve been back and forwards, they can’t pinpoint anything but the more I think about it, I think it’s been down to stress and anxiety, worry.’

(Lone parent with breathing difficulties. On Income Support)

Some health problems seemed to be related to either becoming a parent or becoming a lone parent. Depression, for some, seemed to be a consequence of suffering post-natal depression some years previously:

‘I basically suffered, or knew that I was clinically depressed, when I had my son, which was 15 years ago. I was all right up until that point in my life, got married, got pregnant and everything seemed to be okay, but once I got pregnant something went wrong basically, quite badly.’

(Lone parent with mental health problems and a child with behavioural problems. In work)

In some cases, the post-natal depression was thought, by lone parents, to have been exacerbated by the added concerns of coping with a child on their own:

‘There was always a problem accepting that their Dad had walked out on me. That was very hard – I thought the world of him and I had these two small babies, and when you’ve just had a baby your hormones are everywhere. I was so devastated to find out that he had someone else – it took a toll.’

(Lone parent with mental health problems, high blood pressure and sciatica. On Income Support)

Occasionally, health problems were caused by a problem during pregnancy or child birth, for example, problems with the administration of an epidural during child birth left one lone parent with back trouble. For a few others, health problems were brought on by, or started during, pregnancy:

‘It was mainly him [having her child] where it came on from, because I had quite a lot of trouble when I was carrying him. I had gallstones when I was carrying him, and I was unfit when I was carrying him anyway.’

(Lone parent with breathing difficulties. On Income Support)

4.2.4 Severity of health problems

Lone parents were asked to talk about how severe they felt the health problem to be, in their opinion. In some cases, the view of lone parents about the severity of the health problem might be quite different from a medical perspective. It is worth noting that what is detailed here on how severe lone parents perceived the health problems to be, is not the same as whether or not the health problem is considered by lone parents to be a major constraint to work (this is explored in Chapter 4).

There was a general feeling, across the sample, that health problems were severe. Measures of severity used by lone parents included duration, prognosis, treatment and changes in capability. The view of the severity of health problems was sometimes described as relative to the health of other people:
‘It impairs me from living a normal life, having a normal quality of life, so in my opinion it’s severe because I can’t do what other people do.’

(Lone parent with mental health problems. On Income Support)

Some of those suffering from depression reported that they often felt suicidal. Cases of this were not isolated within the sample.

The view of severity is, of course, a personal one, and there is no indication from the evidence gathered here that the type of health problem contributes to the view of how severe it is. That is, on a case-by-case comparison, the view of severity differed, despite having the same health issue. For some, the health problem was not felt to be that severe at all; though they might have considered it to be at one time, it is now considered to be ‘not as bad’ or ‘mild’. For example:

‘I don’t think it is that severe. A consultant recently discharged me from his care. It’s quite good. I don’t think I need him anymore.’

(Lone parent with kidney problems and high blood pressure. In work)

A few others had simply never considered whether their health problem was severe or not. They expressed that they did not know if it was severe, or had never thought about it.

The health problem seems to be considered to be less severe by those who are recovering, or have found ways to treat or deal with their health problem. For example, a lone parent in work had a child with a hearing problem, which required the child wearing grommets in his ear, for a temporary period. Whilst the child still experiences difficulty with his hearing, his condition was not considered by the lone parent to be serious or worrying anymore. These cases exist both for those in work, as well as for those claiming Income Support.

Of those who did feel that their health problem was severe, not all considered it to be consistently severe. The severity of the health problem was reported to be changeable by some. For instance, some expressed that they have good days and bad days, or even good weeks and bad weeks. This was reported to be the case for both those on Income Support, and those in work.

### 4.2.5 Similarities in health problems of those on Income Support, and in work

There is no distinction to be made in terms of the type of health problem between the ‘in work’ and ‘on Income Support’ groups. Reports of mental health issues and physical health problems were reported in almost equal amount across both groups.

There is little evidence to suggest that those on Income Support have more health problems. Multiple health problems exist in both groups, in almost equal measure. There is no evidence to suggest that cases of child health problems are higher among the ‘on Income Support’ group. Indeed, within the sample, the number of child health cases in each group is identical.

Some of those on Income Support did seem to be more preoccupied by their health problem, in-so-far as they talked about it in more detail and for longer, than those in work.

There is no distinction to be made, from the basis of the evidence gathered here, between those in work and those claiming Income Support, about how serious they feel their health problem is. Often, those in work can feel that their health problems are just as severe, as do those claiming Income Support.
On the basis of the evidence gathered here, there appears to be no health problem that is experienced in the same way by different people. Regardless of type, or severity of health problem, whether it relates to the child or the parent, how the health problem is experienced is different. It appears that health is a deeply subjective issue.

4.3 Benefit and work histories

Within the sample, the longest duration on Income Support is more than 20 years, whilst the shortest claim is five weeks.

For the most part, benefit and work histories across the sample are, unsurprisingly, complicated. This section aims to illustrate this complexity by drawing out some of the typical benefit and work histories, from both the ‘in work’ and ‘on IS’ groups. Whilst there are few differences between those in work and on those on Income Support in terms of health problems, in examining work and benefit histories, some key differences between the groups begin to emerge.

In the main, the Income Support claim was simultaneous with becoming a lone parent. For some, this was from when they had their first child, for some others it was when a relationship ended and they ceased to be supported by their partner. There is very little evidence of working previously when married/cohabiting, and giving up work due to lone parenthood alone. That is, some in this position seemed to go from being a supported housewife and full-time mother to an Income Support claimant.

Some of those currently claiming Income Support had always been on Income Support, or had always claimed benefit, from the date at which they feasibly could. Reasons for this included both lone parenthood, at an early age, and unemployment post-16 (prior to becoming a parent or a lone parent). In only a few cases, pregnancy had occurred towards the end of school. There are a couple of instances, within the sample, where benefit claims began from an early age, in the form of Jobseeker’s Allowance, under the Severe Hardship provision or the ‘prescribed group’ rules (for example, care leavers prior to the Leaving Care Act, 2000).

Many across the sample, including both the ‘on Income Support’ and ‘in work’ group, describe themselves as being ‘on and off’ Income Support since becoming a lone parent. In some cases, there is movement not just between benefits and work, but also between benefits, work and learning. For example, in one case, the lone parent was at university before making a claim for Income Support, and then left Income Support to take up employment. After a short spell in employment, she returned to university, and then went back to Income Support again.

There was a wide range of jobs described, in the work histories of the lone parents, in the sample. They ranged from low skilled to professional. Both full- and part-time work feature, as do temporary, seasonal and permanent jobs. In the main though, previous jobs tended to be low-skilled and tended to be in the service sector.

Many have worked previously to having their first child. This is especially the case in the ‘currently in work’ group, whereas, some of those on Income Support have not worked at all since becoming a lone parent. Often, these are the same lone parents who had not worked prior to becoming a lone parent, either.

In a few cases, undeclared work was reported where Income Support claims had not been closed. Informal economic activity in the sample lasted for relatively sustained periods, where the work was continual rather than sporadic. It was felt that to close the claim for Income Support would result in financial difficulty.
Whilst claiming Income Support, benefit rules allow lone parents to work for under 16 hours a week and earn up to £20 extra a week (increased from £15) – any earnings additional to that cannot be kept by the lone parent. Under these rules, some of the lone parents interviewed, who were claiming Income Support, were also working for under 16 hours a week. For example:

‘I’ve worked in old people’s homes for seven years. I got £15 a week more, they used to take it off but I didn’t mind because I loved it.’

(Lone parent with stomach pains. On Income Support)

Some lone parents on Income Support, as well as some currently in work, had given up previous work due to a health problem. Some had then returned to work when it was felt that the health problem had improved, or was manageable. Some left a job because of issues to do with their child’s health; this is particularly the case where the child has ADHD, or has behavioural problems. This issue is discussed further in Chapter 5, where the issue of how health is a constraint to sustaining jobs is examined, and in Chapter 8, where the issue of how health affects lone parents’ decisions to move into work is discussed.

Whilst health often had a part to play in these complex benefit and work histories, it appears that it was not always the main factor. Many had left jobs for reasons such as not enjoying the work, disagreements at work, childcare arrangements changing, pregnancy, and not feeling any better off in work. However, this is not to say that health was not a factor at all. Chapter 5 explores how health operates as a constraint, alongside other constraints.

Overall, whilst still complex, those currently claiming Income Support had comparably less convoluted benefit histories to those in work. The key difference here is that durations on Income Support were more sustained amongst those in the ‘on Income Support’ group in the sample. Those in work tended to have spent less time on Income Support, overall, than those currently claiming. For example:

‘I stayed there [job in a nursing home] for two years, left there, went into another nursing home, stayed there for a year, fell pregnant, still carried on working ‘till I was eight months. I finished in the February and then Jill was born in March, and then I started claiming. I claimed from March 2002, to December 2002.’

(Lone parent with a child with asthma and eczema. In work)

‘I’ve worked all my life, never been out of a job. Never been on the benefits system [prior to a short spell on Income Support]. There comes a time where you do use it.’

(Focus group participant. In work)

4.4 Attitudes to benefits and work

Lone parents across the sample, were almost unanimous in their dislike of being a benefit claimant. For many, the key problem with claiming benefit is simply to do with the amount of money they receive. Many described the struggle to make ends meet on benefits. Some lone parents voiced their feelings on benefits quite passionately, describing claiming benefits, particularly as a lone parent, to be stigmatising and demoralising. For example:

‘I hate it actually and I’m desperate to find work.’

(Lone parent with a disabled child. On Income Support)
‘Some people think you’re scrounging and they don’t realise how much effort goes into looking after kids.’

(Lone parent with bowel problems. On Income Support)

Some respondents felt they needed to justify their benefit claim, as compared to the benefit claims of others. Expressions of ‘need’ were sometimes expressed about their case in particular:

‘Obviously, no one likes claiming, but I need it.’

(Lone parent with rheumatoid arthritis. On Income Support)

For some, benefits were seen as a ‘fact of life’, a ‘necessary evil’ given the circumstances. However, lone parenthood was never part of a ‘life plan’ for any of the lone parents in the sample. Indeed, some felt surprised to be a lone parent claiming benefits. They had previously envisaged being in, or had at one point been in, a two parent family context. Others had simply imagined their life differently. For example:

‘Benefits? If my life had gone right I would have liked to have been supported by a husband.’

(Lone parent with asthma and eczema, and with a child with asthma, eczema and behavioural problems. On Income Support)

Many lone parents described how being on benefits was boring, as a lot of time is spent in the house, with no prospect of meeting new people, or feeling part of the outside world. Indeed, being on benefits is perceived to be the cause of depression for some, whilst for others, it seems not to help their depression. For example:

‘You’re sat at home and you get depressed. When you’re on benefits it puts a damper on things.’

(Lone parent with mental health problems. On Income Support)

The impact of depression, on lone parents ability to work, will be examined in Chapter 4, but this point is important to note here, in terms of how claiming benefits and health may be related.

Most of those claiming Income Support said that they would rather be working, than claiming Income Support. Reasons for this included financial independence, and providing some social life and contact with other adults. Whilst many wanted to work, fewer were actively looking for work at the time of the interview and some were quite negative about their prospects of moving into work and were resigned to staying on benefits. A few lone parents, whilst expressing a positive attitude to work, questioned how beneficial work was. Some voiced concern over being a full-time parent and working, in terms of how domestic chores would be undertaken, and how work would affect the general up-keep of the house.

It was felt by a few lone parents, that while working would be personally rewarding to them, it would not benefit the tax payer, as they would still be helped by the State financially, whilst someone else was paid to look after their children, rather than them.
4.5 Summary

Examining the types of health problems that lone parents and their children had, has shown that there were no major differences between those on Income Support, and those in work.

Both groups were similar in terms of: the range of types of health problem; the differing durations of the health problem; in having particular circumstances, or triggering events that led to, or exacerbated, health problems; in having links between mental and physical health problems; in having some cases where lone parenthood and health problems are linked; and in terms of the severity of health problems.

However, when examining work and benefit histories, some differences do emerge. Those on Income Support had more sustained periods of claiming Income Support, and more had no previous work history than lone parents in work. However, in terms of the attitude that lone parents had towards benefits, both those on Income Support, and those in work, had very negative experiences of, and attitudes towards, benefits. Most of those on Income Support would rather be working than claiming benefits, particularly those who felt isolated and lacked support networks, and they did not, therefore, seem significantly different in terms of their attitude towards work, than those already in work.
5 How, and to what extent, health problems impede lone parents’ prospects of starting, and staying in, work

5.1 Introduction

This chapter examines why lone parents on Income Support are not working, and to what extent their health is a constraint to working. It also looks at the factors that make working difficult, or threaten the sustainability of work for those currently in employment.

In order to understand the extent to which health is a constraint to starting, or staying in work, health is looked at alongside other constraints to working. Primarily, the analysis presented here is based on how health is perceived by lone parents themselves to be a constraint to working. It is worth noting that the findings are entirely reliant on the subjective accounts of lone parents, and not a medical assessment of how health affects their ability to work.

5.2 Health as a constraint for those on Income Support

5.2.1 How health influences attitudes to work

Overall, lone parents who were currently claiming Income Support did want to work. However, health can have an impact on lone parents’ attitudes to work. A few expressed that, while in principle they wanted to work, they felt it would not be worth it because they feared letting employers down, or they felt that employers would not be happy with allowing them the time off work that they needed for their health problem. Whilst their health problem may not physically prevent them from taking up work, they might not be able to sustain work without taking days off frequently. Lone parents who had regular hospital appointments, either for themselves or their child, thought that this would be a particular problem. For example:
‘I wouldn’t want to go into an employer, take a job, knowing that I need a day off next week because I’ve got a hospital appointment.’

(Lone parent with bowel problems. On Income Support)

Leaving a child with a health problem, and particularly in cases of behavioural problems, was felt to make working not worthwhile. Lone parents envisaged having to leave work because of a problem with their child. For example:

‘I’m always being pulled up the school. ‘Come and get Richard or Jim. Come and sort Jim out, he’s losing his rag. You need to come up and sort it out’.’

(Lone parent with breathing problems. On Income Support)

In some cases, lone parents expressed that because a child had been sick, or had a behaviour problem, that they had always required, and received, a lot of attention. Lone parents felt that to suddenly change this level of attention, by going to work, would cause the child suffering, and would also induce guilt in the parent. For example:

‘My 16 year old’s got special needs as well and he’s not very good when he’s on his own. I worry about him because he’s not very good at communicating with other people.’

(Lone parent with breathing problems. On Income Support)

For those whose children have behavioural problems, work seems difficult, especially when children are excluded from school and parents have to be at home during the day to look after them, or because parents find it hard to concentrate on work or voluntary work due to worrying about their children. Lone parents with children with behavioural problems often felt that they would have to wait until the children were older before considering moving into work.

For others, the primary reason for not wanting to work, at the time of interview, was entirely unrelated to their health problem. For example, because they felt that their children were too young to enable them to return to work. Some lone parents, though not many, had simply never really considered work as an option. The reasons for this are, in large part, to do with attitudes around working mothers, and to an extent, what is the norm of other lone parents in the area. Lone parents mainly identified themselves as mothers first and foremost, and their attitudes to work and bringing up their children were often more important in influencing their attitude to work than health issues.

5.2.2 The different ways in which health is a constraint, for lone parents on Income Support

Health was cited as a constraint by the majority of those on Income Support in the sample. Three main groups emerge among those on Income Support, who differ in terms of how they perceive health as a constraint. Some Income Support claimants (though small and certainly not the majority of the sample) believed their health to be so debilitating they could not physically work at all. This group included those with both physical and mental health problems. Another group felt that while their health did not prevent them from being in a job, it contributed to making their circumstances as a lone parent harder, so as to make the possibility of moving into work more difficult. A third group did not feel that their, or their children’s, health, acted as a constraint to them moving into work. In a small number of cases, where lone parents did not feel that their, or their children’s, health was a constraint, this differed from the researchers’ view.
Some lone parents considered health to be their primary reason for not working and, in some cases, were currently making a claim for a health-related benefit. Conversely, some of those on Income Support, who cited health as a constraint (though not necessarily a key constraint) were making plans to go into work, at the time of interview.

For some with mental health issues, work was perceived to be impossible, as they found it difficult to cope with life altogether. For example:

‘I suffer from a lot of nervousness where I sweat a lot, to the point where my clothes are absolutely wet, and I shake a lot and feel out of breath. I’d rather stop in than go out there and struggle with it.’

(Lone parent with mental health problems and a child with asthma and hay fever. On Income Support)

‘If I can’t get out of the house, then how I can I look for a job?’

(Lone parent with mental health problems. On Income Support)

Many of these lone parents discussed how general levels of worry and anxiety meant that there was too much going on in their lives at the moment to also consider moving into work. Having problems sleeping at night made work seem impossible for some, whilst a high level of worry and stress exacerbated other health conditions. Some articulated that having a health problem tipped the balance of what they were able to deal with, given their other responsibilities as a lone parent.

Some felt very strongly that their child’s health problem prevented them from working, as a child with a health problem requires so much more from the parent than would ordinarily be the case. Being a lone parent, and being the only one to offer support to the child, can intensify this situation. This is particularly the case for lone parents with a disabled child:

‘Having a disabled child is like having maybe two or three children. I wouldn’t, as a lone parent, there is no way I could have gone to work and done everything I would have had to do for him.’

(Lone parent with a disabled child. On Income Support)

For some lone parents, changes in their capability, because of a health problem, means that moving into work would require a career change, and some may not have the necessary skills and experience to move straight into a new area of work. Some lone parents described how changes in their capability affect the type of work they could do:

‘I used to work in an office, I’ve always worked in an office all my life, typing. I wouldn’t be able to do typing because my joints, it goes to my fingers and wrists.’

(Lone parent with rheumatoid arthritis. On Income Support)

‘It’s more a fact that I can’t sit or stand for too long.’

(Lone parent with back problems, high blood pressure and mental health problems. On Income Support)

While some lone parents with health problems have considered other work, or are happy to consider doing other work, this is not the case for all. Some simply did not know what else they could do, or what else they would want to do. Another lone parent who had also always worked in physical jobs, was quite distressed at the prospect of not being able to do physical work again in the future:
‘The thing is with me, I’m not a sedentary person, so I have to consider that. I can’t just sit at a desk by a screen constantly.’

(Lone parent with mental health problems and a child with asthma and eczema. On Income Support)

5.2.3 Other constraints

There were other constraints to work reported by the sample, and in many cases, health was not felt to be the key constraint to work.

The constraints to employment that lone parents face are well documented in other research, charged with the task of looking at these specifically. This research was concerned with how health acts as a constraint, and how health interacts with other constraints.

There were several constraints other than health reported by the sample, varying from problems with housing, to travel and childcare. In the main though, key constraints, other than health, were childcare, lack of work experience, lack of confidence, the attitude of employers to lone parents and health, making work pay, finding a job with flexible hours, and, in a few cases, having English as a Second or Other Language.

Lone parents felt that there was a lack of affordable childcare, and that finding nursery places, and childcare places, during the school holidays was particularly difficult. Some lone parents also felt that childcare providers were not always accessible by public transport, or were not able to find one provider that could take all of their children, or that could pick children up from school. Lone parents who were happiest about the idea of using childcare were often ones that had some knowledge of local childcare provision and had a particular nursery or out-of-school club in mind.

Many of those currently claiming Income Support, as documented in Chapter 3, had very limited, and in some cases, no, work history. Their duration of economic inactivity was considered to be a major barrier, not just in terms of actual work experience, or access to a recent employer reference, but also in terms of how working would be so different to their usual routine. For example, lone parents described how their lack of recent work experience leads to apprehension about moving into work:

‘Not being in work for so long and then, all of a sudden, it’s like the world’s changed.’

(Lone parent with high blood pressure, asthma and mental health problems. On Income Support)

‘I think it’s because I’ve never had a job.’

(Lone parent with a child with asthma. On Income Support)

This was closely linked to low confidence among lone parents, a topic that was discussed in-depth in focus groups. One lone parent described having overcome a fear of walking into a room full of strangers, whilst another said that she would be too embarrassed and scared to apply for a job after so many years out of the labour market. Lacking confidence to go for job interviews was a big issue and lone parents mentioned the fear of being turned down after interview and the impact that could have on their confidence and mental health. Others felt that as they would be up against people in job interviews with a lot more work experience and, therefore, a lot more confidence, they would be very unlikely to get a job. Lone parents on Income Support who took part in focus groups discussed how it was hard to be resilient and to pick yourself up again after yet another set back. One lone parent described this feeling:
‘If you’ve had that many knocks in life where you’re negative all the time, it’s so hard to start thinking positive again’

(Focus group participant. On Income Support)

The attitude of employers to lone parents with health problems, or lone parents who have a child with a health problem, was perceived to be a constraint to work. Many lone parents reported that generally, employers were not sympathetic to lone parents, and would be concerned about lone parents taking time off work because of their caring responsibilities. This situation was considered to be much worse for lone parents who also had health issues. One lone parent described how she felt that her mental health affected her job prospects:

‘I don’t think employers would take somebody who suffers from anxiety and stress and takes diazepam. It would jeopardise your chance of a job when you’ve got people who are confident and outgoing.’

(Lone parent with mental health problems, high blood pressure and sciatica. On Income Support)

A number of the lone parents in the sample had concerns around making work pay. These tended to be those who had been out of work for long durations, and were less likely to have experienced, or in some cases, heard of, tax credits (old and new). Indeed, several lone parents had never heard of the new tax credits, nor did they have an understanding of the impact these might have on their take-home pay, if they were to enter work. Whether or not lone parents had heard of tax credits, there was a fear amongst some that having low qualifications meant that they would only be able to find low-skilled and low-paid work which would not make them any better off than being on benefits. Having health problems that would make work more difficult meant that these lone parents did not feel that work would, therefore, be worthwhile.

Finding a job with the ‘right hours’ to fit in around children attending school, was also often cited as the key constraint. However, there was little evidence to indicate that much job search activity had taken place where this was reported. Therefore, this constraint may well be perceived to be worse than is necessarily the case.

In a very small number of cases, having difficulties with reading and writing, or having English as a Second or Other Language (ESOL) would make entering employment difficult. For example:

‘It’s the lack of English, first of all, that’s probably the main thing, and now over the year her health has gone a bit poorly.’ (Interpreter)

(Lone parent with diabetes, high blood pressure and an ulcer. On Income Support)

As with other research (Pettigrew, 2003), some Asian lone parents that were interviewed in this research, who had stopped working when they were married, did not feel that it was culturally acceptable for them to return to work.

5.2.4 How health interacts with other constraints

Often, health is not the main constraint to work but can exacerbate other constraints to work and make everything harder to cope with. As a general point, it would appear that the more problems a lone parent experiences, the less able they are to deal with any of them effectively. That said, there were some very specific issues raised by lone parents in terms of how their health problem impacted on their other constraints to work, and pushed them further away from employment.
Some of those who suffered from depression also reported low self-esteem and problems with confidence. This may not seem surprising. In some cases, low self-esteem had been an issue for many years and this was probably not unrelated to the eventual diagnosis of depression. However, whilst confidence would have been a constraint to working in the past, this was now made much worse by the depression. One lone parent with depression explained that:

‘This is the thing when you’re trying to get back to work. If you’re anxious and depressed you do have quite low self-esteem. Any time you get a rejection it magnifies.’

(Lone parent with back problems, high blood pressure and mental health problems. On Income Support)

Childcare is a constraint frequently mentioned by lone parents. For lone parents who have a child with a health or behavioural problem, finding childcare can be even more difficult. Even if appropriate childcare can be found, very often, lone parents would be ‘too worried’ to leave their child who has health problems.

5.3 Health as a constraint for those in work

It may appear to be unnecessary to ask if health is a constraint to those in work. Instinctively, it would seem that if someone is working, then health does not impede their ability to work. However, many lone parents in work did feel that health impeded their ability to work.

There was evidence of some lone parents with health problems working long hours, in low paid jobs, and in poor working conditions. Some were working in jobs that are physically exhausting, while others, for example, care assistants, were particularly vulnerable to work-related stress. Some workers in the service industries (private sector) reported that their current jobs were the ‘worst that they have ever had’.

There is very real concern, amongst some of those currently in work, about how sustainable their job was, due to their health problem. Some even reported that, at the time of interview, they were considering giving up work because they were not coping. For example:

‘I’ve been wanting to give up work because with having rheumatism and arthritis I swell up real bad, so I’m waiting to see if I can finish work.’

(Lone parent with kidney problems, rheumatism and arthritis. In work)

In a few cases, the situation has been discussed with a General Practitioner (GP) who has offered to ‘sign them off sick’ if they feel that they cannot sustain work:

‘They said they would sign me off if I wanted to, I’m really trying hard not to.’

(Lone parent with mental health problems and a child with behavioural problems. In work)

Eventually, this scenario can lead to lone parents leaving work and going back on to Income Support (depending on the age of the child), without ever making a claim for health-related benefits. (See Chapter 9 for a discussion of lone parents’ awareness of health-related benefits.)

Working can make the health problem worse for some, or have an impact on their ability to cope with the health problem. This is most evident among those with musculoskeletal problems, where sitting for long periods, or the repetitive movement of the job, can worsen their problem. For example:
‘I’ve noticed that since I’ve been in the job I’ve been getting a lot more pain in the back of my neck, it’s tense and it crunches.’

(Lone parent with back problem, knee problem and mental health problems. In work)

For some others, workplace stress can worsen health, particularly where the health problem was depression or anxiety. However, the opposite can also be the case. Some of those with depression, currently on Income Support, expressed that going into work might actually help to alleviate, or improve, their health problem. In addition, some of those in work with mental health problems, moved into work with the aim of improving their depression in mind. For example:

‘I think if I were going out to work, I don’t think I’d get depressed.’

(Lone parent with mental health problems. On Income Support)

‘Now it is not as severe as it has been. When I was off of work with depression it was that bad that I seriously wanted to kill myself, I just wanted to end it all.’

(Lone parent with mental health problems, and a child with asthma. In work)

Being out of work, spending long periods in the house with few prospects of meeting new people, having less money than would perhaps be the case in work, can contribute to feelings of depression, and certainly have an impact on self-confidence. In contrast, moving into work can have a positive impact, as one lone parent explained:

‘I was bored stiff in the house. I’ve got more friends now. Tomorrow I am going out with the people from work.’

(Lone parent with child with hearing problems. In work)

Whilst some lone parents found that work had improved their mental health, others who thought that work would improve their mental health have found that work actually made their health worse.

For further discussion of how health affects lone parents’ decisions to move into work, see Chapter 7.

What was most notable, about many of those currently in work, was their sheer resilience to their health problems, and other difficulties, as well as their determination to work. In one case, working in spite of health and lone parenthood was described as a way of ‘fighting back’. In some cases, this was the only discernible difference from one lone parent in work, and another on Income Support, with similar health problems. The perceived severity of the health problem had little impact. The ability to work, therefore, can sometimes be to do with an attitude of mind.

Even when health actually does make sustaining work difficult, some lone parents push themselves to work regardless, rather than make a new claim for Income Support. Often, it is the children that provide the motivation:

‘You can feel like staying in bed for the whole week and not getting up, obviously because I’ve got two kids, it’s them that make me want to strive for more.’

(Lone parent with mental health problems and a child with asthma. In work)

Some lone parents, currently in work, were resolute that they would not let their health affect them. This attitude was derivative of a quite traditional work ethic, where employers are not expected to be sympathetic, and employees should work hard, regardless of adversity. For example:
‘You don’t take your problems to work. That’s how I’ve been brought up, I have always been brought up to work. As soon as I had my kids, I’ve worked my socks off. My mum has always worked. The jobs that I have done you can’t take your problems to work.’

(Lone parent with mental health problems and a child with asthma. In work)

5.4 Summary

Health acted as a constraint, to lone parents on Income Support, in a number of ways. Health problems affected the attitude to work that some lone parents on Income Support had. Some felt worried about letting employers down, or about not being able to be with children with health problems all the time, if they went out to work. Others felt that their, or their children’s, health meant that they already had too much to cope with, without moving into work as well.

The extent to which health was a constraint differed among lone parents on Income Support. One group felt that they could not work, another group felt that health problems made working more difficult, and a third group felt that health was not a constraint. Those that felt that they could not work were prevented by their mental health problems, or their child’s health problems. Those that felt that health would make working more difficult, cited changes in their capability due to health problems, and in some cases, the resulting need for a career change that was not always desirable.

For many lone parents on Income Support, health was not the key constraint to moving into work. Other constraints were childcare, a lack of work experience, low self-confidence, the perceived attitude of employers to lone parents and health issues, making work pay, finding a job with the right hours, and ESOL needs. In some cases, health interacted with other constraints, with depression leading to low self-esteem and confidence, and childcare being more difficult to access for children with health problems.

For lone parents in work, health can impede their ability to work. Some lone parents were concerned about the sustainability of their employment, with work making physical health problems worse in some cases. For those in work, with mental health problems, work had made mental health better for some, and worse for others.

A key difference between those on Income Support and those in work, seems to be the resilience of those in work, compared to those on Income Support, who may have similar health problems. Lone parents in work often described themselves as ‘fighting back’ against their health problem and refusing to let their, or their children’s health affect them, or prevent them from working. In contrast, some lone parents on Income Support found it difficult to be resilient and to pick themselves up after yet another set back. This does not mean that some lone parents on Income Support were using health to avoid work. It does indicate that health, like many constraints to work, is deeply subjective, and is not felt and experienced in the same way by different people.
6 What families with poor health are doing (with medical support) to overcome the problem

6.1 Introduction

This chapter will document what lone parent families are doing, with medical support, to overcome their health problems. It looks at the different types of health problems, mental and physical, experienced by lone parents, both in and out of work, and the general medical support and advice received in relation to their conditions. It then further identifies some of the main differences, where it is possible, between those lone parent families in and out of work.

It is important at this stage to make the distinction between those lone parents who are using medical support, to help overcome their health problem, and those who are using what support is available to them to best cope with, or manage, their health condition, or that of their children. Some of the health problems experienced by lone parents (both in and out of work) are persistent. At the same time, some conditions, regardless of their permanence, are more severe and debilitating than others. The nature of health conditions means that for some, support needs are more frequent and intensive.

6.2 Medication and treatment from medical professionals

6.2.1 Mental health

It was evident that some lone parents had not seen a doctor about their health problem. However, lone parents and children with health problems had, in the main, been diagnosed by a doctor, and had been prescribed medication or treatment.

In the main, lone parents with mental health issues had been prescribed anti-depressants. Some of those who had been prescribed anti-depressants were taking them with differing results. Some did acknowledge the benefits of prescribed drugs, for example:
‘I was on Prozac for about two years. That did lift, it’s not miraculous but it helped. It gave me enough impetus to look at university courses.’

(Lone parent with mental health problems. On Income Support)

Others had chosen either not to take medication, or had stopped their medication because of the side effects, and the fear of becoming addicted. In particular, young mothers who are breast-feeding cannot take some forms of medication.

Some lone parents with mental health issues had also received counselling, or had seen a psychiatrist. In a few cases, individuals had used residential mental health care services.

Overcoming depression with medical support (both through medication and counselling) is complicated by other circumstances. The evidence of lone parents who reported improvements in their mental health, often relates to a change in circumstances, rather than the direct benefits of prescribed drugs or counselling, including environmental (housing), social (personal relationships), as well as, in some cases, the positive effects of returning to work. It is worth stressing that not all lone parents with mental health problems, who had moved into work, had seen an improvement in their mental health. In cases where the depression is historical and long term, treatment helps to manage or contain the problem, but not necessarily to overcome it.

6.2.2 Physical health

Those with physical health problems were also receiving medication or treatment for their condition, except where there was nothing that would alleviate the problem: for example, in the case of some back problems.

The types of medication and treatment being used for physical health problems, by lone parents and their children, included, for example:

- tablets for under-active thyroid conditions;
- inhalers, tablets and steroid injections for asthma;
- creams for eczema;
- tablets for high blood pressure;
- steroid injections for rheumatoid arthritis and lupus;
- specialist consultants for kidney problems and cancer;
- physiotherapy for back problems;
- osteopathy; and
- operations for cancer and gynaecological conditions.

Lone parents also felt that there was a link between some physical health problems, for example, respiratory problems like asthma, and wider environmental and social circumstances, including poor quality housing. In many cases, particularly child health problems, lone parents felt that there was a direct link between these external factors and the cause of the diagnosed health problem, or the severity of the symptoms and intensity of medical support needed. For example:
‘It was more obvious [wheezing] when she was a baby, growing in the damp place that we were living in. She got ill quite easily as a baby. I had to keep taking her to the doctor. I had to call them out in the night when she had been unwell.’

(Lone parent with mental health problems and a child with asthma and eczema. On Income Support)

In these circumstances, medical support alone will not enable lone parent families to overcome their health problems.

6.2.3 Children with health problems

All lone parents who have children with health problems, within the sample, were receiving medical support for their children’s condition, and were administering medication and treatment as prescribed. Lone parents whose children have more severe health problems have greater caring responsibilities, often having to nurse their children on an intensive basis. For example:

‘At the moment he’s on wet wraps... That takes a lot of time, and he doesn’t like it... I’ve got to get up in the middle of the night, re-cream him so that he doesn’t keep scratching.’

(Lone parent with asthma and eczema, and a child with asthma, eczema and behavioural problems. On Income Support)

This can impact on the ability of some lone parents to work. Other constraints, like available childcare, or flexible working conditions, can also be the main issue here. However, there are some lone parents in work whose children have severe medical conditions requiring regular hospital stays (eg hole in the heart).

Some lone parents were experiencing difficulties in gaining the support they need for children with psychiatric or behavioural conditions. Many children with behavioural problems were receiving counselling, while some lone parents report difficulties in accessing support, including counsellors and social workers. Some parents are also in receipt of counselling and advice, including participation in parenting classes.

Again, there are further cases of child health problems, including behavioural difficulties, where medical support and counselling alone will not help overcome the condition. One parent described how her living conditions had an impact on her child’s behavioural problem:

‘There’s four of us in a one bedroom [flat]. No space for anybody. He can’t have his own space and I’ve been going parenting classes to help deal with his behaviour but it’s hard to do the strategies they want us to do because the spaces are limited. I can’t separate all the kids so we can’t do the one-to-one. My psychiatrist said that’s a big problem, the space. Get him his own space, then he can feel like he’s got his place, and his behaviour should be better, and I can do the strategies with him.’

(Lone parent with asthma and eczema, and a child with asthma, eczema and behavioural problems. On Income Support)
6.3 Differences in medical support between mental and physical health problems

It is worth noting, that in some instances, lone parents had been diagnosed for multiple health problems, including both mental and physical conditions. In some cases, mental health problems, particularly depression, have resulted from, or been exacerbated by, a persistent physical condition. In some such instances, the main form of treatment has concentrated on the primary physical condition.

There is little evidence to support any major distinctions between mental and physical health treatment, in terms of awareness of additional, or available, support. Lone parents with mental health problems were generally aware of counselling, as an alternative to continued medication, even if this support has not been specifically suggested by their GP, or requested, or had not been taken up by the patient. Those with physical health problems were generally aware of the alternative to painkillers or anti-inflammatory drugs available to them, for example, physiotherapy. Others were aware of the limitations about what could be done for their condition.

Some lone parents had expressed an interest in counselling and physiotherapy, which they had not yet received, and there was evidence of both limited availability of medical support, or difficulties experienced with waiting lists (which would support known geographical differences in availability of health services, between London compared with the other English regions covered in this study). One lone parent described her experience of trying to get access to counselling:

‘I asked if there is counselling at the surgery and she said there’s a six month waiting list, ring up every morning and if she’s free she’ll see you. That’s not good enough. No support. I’ve just got to ‘phone up every morning. I put money on my ‘phone, I’ve got £1.50 left on it. It’s a vicious circle, I can’t afford a ‘phone.’

(Lone parent with mental health problems and a neck injury. On Income Support)

Some lone parents had a general dissatisfaction with the effectiveness of treatment received, including dissatisfaction with GPs, and counselling for mental health. Some lone parents had either changed their GP or would like to do so if possible (again with major difficulty in London). There was a discussion in focus groups about GPs, and how lone parents felt rushed during appointments, and felt that if the GP gave them more time in the first appointment to accurately diagnose their condition, or to refer them to a specialist, it would prevent them from having to return for more appointments later. A feeling amongst many was:

‘Sometimes you feel like a time waster and you’re rushed in there and rushed out.’

(Focus group participant. In work)

Some lone parents had given up counselling due to their negative experiences of treatment. For example, one lone parent did not feel that counselling in the past had helped her:

‘In my early twenties I had counselling for a couple of years and after that I saw a cognitive psychologist for a couple of years, and then I saw a trainee psychiatrist for a while as well. It helps you work out why you have a problem but it doesn’t help to do anything about it.’

(Lone parent with mental health problems. On Income Support)

There is little evidence to support a distinction in the availability or quality of medical support, as it relates to either mental or physical health problems.
6.4 Differences in medical support between those on Income Support and those in work

There is little evidence to support significant differences between lone parent families in and out of work, in terms of what they are doing with medical support to overcome their health problems, be they mental or physical conditions. The main difference between those in work and those out of work related to the ability to make choices, often financial, about the type and frequency of support necessary to help their situation.

Some of those in work are able to take advantage of private health treatment, including using BUPA (British United Provident Association), some through work-based schemes where employers make financial contributions. Others are able to afford osteopathic treatment for back problems, which is expensive (about £40 per session), and not available on the National Health Service (NHS), or paid for alternative treatments such as reflexology. However, there was little evidence of an awareness, or take-up, by those in work, of available occupational health services. This may be because few employers, particularly those in low-paid sectors, are likely to provide this service.

Those in work have access to a wider social network and there are instances where work colleagues have offered information and advice about treatments they may have had, or are aware of. In some cases, lone parents in work have been referred by colleagues to specialist organisations for help. In contrast, lone parents out of work, particularly those with mental health problems, are more withdrawn from wider social networks, which limits their awareness and access to alternative or additional medical support.

Some of those in work felt more empowered to take charge of their situation. There is evidence to support lone parents changing doctors, because they are not satisfied with their local GP, or because they have been advised by a friend that another doctor is particularly sympathetic or understanding. Some have refused prescribed medication, or simply demanded alternative treatments, be that counselling or physiotherapy, from their GP. Others have chosen to ignore their GP and have not been back to them about their health problem. One lone parent described her negative experience with GPs:

‘I changed doctors and I went to him three times. I actually asked for sleeping tablets because I wasn’t sleeping and I was up all night. He said no. I bought myself a tonic that day because he gave me nothing and I haven’t been back to him since.’

(Lone parent with mental health problems. In work)

It is worth noting that it was a common experience that lone parents in work, who have been prescribed anti-depressants, have either refused to take them, or have stopped taking them within a short period of time. This was because of having problems coping with medication and finding their circumstances, including holding down a job, more difficult to deal with whilst taking tablets. For example:

‘I refuse to take them because they make you walk round like a complete zombie and I’m not doing it, I’ve got better things to be doing with my time.’

(Lone parent with mental health problems and anorexia. In work)

In contrast, some of those lone parents out of work had established long term dependency on anti-depressants, often having not been offered alternatives, which have meant that they did not feel able to cope with working.
Those lone parents out of work, and with young children, found the combination of difficult travel routes to hospital, cost of travel, and available or affordable childcare, a major constraint to taking up continued medical support. It is difficult in these circumstances for lone parents to keep up with the regular treatments necessary to overcome their condition.

6.5 Advice from medical professionals

Some lone parents had not been given any advice from medical professionals on what they could do to alleviate their, or their children’s, health problems. However, others had had advice from their doctors, which they had found helpful. This included advice on exercises to help alleviate back problems, advice on how to cope with mental health issues (including advice on relaxation techniques and breathing exercises), and being told to stop smoking to alleviate asthma.

Others have chosen to ignore medical advice, for example, those who have been told to stop smoking in order to overcome their medical problem, but have not done so. There is no evidence to suggest that the advice given by medical professionals is different for those lone parents on IS or in work.

6.6 Use of specialist organisations

A few lone parents are using specialist organisations that support people with particular health problems, although there is evidence to suggest that many lone parents are not currently using specialist support organisations, or have not used any in the past. In one case, a lone parent with a disabled child had used a local charity, which provided free physiotherapy, another lone parent with depression had used the charity ‘M IND’ and the Samaritans, and one had used a drug rehabilitation centre.

Many lone parents are unaware of specialist organisations which could help with their health issue, and rely on information about their health problem from the doctor, and from information provided on the leaflets that come with their medication.

Again, there is little evidence to suggest a significant difference in the use of specialist organisations between those in work and those on IS.

6.7 Summary

For those with mental health problems, most had had a diagnosis, and many lone parents had been prescribed anti-depressants, with some finding that they helped their health, whilst others found that they made it worse. Some of those in work found coping with a job, whilst on anti-depressants, was too difficult due to side effects, so had stopped taking their medication.

A few had also used counselling and psychiatrists. Some were currently on waiting lists to see counsellors, whilst others had used counselling previously and had not found it useful. Although counselling was not a positive experience for all, the high incidence of depression amongst lone parents, both in and out of work, and the low take-up of counselling, suggest a need for improved awareness and availability of this type of support.

For those with physical health problems, most were receiving medication and/or treatment, having had a diagnosis. All those children with health problems had been diagnosed. Lone parents who had children with health problems had additional caring responsibilities, and some had difficulties getting the support that they needed to look after their child.
For all types of health problems there were links between health and wider circumstances, eg housing, and for all types of health problems, lone parents were generally aware of what standard of medical support was available, although there was some dissatisfaction with GPs, and it was difficult to change them in some areas, particularly London.

The main difference between those on IS, and those in work, was the ability of those in work to make choices about private medical support. Whilst they had more financial resources to access treatment not available on the NHS, they also had a wider social network to get advice about alternative treatments or specialist organisations. In contrast, it was difficult for some lone parents on Income Support to keep up with regular treatment due to transport and childcare problems.

Most lone parents found advice that they had received from medical professionals useful, and there was not much use of specialist organisations, with lone parents relying, instead, on information from doctors, and medication leaflets.
7 Whether the support needs of families with health problems are being met

7.1 Introduction

Building on the previous chapter, which looked at what lone parents are doing with medical support to overcome their, or their children’s, health problems, this chapter examines whether their support needs are being met. It looks at what support lone parents say they need, what support they are actually receiving, and how they cope with their, or their children’s, health problems. It then analyses the gaps in support, and the key areas where support could be improved.

7.2 What support do lone parents need for their health problems?

7.2.1 Lone parents on Income Support

Lone parents on Income Support felt that they needed a range of support for their, or their children’s, health problems. A common finding was that having more information and advice about the health problem was very important. Lone parents wanted more information on what triggered the health problem, on what they could do to alleviate the problem, and on how the problem was likely to develop in the future.

Other lone parents required more practical support. Lone parents, whose children had health problems, often felt that they would benefit from help from social services, or from having support in the home to help care for their child. For those lone parents who had children with health problems, respite care could provide support. One lone parent (on Income Support with a disabled child) felt that respite care would have been helpful in enabling her to work, if she had been offered it, when her son was younger.

A common experience was lone parents with mental health problems in our sample wanting to have someone to talk to about their health problem, or specifically wanting to see counsellors or psychiatrists. Lone parents with physical health problems often required practical support. One
wanted help with her garden, which she could not clear because of her back problem, another felt that help with dieting and stress management would help relieve her high blood pressure.

There was also a group of lone parents on Income Support who felt that they did not need any help with their health problems. Some felt that they were already receiving the help they needed, eg from a health visitor, or that the medication they were on was sufficient to manage their health problem. For example, this lone parent felt:

‘I don’t think I need any [support]. If we’ve got the medication it’s fine. I don’t think there’s nothing else anyone can do. You have to get on with it don’t you?’

(Lone parent with asthma and an under-active thyroid, and a child with asthma. On Income Support)

Others felt that there was nothing that could help them, other than the health problem getting better, which in some cases they knew would not happen.

### 7.2.2 Lone parents in work

Some lone parents in work also wanted more information about how their, or their children’s, health problem would develop. In one case, a lone parent had not had her health problem diagnosed, as it was not recognised as a condition by any doctors that she had seen. Getting a diagnosis was, therefore, her priority, as it would mean being able to access medication, advice and support. In other cases, lone parents in work wanted more advice on what they could do to make the health problem better, or prevent it getting worse, rather than just being given medication.

Other types of support, that lone parents in work felt that they needed, were someone helping to care for children with health problems, access to physiotherapy, and for those with mental health problems, access to counsellors and psychiatrists, without having to wait for long periods before seeing someone.

As with lone parents on Income Support, a group of lone parents in work did not feel that they needed any support. For those with mental health problems, the reasons given for not feeling that they needed support included: feeling that the support they received from the doctor was adequate and that additional support was there if they needed it, feeling that they did not need any support at the moment, and not wanting counselling for mental health problems because they did not want to discuss it with anyone other than their doctor.

Reasons for not needing support given by those with physical health problems included: feeling independent and not wanting help, having flexible and understanding employers, medication being sufficient, and just coping with the health problem themselves.

### 7.3 What support are lone parents receiving for their health problems?

In terms of support they were currently receiving, many lone parents on Income Support received support from their families and friends. This included emotional support, as well as practical help, such as help with cleaning, cooking, and taking their children to school. For example:

‘My family help me a lot. They stick by me a lot.’

(Lone parent with high blood pressure, asthma and mental health problems. On Income Support)
Others received a lot of practical support for their health problem from their children, and some lone parents had health visitors who supported them with their, or their child’s, health problems. Some lone parents with mental health problems were supported by talking to members of their local churches.

Whilst lone parents on Income Support were supported with their health problems in a number of ways, another group of lone parents on Income Support were not receiving any support for their health problems. These lone parents often felt isolated.

Many lone parents in work were also supported by friends and family, with both emotional and practical support, whilst some had children who provided them with support. One lone parent had been helped by her doctor to move from her council property, which was damp and was exacerbating her, and her child’s, asthma, and causing her severe chest infections. This support had enabled her to move into work. There was also a group of lone parents in work who were not receiving any support for their health problems.

7.4 Coping with health problems

Lone parents used different strategies to cope with their, or their children’s, health problems. Many spoke about learning what aggravates their, or their children’s, health problems, and avoiding it, and using medication to regulate or alleviate their health problems.

One lone parent with depression had developed a structured routine to help get her through each day. Others smoked, or drank coffee or alcohol to help them cope, or ‘had a good cry’ every now and again. One lone parent described how she smoked to help cope:

‘I used to smoke baccy but the tabs kept us sane, that was my pleasure, it was the only thing I ever got. If they said, ‘if you didn’t pack it in you’ll not last 6 months,’ then I might seriously think about it, but ‘til then it would have to be something really drastic. I tried to give up and managed two and a half days because I had ‘flu, and as I got to feel better I smoked a cigarette again. I’ve smoked since I was 11.’

(Lone parent with chest problems. In work)

Some lone parents spoke of just having to get on with it, and the importance of trying to stay positive. For example:

‘I just get on with it really.’

(Lone parent with a disabled child. On Income Support)

‘You take it day by day and try and find positive things – spending time with my son. Doing anything with my son gets me out of it.’

(Lone parent with mental health problems and anorexia. In work)

‘You have to stay positive. You cannot let it get you down. You have to accept it and make sure you do all the right things.’

(Lone parent with kidney problems and high blood pressure. In work)

Other lone parents didn’t feel they were coping, particularly those with severe mental health issues. One lone parent felt that she could not leave her house, while three lone parents on Income Support described themselves as currently suicidal.
7.5 Summary

In terms of health support that lone parents felt that they needed, and health support that they received, there are no obvious differences between those in our sample who were on Income Support and those who were in work.

Most lone parents are supported by family and friends who provide both emotional and practical support, although some lone parents were not receiving any support. Lone parents were using a variety of coping strategies to manage their health problems, including avoiding things that make their health problems worse, smoking to relieve stress, and trying to stay positive. However, some lone parents did not feel that they were coping.

For both lone parents on Income Support, and lone parents in work, there was a lot of additional support that some lone parents felt that they needed, that they were not currently receiving, and that friends and family in particular were not able to provide.

Having enough information and advice about their, or their children’s, health problems, and what they can do to prevent their health getting worse, or to help it get better, is important for lone parents to be able to manage the health problems. Some of those with mental health problems felt that being able to access counselling, or to see other mental health professionals, without having to wait for long periods, would help them manage their health problem. This is particularly important for those with mental health issues who felt that they are not currently coping.

For those with physical health problems, and those who had children with health problems, some lone parents suggested that access to practical support would help them manage their, or their children’s, health problems. Enabling lone parents to better manage their health problems may be an important way of enabling lone parents to move into work and to sustain work.

However, there were a number of lone parents within our sample who felt that they did not need any support. Whilst in some cases this is because lone parents are already receiving the support they need, in other cases it is due to a strong feeling of independence, and preferring to cope with the health problem by themselves, rather than asking for help, or having to discuss the health problem with strangers. There is also a group of lone parents who feel that the only thing that would help them is if their health problem got better, and who feel that there is no support that could be offered to alleviate the problem. Helping these lone parents to start and stay in work will be more difficult.
8 Triggers that made those in work look for work, or that would facilitate those on IS to look for work

8.1 Introduction

This chapter examines the reasons why lone parents with health problems in work decided to move into work. It looks at the changes in circumstances and the conditions that made work feasible for these lone parents. It also explores what would trigger those currently on Income support to take up work or to begin looking for work.

The research aimed to investigate what triggered lone parents to move into work. However, the term ‘trigger’ implies that the decision to move into work was spur-of-the-moment or unprompted. This was rarely the case. In most cases, lone parents’ decisions to move into work are not at all sudden. This chapter aims to demonstrate the dynamics and complexities around decisions to move into work for this group.

8.2 What would attract those on Income Support into work?

When asked whether they wanted to work, almost all lone parents on Income Support said that they did. Reasons given for wanting to work included being fed up with being on benefits, wanting independence, wanting to have more money, wanting to be self-sufficient, and wanting a better life for themselves and their children. However, there was a small group of lone parents who felt that they could not work because of their, or their children’s, health problem.

Many other lone parents on Income Support, while not ruling work out as an option, said that they did not feel ready to work at the moment. This group included those who thought health was a constraint to work and those that did not feel that their, or their children’s, health problems were a constraint to work. Reasons for not feeling ready to work included recently having had a baby, wanting to wait until
their youngest child reached school age, or their or their children’s health problems making work difficult at the moment. Even though many lone parents did not feel ready to work, they cited a number of things that might attract them into work.

The kinds of things that lone parents on Income Support said would attract them into work are closely related to what they perceived as being their biggest constraints to working. As detailed in Chapter 4, the key constraints lone parents cited alongside health were:

- a lack of childcare;
- a lack of work history;
- low self-confidence;
- a perceived lack of understanding employers;
- a perceived lack of jobs that would make them better off in work; and
- a perceived lack of jobs that had hours that would fit with their childcare responsibilities.

Unsurprisingly, therefore, lone parents on Income Support described, in particular, the availability of affordable childcare, understanding and flexible employers, and jobs that paid well and had training as key factors that would attract them into work. For the most part, these are not dissimilar to the factors that lone parents without health problems would cite as making work attractive.

Lone parents cited finding appropriate childcare as something that would attract them into work, particularly: finding affordable childcare, finding nursery places, finding childcare during the school holidays, finding childcare that was easily reached by public transport, finding one childcare provider that could take both children, and finding someone who could pick children up from school. Lone parents also said that finding understanding employers, who would let them have time off if their children were ill, would attract them into work.

The level of pay was a factor mentioned by many of those on Income Support. It was felt that good pay was essential to make work ‘worthwhile’ and some lone parents had fears that they would be significantly worse off financially, in work, than they would be on benefits. However, as mentioned in Chapter 4, there is an issue here around awareness of tax credits. Those lone parents who felt that good pay would attract them into work, and were concerned that they would not earn sufficient money, were often the same lone parents who were unaware of the new tax credits and how this might impact on their take-home pay. Some were also unaware of the broader package of financial help available if they move into work, suggesting a need for more awareness raising about tax credits and other financial benefits for those who move into work from Income Support.

A few lone parents reported that they would be attracted into employment if they could find a job that provided training and career progression. Career progression was a concern of several of those across both the ‘in work’ and ‘on IS’ group. It was expressed that working in ‘dead-end’ jobs, whilst providing a wage, could seriously jeopardise their quality of life, and in the long-term would not benefit their children.

However, for some lone parents on IS, an improvement of their health was the only factor that would move them into work. While some lone parents on IS felt that health improving was a key factor that would attract them into work, those in work did not cite health improvement as the key reason for their decision to take up work.
It is interesting to look, in particular, at what would attract lone parents who have never worked, into work. Whilst some of these lone parents felt that they couldn’t work because of their, or their children’s, health, others cited a number of specific things that would attract them into work: getting training to become a midwife, learning the English language, finding the right job, and building motivation and confidence.

8.3 Reasons why those in work moved into work

In almost all cases, there had not been a single reason, or factor, that provided the ‘push’ to move into work, for those currently in work. Often there were a myriad of factors that had resulted in the overall situation of the lone parent changing, which made work a real option. Conversely, there were many lone parents in work whose circumstances had not changed at all. In these cases, decisions to move into work were personal and in some instances, represented a ‘grand step’ or ‘leap of faith’ on their part.

There are a range of reasons that lone parents moved into work, which are discussed below. These include: health improving or a feeling that work would improve their health, having a strong work ethic, getting a sense of identity from work, setting an example to their children, and finding the right job. Making work pay did not seem to be as big an issue as it was for those on IS.

8.3.1 The link between health and moving into work

Health improving was rarely the factor that had moved lone parents into work. In a few cases, where improvements in health provided the incentive to work, lone parents had a history of work and the claim for IS was a temporary measure. For example, a ‘break’ from work was taken to have an operation that involved a sustained period off work. Once recovered, the claim for IS was closed.

Rather than improvements in health providing the trigger to move into work, what appeared to be the case is that health improving provided a trigger to return to work after a short break, rather than move into work for the first time, or for the first time in a long time. For example:

‘I’ve always felt I’ve got to get back to work at some stage, this is the longest period [claiming benefits]. I don’t believe in not working, so it was only a matter of time.’

(Lone parent with neck and back problems. In work)

The links between mental well-being and economic inactivity have already been mentioned, insofar as some felt that they were depressed because they were out of the labour market, and that working would boost their self-esteem and help their depression (see Chapter 4). This finding is supported by research which has shown that joblessness damages self-esteem by generating feelings of depression. Having recently completed a spell of joblessness, due to either unemployment or a break from the labour market, damages an individual’s perception of self-worth and significantly harms self-esteem; an effect that persists (Goldsmith et al., 1996). Other research has shown that distress levels in terms of mental health fall on re-employment, and that moving from unemployment to employment produces a statistically significant positive change to mental health (Murphy and Athanasou, 1999).

For some lone parents in our sample, feeling that work would help them overcome their health problem provided the trigger to work. For example:
‘I was getting depressed at home when I was on my own, I was getting down about the whole thing. That’s what pushed me [back into work].’

(Lone parent with back problems, knee problems and mental health problems. In work)

This approach clearly does not apply to all of those with depression and is very much personality dependent. Some lone parents, while believing that work would help to improve their health, felt too depressed to begin looking for a job. These lone parents remain in something of a ‘catch 22’ situation. There is also some evidence to suggest that for some, taking up work actually served to worsen their health problem. This is only in a few cases and is often related to the kind of work, or the kind of workplace, they were in.

One lone parent had been referred to ‘Home Start’ (an organisation that provides support to families) by her health visitor and had found it very useful to meet other lone parents in a similar situation. Having peer support had been a very important part of feeling able to move into work for this lone parent:

‘I think it definitely helped me with my self-confidence because I met up with people that were in a similar situation and I was part of a community of people. There were a lot of women who wanted to go back to work and it meant I had people I could relate to.’

(Focus group participant. In work)

8.3.2 A strong work ethic

One of the key differences between those in work and those on IS, as noted in Chapter 3, is their work history, and the length of stay on Income Support. It is, perhaps, unsurprising then that ‘being used to working’, or having positive memories of work, provided the incentive to move back into work at the earliest opportunity for many of those currently in work. Rather than being suddenly propelled into work, some lone parents have, in fact, always worked, and whilst they were on IS, they were very eager to get back into work. For example:

‘I really am a work-orientated person.’

(Lone parent with mental health problems, and a child with behavioural problems. In work)

Some lone parents in work had very strong attitudes in favour of work, and were happier with the idea of using childcare when their children were young, than some of those on IS were. For example:

‘I can’t just be saying, ‘when my son’s older I’ll go to work,’ and for years sit around doing nothing. That’s just not me. I wouldn’t be able to handle that. I have to be doing something.’

(Lone parent with back problems, knee problems and mental health problems. In work)

However, for others in work, the opposite was the case. Work had always been something they intended to do, as a lone parent, but not until they felt that the children were old enough and required less time from their parent:

‘It was a case of waiting ‘til the children were old enough to look after themselves. I’ve always known I will work full-time eventually.’

(Lone parent with back problems and gynaecological problems. In work)

Many lone parents currently in work, described how work had broadened their horizons, and said that this was one of the key reasons for them working. For example:
‘It opens up a lot of opportunities. You have freedom, you don’t have a lot left after you pay everything but it gives you a wider scope.’

(Lone parent with kidney problems and high blood pressure. In work)

8.3.3 Getting a sense of identity from work

Some lone parents in work reported that being in work provided them with a sense of identity, outside of family life, that they did not have when they were a benefit claimant. There are some interesting links here between benefits, work and citizenship. Certainly, some lone parents felt that they were ‘more involved’ in life and society in general. There are some obvious reasons for this, including perceived attitudes towards benefit claimants, but also being out of the house more, meeting new people, and having increased spending power. The factor of paying taxes and ‘contributing to society’, rather than being on the receiving end, also came into play here. In some cases, it was this desire alone to feel like ‘somebody’ that was sufficient to begin looking for work in earnest.

Work, it was felt, brought with it a sense of pride and self-respect. Again, this stemmed from perceived attitudes of benefit claimants and having a traditional work ethic, but also from the desire to ‘pay your own way’. These lone parents did not want to be seen as the typical stereotype of lone parents who collected money from the Post Office and are not interested in working. For example:

‘I was sick of being classed as one of those people that stand in the post office.’

(Lone parent with mental health problems, and a child with asthma. In work)

Some reported the satisfaction they got from going to pay their own rent, rather than queuing up to receive benefits. The money gained from work was felt to be ‘more valuable’ and gave a greater sense of reward than receiving money through benefits.

A less cited reason for moving into work, but worth a mention here, is escape. For some, work provided a route out of a situation deemed to be less than satisfactory. Reports of being fed up with caring responsibilities, and with lone parents feeling that they were not doing anything for themselves, can provide the incentive to move into work. In one instance, work provided an escape route from caring for an ill family member:

‘My mum had been ill for a while and other members of the family were not really doing their bit to help, everything was burdened on me. I think I was trying to escape from that.’

(Lone parent with back problems, knee problems and mental health problems. In work)

8.3.4 Setting an example for their children

The children were often the key motivating factor for moving into work. Many felt that being a working parent would set a positive example to their children as they were growing up. This became more of an issue as the child started to grow up and attend school, and was less of an issue whilst children were still babies. For example:

‘I didn’t want my son thinking it was all right to sit around and get your money that way [benefits].’

(Lone parent with mental health problems and anorexia. In work)
The age of children was a key factor for some moving into work, particularly, and most obviously, when children reached school age. Less obviously, the children growing up meant increased financial demands on the parent, which in a few cases provided the motivation to move into work. Items such as new clothes and ‘trendy trainers’ were increasingly requested, as children grew older, and some lone parents felt that they must be able to provide such items so that their children did not ‘go without’.

8.3.5 Finding the right job

It would appear that getting the type of job right is a key trigger to moving into work. Some of the lone parents in work reported that they are currently in work because they finally found a job which met their needs. One lone parent went into teaching precisely because the hours fitted around her children:

‘It was the type of profession that would suit me and my kids, so if they’re on holiday, I’m on holiday.’

(Lone parent with kidney problems and high blood pressure. In work)

By matching lone parents to the kind of job that suits their needs, lone parents could be helped to reap the benefits of working, including in some cases the potential benefits to their health.

8.4 Summary

Of those lone parents on Income Support, most want to work, except for a small group who felt that they could not work because of their, or their children’s, health problems. Of the remaining lone parents, who are not ruling work out as an option (and who may or may not feel that their, or their children’s, health problems, are a constraint to working), many do not feel ready to work at the moment. Nevertheless, these lone parents cited a range of things that might attract them into work. These ‘triggers’ were linked to what they felt were their barriers to work, and included having affordable childcare, having jobs that paid enough that they were better off in work than on benefits, finding jobs with training and career progression, and their health improving. Some of those lone parents who felt that they might not be better off in work were not aware of the new tax credits or the broader package of financial help available if they move into work, suggesting a need for more awareness raising about tax credits and other financial benefits for those who move into work from IS.

Movement off IS and into work is not necessarily ‘triggered’. Certainly, there is rarely a single factor involved in taking the decision to move into work. It would appear that, overall, reasons for taking the decision to move into work are extremely heterogeneous among the ‘in work’ group. Of those lone parents in work, improvements in health did help a small group of lone parents move into work, but this was only the trigger for a few. Another group of lone parents were helped into work by feeling that their health would improve if they were in work.

Those in work with recent work histories, and positive memories of work, reported that they had always planned to return to work. This, in large part, explains the comparably shorter durations on IS amongst the ‘in work’ group. A related point is the general attitude to work and work ethic amongst those in work. Some felt quite strongly that far from there being a trigger that moved them into work, they had simply always worked, and hoped that they always would in the future. Many lone parents cited moving into work because of the identity, pride and satisfaction they got from working. Others stressed the importance of setting an example for their children and being able to provide their children with extras, whilst others felt that finding the right job had helped move them back into work.
What would help lone parents with health problems start work, and stay in work?

9 What would help lone parents with health problems start work, and stay in work?

9.1 Introduction

This chapter examines what would help lone parents with health problems, or whose children have health problems, to start work and stay in work. It looks at what lone parents on Income Support felt would help them into work, and what lone parents in work felt had helped them move into work. It then examines what lone parents in work felt that they needed in order to sustain employment. It concludes by suggesting areas where support to move lone parents into employment, and support to help them sustain employment, could be improved.

9.2 What would help lone parents start work?

9.2.1 Lone parents on Income Support

Lone parents on Income Support, in our sample, were asked what would help them start work. A number of lone parents described needing help with job search. This included being told how to go about finding a job and help with CVs, application forms and interview skills. One lone parent expressed her need for help with interview preparation:

‘I’ve never really had an interview... I always knew somebody and I’ve got in there, but I’ve never sat down, and wear a suit and tie and answer 1,001 questions. It’s a bit scary for me because I’ve never had to do it. That would be new to me.’

(Lone parent with asthma and eczema, and a child with asthma, eczema and behavioural problems. On Income Support)
Other lone parents also wanted help with matching a job to their needs. Lone parents described needing someone to help them find a job that matched their skills, needing help with finding the type of job they wanted to do, and needing help with finding a job where they would be better off. Some lone parents on IS also emphasised needing help with finding a job they could do, despite their, or their children’s, health problems. They suggested that someone helping them find out in more detail what a job entails would help them start work.

Another group of lone parents wanted training or education before moving into work. Some wanted help with going back to education, or help with updating their skills, e.g., computer literacy, or funding for specialist courses, such as a proof-reading course, that might enable one lone parent to work from her own home.

Some lone parents also wanted help with confidence, information on childcare options, and help with self-employment. One lone parent felt that to move into work she would need assurance from the doctor that she would be able to cope with working:

‘Like an assurance from the doctor to say you’re going to be OK, you’re going to be fine. The medication’s going to be fine, give it a go and don’t worry about it.’

(Lone parent with rheumatoid arthritis. On Income Support)

None of those on IS were currently participating in the New Deal for Lone Parents (NDLP) at the time of the interview. Although many had participated previously, they described needing the kind of help to start work that is already available to them through NDLP. Chapter 9 explores this issue in more detail.

9.2.2 Lone parents in work

Lone parents in work were asked what had helped them move from IS into work. Some lone parents were self-starters, who had used their own initiative to find work. One lone parent in London, for example, had gone to a recruitment fair where she found out about a local training centre, then gone on a course and got a job through her work placement.

Sometimes, health problems improving had helped lone parents move into work, although this was not in the majority of cases. In some cases, it was family and friends agreeing to help with childcare, or attending college courses that had enabled lone parents to move into work.

Some lone parents are motivated and confident self-starters, and feel that they do not need the services of NDLP to move into work. Some attended NDLP, but did not think that it had helped them move into work, as they had already found a job. One felt that the NDLP experience had been a hindrance rather than a help. However, many did find NDLP helpful. The better-off calculation helped some lone parents realise it was financially worthwhile to move into work, others found help with in-work benefits helpful, and receiving back to work bonuses and benefit run-ons helpful. One lone parent felt strongly that she could not have moved into work without NDLP:

‘If it hadn’t been there to give me advice on the financial side I don’t think I would have done it.’

(Lone parent with asthma and chest infections, and a child with asthma. In work)
9.3 What would help lone parents stay in work?

9.3.1 Non health-related factors that would help lone parents stay in work

Lone parents currently in work were asked what would help them stay in work. Some needed help with specific problems, such as help with getting rent arrears sorted out or help with tax forms for the self-employed. Other lone parents wanted to change jobs, as they were not happy in their current jobs. These lone parents needed help with finding jobs that they liked, help with getting jobs that paid better, help to find jobs that did not involve so much costly and time consuming travel to work, and help with finding jobs that fitted around school hours, or had flexi-time.

Others needed to have access to cheaper childcare and to have more help with finding and paying for suitable childcare in the school holidays, particularly in the summer. Some had concerns about finding childcare provision for children aged 11 and above who were still too young to be left alone in the house after school.

9.3.2 How health problems can make staying in work difficult

As mentioned in Chapter 4, some lone parents’ work histories are often chaotic, with frequent moves in and out of work, and benefit. In some cases, chaotic work histories are due to health problems, and some had left jobs because of their health, or their children’s health. For example:

‘I got signed off work. I had just started a new job, I was there two weeks, the doctor signed me off with postnatal depression. It wasn’t a good idea me trying to go out and do it when all I wanted to do was sit at home and cry.’

(Lone parent with mental health problems and anorexia. In work)

Reasons for leaving jobs because of health were: the health problem starting or getting worse, side effects of medication being too bad, the nature of the work being too physical, jobs being too stressful, and employers not being happy with them having to taking time off for their, or their children’s, health problem.

Some lone parents who were currently in work said that they were thinking of leaving jobs because of their health problems, and that the only thing that would help them stay in work was if their health got better. Others wanted to find jobs where it was easier to take time off when they, or their children, were ill, or to find jobs that were less stressful and did not exacerbate their mental health problems.

9.3.3 The role of employers

Difficulties with discussing health with employers

There is little evidence to suggest that those who left jobs due to health problems were forced to do so by their employer. Indeed, almost exclusively, lone parents who left work due to health problems did so because they did not feel they could cope at work, or could not cope with balancing their responsibilities as a lone parent with work commitments. It appears that health was often not discussed with employers prior to leaving the job and as such, employer support was not sought or offered. Arguably, this may largely be due to the low-skilled, low paid jobs in which the majority of the sample worked (see Chapter 2).
Some lone parents were afraid of discussing health with employers. At interview, lone parents felt that mentioning their, or their children’s health, would put employers off employing them. However, once lone parents had started jobs and had not mentioned the health problem in the selection process, many felt unable to then tell the employer about the health problem. This was especially the case for those in physical jobs. Some of these lone parents wished that they had mentioned their health problem at interview stage and found out how flexible employers were prepared to be.

Some lone parents described how no-one in their workplace knew that they had a health problem. Feeling that they could not tell anyone at work was often reinforced by negative experiences lone parents had of employers in the past, particularly with employers discriminating against them when they were pregnant in the workplace. Many felt that if they took too much time off for their health problem they would be sacked.

Some lone parents felt that telling their employer about their health would mean that they would be treated differently, or an assumption would be made that they were not capable of doing the job. This led to reluctance to talk to employers:

‘When you have got an illness you don’t really want to be treated differently from other people at work...You want to be treated the same but you just want people to be aware that sometimes you will not be on your best, rather than treat you as if you’ve got an illness.’

(Focus group participant. In work)

‘The problem is it’s difficult to discuss [health] with anyone when it’s work and a professional level, because you don’t want people to think you’re incapable of work, so you choose not to say anything.’

(Focus group participant. In work)

**Employers’ responses**

Having understanding employers has made a big difference to many lone parents in work. Lone parents in work who felt that they would be able to continue working often had understanding employers. Employers in these cases had dependency leave that could be used to care for a sick child, were happy to change working hours over the summer period, allowed children to be brought into the workplace if necessary, fitted hours around the lone parent’s needs, and were understanding about the need for lone parents to take time off because of health problems.

Lone parents with understanding employers felt that they could be more honest about their health problems. One lone parent described how her employer had offered to make adjustments to her working practices and work environment and made sure she had regular breaks, offered to change her chair and the height of her computer, and was keen for her to let them know if she had any problems that they could help with. This made her feel more confident to discuss her health with her employer if necessary:

‘The fact that I can be honest [about the health problem] means that I’m more comfortable there and my work is a lot better because I’ve got that sort of work environment, and I’ve got a decent relationship with my employer and I’m able to tell them if something’s wrong. I’m more relaxed.’

(Focus group participant. In work)
Other lone parents stressed the importance of being in a workplace with a proactive attitude towards equal opportunities:

‘They’ve got a massive equal opps policy, so you know that whatever your situation is personally, it’s not going to affect the work environment or the way that you work amongst colleagues. They’re against discrimination in every form and it makes a big difference to me to know that they’re supportive to any personal situation. It’s made a massive difference in the way that I work because I know that I’m well treated there, I’m not different to anyone else but my circumstances are considered as well.’

(Focus group participant. In work)

Other lone parents have told employers about their health and have had unhelpful responses. One lone parent asked if something could be done to stop her having to open a heavy receptionists’ window as part of her job, which was making her back problem worse, but she felt that they did not take her seriously. Whilst they oiled the window, it was still a problem and when she tried to leave the window ajar, she was told she had to close it because of noise. She felt:

‘My manager doesn’t seem to take things very seriously. It seems to go in one ear and out the other.’

(Focus group participant. In work)

Another lone parent had to take time off because of her child’s health problem, but her employer would not allow her to take sick time or leave, and instead forced her to make up the hours she had missed as unpaid overtime. This meant that she had to find and pay for extra childcare for the extra hours she had to work.

**What employers can do**

Some lone parents might have been able to continue working if they had support to stay in work, for example, by employers being more flexible about lone parents’ needs to take time off because of a health problem. Employers could, perhaps, also do more to encourage employees to discuss their, or their children’s, health problems, and to work with employees to make adjustments to the nature of the work, or working hours, for example, to help lone parents continue in work. From 1 October 2004, small employers (those employing 14 people or less) will be brought into the scope of the employment provisions of the Disability Discrimination Act (DDA) 1995. One of the provisions of the DDA is that employers are obliged to make reasonable adjustments for disabled staff, both in their work, and in the recruitment and selection process. Employers could be encouraged to develop good practice for all employees with health issues, whether or not these employees are defined as disabled under the Act.

**9.4 Summary**

Lone parents on Income Support felt that a number of things would help them move into work: help with job search, a job match service, help building skills and confidence, childcare information and help with self-employment. These are all available through the New Deal for Lone Parents (NDLP). Not all the lone parents on IS had heard of NDLP, suggesting that NDLP could be more proactively marketed to lone parents on IS with health problems. However, many lone parents on IS had been on NDLP, and still described needing the kind of help to start work that is available to them through NDLP. This suggests that NDLP Personal Advisers (PAs) need to ensure that lone parents on NDLP are aware of, and have access to, all of the services that NDLP can provide.
What would help lone parents with health problems start work, and stay in work?

Many of those in work were self-starters who had not required much help to move into work. Others had help with childcare, or had help to go to college, as a step towards work. Some had received help through NDLP, finding the better-off calculation and financial support particularly helpful. In terms of staying in work, in some cases, nothing would have helped lone parents stay in work, as their, or their children’s, health had become too severe. However, in other cases, lone parents could have been helped to find more suitable jobs which they could do despite the health problem – jobs that were less physical, less stressful, and jobs that were with employers who were understanding about the need to take time off because of health problems.

NDLP provides an ‘in work’ service to lone parents. This service could be used to help lone parents who are thinking of having to give up work, to find more suitable jobs, rather than having to return to Income Support. This service could also help with problems that lone parents who have moved into work are having, and need help with, in order to stay in work. This could be marketed to all those who leave Income Support for work, to ensure that all lone parents know it exists, whether or not they have ever taken part in NDLP.

This research suggests that there is also a role for employers to play in working with employees with health problems. Employers could encourage employees to discuss their health problems, and could support employees with health problems by making it clear that they could come to them with any problems, through policies such as dependency leave, and by making adjustments to the nature of the work or working hours to help lone parents continue in work.

For many lone parents, childcare costs and availability were also major constraints to moving into work, and to staying in work. This research suggests that the issue of providing cheaper childcare and/or providing more financial support with childcare to help lone parents stay in work, also needs to be tackled.
10 How existing provision could, or does, deliver support to lone parents with health problems, wishing to enter or remain in work

10.1 Introduction

This chapter explores how existing schemes deliver, or could deliver, support to lone parents with health problems, wishing to enter or remain in work. It examines how health-related benefits could provide support, and examines how Personal Adviser (PA) meetings, the New Deal for Lone Parents (NDLP) and other provision delivers support. It then goes on to look at whether lone parents had discussed their health with anyone from Jobcentre Plus, and concludes by looking at what more can be done to support lone parents with health problems, wishing to enter or remain in work.

10.2 How health-related benefits deliver, or could deliver, support

10.2.1 Knowledge of health-related benefits

Many of the lone parents interviewed had not heard of Incapacity Benefit, Income Support Disability Premium or Disability Living Allowance. Some had heard of one of them, but there was a great deal of confusion amongst lone parents about what they had heard of, and if they had applied for some type of illness or disability benefit, which it had been.
10.2.2 Experiences of trying to claim health-related benefits, or claiming health-related benefits previously

There has been an in-depth evaluation of the Personal Capability Assessment (PCA) process (Legard et al., 2002) applied to anyone going onto long-term IB, as well as to those going onto short-term IB, and the process is not a focus of this research. However, some lone parents in this research had applied for health-related benefits in the past, had a PCA, and had been turned down. Most of these lone parents had mental health problems, and one had rheumatoid arthritis. Some lone parents who had been turned down after a PCA felt that the process had not taken into account the severity of their mental health problems. Two separate lone parents with mental health problems described being turned down after a PCA:

‘Because I had someone that could go to the shops and I could cook and clean for myself and my kids, that was what the reasons were, even though my doctor and psychiatrist said otherwise, that I was unable to look after myself and function properly as a normal individual able to lead a normal life, but because I could cook and clean within the home they did not consider me to be severely disabled.’

(Lone parent with mental health problems. On Income Support)

‘I’m not able to cope. I’m not able to do lots of things, so obviously I must have heard from somebody, or someone said to me you should be claiming, but I can’t remember. But I did try to express what I was going through and they turned it down, so I never really picked it up again.’

(Lone parent with mental health problems. On Income Support)

Some lone parents who do not satisfy the PCA still perceive themselves to have significant mental health problems. One lone parent, with mental health issues, who described herself as suicidal, had been turned down after a PCA on three separate occasions, having been referred to a PCA by her doctor.

Some lone parents had been on health-related benefits in the past. One lone parent had been on Income Support with Disability Premium (ISDP) after having an accident, two lone parents with mental health issues had been on ISDP in the past (one of them had just made another claim when interviewed), and another lone parent had been on ISDP whilst going through drug rehabilitation in the past. These lone parents had often tried to claim Incapacity Benefit (IB) on the advice of their doctors, and had gone on to ISDP, as they did not have enough National Insurance contributions to receive IB.

Five lone parents, all of whom were on Income Support, were currently receiving Disability Living Allowance (DLA) for their children. Another lone parent, on Income Support, had been claiming DLA for her child in the past, until they reached 16. Another lone parent, in work, had claimed disabled child premium for one of her children in the past, but had stopped claiming it because she felt that other people needed the money more than she did.

There was a small group of Income Support claimants who felt that their health was so debilitating, at present, that they could not physically work at all (see Chapter 4). This group included a lone parent with pleurisy and a child with asthma, and two lone parents with mental health problems, one of whom was agoraphobic.
These lone parents were all aware of health-related benefits and had either accessed, or had tried to access them. The lone parent who was agoraphobic had been on health-related benefits before and was currently being re-assessed, the other lone parent with mental health problems had a PCA and had been turned down, and the lone parent with pleurisy and a child with asthma, felt that she could not work because of her child’s health, and the child was receiving DLA.

10.2.3 Why some lone parents had not tried to claim health-related benefits

There were a number of reasons, other than a lack of knowledge, that prevented lone parents with health problems trying to claim health-related benefits. Some lone parents, with both mental and physical health problems, had heard of health-related benefits, but had not tried to claim them in the past because they did not think they would be eligible. For example:

‘I don’t think I would have been entitled to Incapacity Benefit or anything like that.’

(Lone parent with back problems, knee problems and mental health problems. In work)

‘No, I didn’t think I’d qualify for it so I didn’t really look at it.’

(Lone parent with kidney problems and high blood pressure. In work)

One lone parent had not had her health problem diagnosed and therefore knew she would not be eligible, whilst another had been told by their doctor that they were not eligible for health-related benefits as they were not registered as disabled. Others felt that their health problems were not serious enough, or hoped that their health problems would get better.

Some lone parents did not want to claim health-related benefits as they did not want to be ‘written off’ as sick, or as an invalid. For example:

‘I knew I’d come through it and I didn’t see myself as incapacitated. I thought if I did something like that [claiming health-related benefits] I would end up giving up. I know people once they’re on it, they stay on it forever.’

(Lone parent with carpal tunnel syndrome, spondylosis and migraines. On Income Support)

One lone parent who was off sick from work, with mental health problems, was advised by the benefit helpline that she might be entitled to health-related benefits if she stayed on sick leave, and then claimed Incapacity Benefit when her sick leave ended. Although she found it useful to know that she might be entitled to health-related benefits, she decided to have a career break and ‘get her head together’, and, therefore, chose to give up her job and claim Income Support, rather than claim health-related benefits. Others did not see the point of claiming health-related benefits as they wanted to move into work.

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5 Since the introduction of the DDA, there is no such thing as ‘registered disabled’.
10.3 How Work Focused Interviews (WFIs) deliver, or could deliver, support

Work Focused Interviews (WFIs) are mandatory for lone parents making new and repeat claims to Income Support. They have also been rolled out for existing (stock) claimants by the age of the lone parent’s youngest child. From 2001 to 2002, WFIs were rolled out for those with a youngest child aged 13 to 15 years old, from 2002 to 2003, WFIs were rolled out for those with a youngest child aged nine to 12 years old, from 2003 to 2004, WFIs were rolled out for those with a youngest child aged five to eight years old, and from 2004 to 2005, they will be rolled out for those with a youngest child aged nought to five years old. WFIs aim to encourage lone parents to join NDLP, although participation in NDLP remains voluntary. Stock claimants are required to attend annual review meetings subsequently to their initial WFI.

Most lone parents interviewed, on Income Support, had not had a WFI. Of those that had a WFI, two lone parents had one at the start of a new claim (one with children aged nine and 16 at the time of the interview, and one with children aged 12, 14, 16 and 18 at the time of the interview), and four had a WFI as an existing claimant. These existing claimants who had a WFI were:

- a lone parent with children aged six, eight, nine, 16, 17 and 24 at the time of the interview;
- a lone parent with children aged 14 and 15 at the time of the interview;
- a lone parent with a child aged 14 at the time of the interview; and
- a lone parent with children aged 14, 15, 16, 18, 19 and 20 at the time of the interview.

Of those on Income Support, that had a WFI, many lone parents discussed the possibility of work with the PA.

As with those on Income Support, few lone parents in work had WFIs whilst on Income Support. Some lone parents had a WFI at the start of a new claim. These included:

- a lone parent with one child aged 15 at the time of the interview;
- a lone parent with children aged 12, 16 and 21 at the time of the interview;
- a lone parent with children aged one, seven and nine at the time of the interview; and
- a lone parent with children aged six and ten at the time of the interview.

Only one lone parent, now in work, had a WFI as an existing claimant. She had children aged ten and 18 at the time of the interview. Many of those lone parents currently in work who had a WFI were already actively seeking work at the time of the meeting. Others had discussed the possibility of work with PAs.

10.4 How the New Deal for Lone Parents (NDLP) delivers, or could deliver, support

10.4.1 Lone parents on Income Support

Most of the lone parents on Income Support had heard of NDLP, although some had not. Many of those that had heard of NDLP had been on the programme in the past, although none were on NDLP when interviewed.
Of those who had heard of NDLP, lone parents had received information about the programme from a range of sources. These included: friends, family, TV adverts, receiving a letter from Jobcentre Plus, getting a leaflet with a new claim, billboard adverts, picking up a leaflet in the post office, hearing about it through a local computer course, and hearing about it through WfIs.

Some lone parents on Income Support felt that their health was a constraint to taking part in NDLP. Some did not feel well enough to take part, one had a health problem that made it difficult for her to travel and to be in a Jobcentre that did not have toilet facilities, and another with mental health problems said that she did not have the confidence to ring the number and make an appointment.

Of those that had been on NDLP, many had positive experiences. The main activities that lone parents took part in were: discussing the types of jobs they wanted, doing job search with their NDLP PA, and having ‘better-off’ calculations done. Others had received help with contacting the Child Support Agency and had been on training courses. Some left NDLP because of their health or because they had gained what they wanted from the programme. The examples below show some of the experiences that lone parents on Income Support had of NDLP.

Lorna from Newcastle has stomach pains and is on Income Support. She went to see an NDLP PA but then went back into hospital. She is waiting until she is better and will then go back on to NDLP.

Kate from London has a child with asthma and is on Income Support. She was on NDLP two and a half years ago, and her PA did a ‘better-off’ calculation for her which she found useful – she still has a copy of it. She received another letter about two months ago, but she didn’t respond because she was pregnant.

Emma from Leeds has rheumatoid arthritis and is on Income Support. She went to see an NDLP PA a few times, having got a letter about NDLP two years ago. She joined NDLP because she wanted to go back to work, but before she knew the extent of her health problems, and before she had been diagnosed. She had a ‘better-off’ calculation done and found it very helpful, and was also advised to contact the Child Support Agency (CSA) to sort out child support payments, which would make her much better off in work. The PA suggested that she apply for a few different jobs but she didn’t because she didn’t feel confident enough. Five months after starting NDLP she then started working a few hours a week at a local school, whilst still receiving IS. She feels that NDLP did improve her confidence. She is not currently seeing a PA.

Sam from Newcastle has bowel problems and is on Income Support. She first went to see an NDLP PA two years ago when her youngest child started school, to see about the possibility of going back to work. Then she did some courses to improve her skills. She saw a PA again a couple of months ago. They did a ‘better-off’ calculation and she found it very useful. She is not currently seeing a PA.

Carla from Bradford has mental health problems, problems with her knees, and a child with asthma and eczema, and is on Income Support. She saw an NDLP PA once, three years ago. She wanted to find out about teacher training courses and her PA sent her lots of information about courses, which was really useful. She then found out she was pregnant, and didn’t go and see her PA after that, as she had got the information she needed. She was going back to college in September 2003, to do a teacher training course, now that her youngest child is 18 months old.
10.4.2 Lone parents in work

Of those lone parents in work, most had been on NDLP before moving into work. A small group had not heard of NDLP, whilst others had heard of it but had not taken part in the programme, often because they felt that they did not need help moving into work.

As discussed in Chapter 9, of those lone parents in work that had been on the programme, most had found it useful. In particular, lone parents in work had found the following useful: ‘better-off’ calculations, getting money to help with work clothes, help with claiming tax credits, and getting benefit run-ons. Many lone parents had been on NDLP until they moved into work. Some did not think that NDLP had helped them move into work, as they had already found a job, whilst one felt strongly that she could not have moved into work without NDLP. The examples below show some of the experiences that lone parents in work had of NDLP.

Ayesha from Bradford has mental health problems and a child with asthma, eczema and hay fever. She works for a bank in a call centre. She went to see an NDLP PA once, just after she found her current job, as she wanted to know if she would be better off in work. Her PA did a ‘better-off’ calculation for her and she started work. She found it useful to know that she’d be better off and to know that she could get help with childcare and working part-time.

Louise from Bradford has asthma and chest infections, and a child with asthma. She works as a healthcare assistant in a hospital. She had received letters about NDLP but it was her friend who persuaded her to join. She talked about childcare with her PA, had a ‘better-off’ calculation done and had help with claiming tax credits, and received a grant for clothes. She was on NDLP until she started work and she found it very helpful.

Jane from Leeds has mental health problems and anorexia. She works as a care assistant in a nursing home. She saw a TV advert about a year ago and went to join NDLP with a friend, who was also a lone parent, because she thought it might help her get a job. She saw an NDLP PA two or three times. She wanted to get a job but they kept pushing her into getting more qualifications, and they put her on a course she didn’t want to do. She told them she wanted to work with children, but they wouldn’t listen and told her that she should work in an office because she had experience of doing that. They also advised her not to work in a children’s home because she wouldn’t be able to get childcare to fit her hours, and people at the college she attended for her course told her she shouldn’t work in a children’s home because it might make her depression worse. She didn’t feel they had any basis for saying that and feels her NDLP experience made her depression worse.

Sue from London has back, knee and mental health problems. She works as a receptionist in a school. She was on NDLP until she moved into work, and had a ‘better-off’ calculation, got some money to help with work clothes, went through tax credit forms, and got the benefit run-ons.

Gwen from London has a child with asthma, and has mental health problems herself. She works as a dental nurse in a dental surgery. She found her PA very helpful. Her PA asked her what types of work she wanted to do, telephoned employers and found out information for her, and never rushed her. She said, ‘He never flung any old job at me. He worked with me.’ She used to go more than once a week. She also went on a training course which she felt was a waste of time.

continued
Alex from Newcastle has chest problems. She works behind a bar in a club. She went to see an NDLP PA after receiving a letter and was on NDLP until she moved into work. She was working while on IS but didn’t feel she could work full-time. Her PA told her she could increase her hours to 16 hours a week and get tax credits and a back to work bonus. She said, ‘I couldn’t believe the help I actually got for going back. It was well worth it in the long-run and I wish I’d done it sooner.’

10.5 Does other provision deliver support?

None of the lone parents interviewed had had any contact with the New Deal for Disabled People (NDDP). As this group of lone parents were not on health-related benefits, it would not be expected that they would have had any contact with NDDP. Five lone parents in our sample were over 50 when interviewed. Of these, two had contact with New Deal 50 Plus and one had been on a training course through New Deal 50 Plus.

10.6 What more can Jobcentre Plus do to help?

Some lone parents on Income Support felt that their PAs had not been proactive enough, and felt that they needed a more intensive experience to keep them engaged with the programme, rather than waiting two weeks before their next appointment.

‘It’s not disciplined enough. All I did, I went to two meetings and that’s it. There’s no keeping up to date. It’s not progressive enough. When your appointment’s two weeks away it’s two weeks wait.’

(Focus group participant. On Income Support)

‘They didn’t push me. He only encouraged people who had kids over five because they know you really are capable, but I asked him to push me because I would like to be back in work.’

(Focus group participant. In work)

Taking part in the focus groups led to many participants suggesting that group sessions with other lone parents might help them move back into work. Meeting other lone parents who also wanted to go back to work was seen as very important, particularly for lone parents who felt isolated or had little support. It is worth noting that those lone parents on Income Support who attended focus groups seemed more able to think about moving into work and more able to meet other people than some of those interviewed on Income Support who did not feel they could take part in focus groups. Those individuals who did not take part may require more one-to-one support. In contrast, many lone parents on Income Support who did attend the focus groups did so precisely because they wanted help and wanted to talk about work. At the end of one group, lone parents asked if they could meet up again as they had found it a very useful experience (it was suggested that they could arrange this themselves). In other groups, lone parents exchanged contact details at the end. For these lone parents, engaging with other lone parents in a group situation may be a first step to them moving closer to the labour market.

Other lone parents suggested having mentors so that they could meet people from similar situations who have been successful in moving into work. It was suggested that it would allay fears of not being able to manage the move into work.
'I think it would be good to have a mentor when you go back to work, not one that you’d have for ever, but maybe for the first year that you are in work.'

(Focus group participant. In work)

On a practical note, lone parents suggested ways that would make the Jobcentre an easier place for them to get help with moving into work and to discuss their health problems with advisers. One lone parent suggested that it would be helpful if there was somewhere for children to play at the Jobcentre, whilst another emphasised the lack of privacy that discouraged them from discussing health problems:

‘My daughter kept running riot round the place and it meant, whilst talking to them, running to the other end of the office, grabbing her. I don’t mind doing it but it’s anti-social and difficult to conduct an interview with an adviser when you’ve got a child who needs attention.’

(Focus group participant. In work)

‘It was an open-plan office. There’s an adviser sitting next to you, there’s advisers behind you, there’s people around you. You’re not going to sit there and say, ‘I’ve been really depressed in the past and it’s knocked me for six,’ you’re not going to want to say that to just anyone.’

(Focus group participant. In work)

10.7 Discussing health with Jobcentre Plus

Most lone parents, both on Income Support and in work, had not mentioned their health problems to anyone from Jobcentre Plus. There were a number of reasons that lone parents had not discussed their, or their children’s, health problems. As discussed in Chapter 6, some lone parents feel that they do not need any support for their health problem. Others did not want to discuss their health problems with anyone from Jobcentre Plus, or felt it was none of their business, and some were very independent and preferred to deal with their health problem themselves.

Some lone parents had not talked to advisers about their health and said that they did not realise that they could discuss their health with anyone from Jobcentre Plus. For example:

‘It would be a good idea for there to be more information relating to people’s health problems because I do think that people think it’s just a job centre. I know they’re trying to be everything, like a one stop shop, but I don’t think that’s an area that’s known to many people, that you could discuss your health issues there.’

(Lone parent with mental health problems, and a child with behavioural problems. In work)

‘They didn’t really ask about health problems, maybe they should. They just wanted to know what experience you had of working, just about work, nothing else. That must be why I never mentioned it anyway.’

(Lone parent with mental health problems, and a child with asthma. In work)

Some lone parents had not discussed their health with anyone from Jobcentre Plus because they had not been diagnosed when on NDLP, or because they felt that they had a bad reaction from health professionals in the past. Others did not think that their health was relevant or important. For some, the stigma of mental health problems meant that they did not want to discuss it:
‘I always see it as mental health, you’re not incapacitated, but in a way you are because you can’t see it, it’s brushed under the carpet somewhat. You feel that you’re not well, but somebody else could say, ‘she’s fine, she’s all right, how can she say she’s not well, her leg’s not broken.’ I’ve always had that stigma with it. Everyone says they’re depressed at times – but it is real, it’s quite a frightening feeling.’

(Lone parent with mental health problems, and a child with behavioural problems. In work)

For those that had mentioned it to someone from Jobcentre Plus, some found that PAs did not want to know, or did not think it was that important. For example:

‘They don’t really want to know. If you go for an appointment they don’t want to talk about your health.’

(Lone parent with mental health problems, cancer, and ankle and arm problems. On Income Support)

‘I have mentioned it. They don’t seem to think it’s that important.’

(Lone parent with back problems, high blood pressure, and mental health problems. On Income Support)

However, when most lone parents mentioned their health problems to PAs, they felt that PAs had been very understanding. In some cases, PAs had agreed with lone parents that it would be hard for them to work because of their health, and told them that they, therefore, did not have to worry about moving into work, as they could stay on Income Support until their youngest child was 16. Some PAs in this research suggested that lone parents get in touch again when their child reached 16, or when their health was better. For example:

‘I explained about [child with health problem] and she said, ‘when you feel better, come back and see us.’ She understood the situation I was in at the time.’

(Lone parent with pleurisy, and a child with asthma. On Income Support)

In one case, a PA had advised a lone parent to try to claim health-related benefits.

Whilst many lone parents found PAs were understanding, some lone parents suggested that PAs could have been more helpful had they mentioned particular forms of support that were available. None of the lone parents in our sample had received any kind of support from PAs when they had told them about their, or their children’s, health problems. Whilst lone parents did not expect to get medical advice from PAs, they felt that signposting to other organisations, for example, might have been helpful. However, in many cases, lone parents found that PAs listened but did not provide any support. In some cases, lone parents would have appreciated more advice or guidance:

‘They listened, but told me nothing.’

(Lone parent with mental health problems, and a child with asthma. In work)

‘There are lots of ways of working around health problems aren’t there? It’s not as though I’m terribly incapacitated.’

(Lone parent with back problems, high blood pressure and mental health problems. On Income Support)
These lone parents felt that they would have benefited from help to find jobs that they were capable of doing despite their health problems, or jobs with flexible employers, rather than advisers assuming that their health problems meant that they could not work.

Other research has shown that advisers do not feel it is appropriate for them to suggest work if lone parents have evident health problems and express a preference not to work (Thomas and Griffiths, 2003). Many annual review meetings with lone parents with disabilities or health problems were felt by PAs to be an embarrassing recap of information given previously, with little or no benefit gained. However, in the research on WFi’s for lone parents, some customers with health problems felt that the PA had not believed them about how serious or limiting it was and had continued to suggest that there might be work that they could do. The authors of the WFi’s for lone parents research suggest that this may be a testimony to good practice as it reflects the willingness on the part of some PAs to push the boundaries of people’s preconceived ideas and to be forceful in persuasion and presenting alternative options (Thomas and Griffiths, 2003). This supports our suggestion that PAs could do more to provide advice, and suggest work that lone parents could do despite their health problems.

10.8 Summary

There was a lack of knowledge, and there was confusion about health-related benefits, amongst lone parents in our sample. However, some had applied for health-related benefits in the past, and had been turned down after a PCA, and others had been on health-related benefits in the past. A group of lone parents were receiving DLA for their children at the time of interview. Other lone parents had not tried to claim health-related benefits because they did not think they would be eligible, they did not want to be ‘written off’ as sick, they did not see the point if they wanted to move into work, or because they chose to stay on Income Support. The group of lone parents who felt that they could not work because their, or their children’s, health was too severe, were aware of health-related benefits and were accessing, or had tried to access them.

Most lone parents in our sample had not had a WFI. Those that had one, had either had one when making a new claim, or had children of ages that meant that they were in the target group that WFi’s had been rolled out to, at the time of interviews.

Most lone parents on Income Support had heard of NDLP, and many had positive experiences of taking part, although some had not taken part and felt that their health was a constraint to participation. However, none of the lone parents interviewed on Income Support were on NDLP when interviewed, although many had been in the past. These lone parents need to have more regular contact from PAs to encourage them to continue to engage with the programme, or come back to NDLP when they feel ready. Most lone parents in work had been on NDLP before entering work. Many had found it useful, with some going on to NDLP, when they had already found a job, to see if they would be better off in work.

Lone parents also suggested that having group sessions with other lone parents who also wanted to move into work would be helpful, particularly for those who felt isolated or had little support. Engaging lone parents who feel comfortable about attending groups may be a first step to moving them closer to the labour market. For lone parents who are not confident enough to attend group sessions, or who cannot attend for other reasons, one-to-one support may be more appropriate. Some lone parents also felt that having lone parents who had succeeded in moving into work as mentors would be helpful, as mentors could act as positive role models and help allay fears about moving from benefits into work. On a more practical note, lone parents suggested that Jobcentres could be better designed so that children had somewhere to play whilst interviews were taking place, and so that they could discuss their health issues in private.
Most of the lone parents in our sample had not mentioned their health to anyone at Jobcentre Plus. In some cases, this was because they did not want to discuss it, did not feel it was the business of Jobcentre Plus, or because of the stigma of mental health. However, some lone parents did not know they could discuss it. One lone parent suggested that Jobcentre Plus could make it clear in advertising material and correspondence with lone parents, that lone parents could talk to advisers and Jobcentre Plus staff about their health problems.

It was suggested by some that lone parents could be asked about their health in interviews with advisers, rather than be expected to bring it up. When lone parents did mention health to their Personal Advisers, they found PAs understanding, but had not received any advice or signposting from PAs, which would have been helpful to some. PAs could support lone parents who do talk about their health problems, by signposting them to specialist organisations, or organisations that could provide support.

When health is discussed, advisers could also discuss work with lone parents, rather than assuming that their, or their children’s, health problems mean that they cannot work. Some of those who are not currently on NDLP may have left because they were told that they did not need to think about working because of their health problem. Instead of giving this message, PAs could, instead, help lone parents find work that they could do, despite health problems. NDLP PAs could, perhaps, also be incentivised to help lone parents with health problems, who may be more difficult to move into work, than other lone parents without health problems.
11 Conclusions

11.1 Introduction

This chapter highlights the key findings and conclusions from this research examining lone parents, health and work. It outlines: the results from the use of the General Health Questionnaire; whether there are differences between lone parents on Income Support and in work in terms of health and attitudes to work; how health acts as a constraint to moving into work and staying in work; how lone parents are using medical support to try and overcome health problems; the support lone parents need and receive; what makes lone parents look for work; what helps lone parents start work and stay in work; and how existing schemes are supporting lone parents.

11.2 Results of the General Health Questionnaire

The use of the General Health Questionnaire (GHQ12) in this research, suggested that lone parents interviewed as part of this sample, have poorer mental well-being than the national average. Whilst using the GHQ12 enabled us to provide a snap-shot of current mental well-being, independent of identification of mental health problems by the respondents, it is important to remember that GHQ12 is a quantitative tool, which is commonly used to provide analysis of mental well-being across large populations, and over time.

The GHQ12 scores only show the mental well-being of the small group of 53 lone parents who completed the GHQ12 as part of this research, and are not representative of all lone parents, or all lone parents with health problems. They also only show us the mental well-being of lone parents at the time of the interview, and do not allow us to see how mental well-being changes over time, for example, as individual lone parents move from benefits into work.

11.3 Differences between lone parents on IS, and lone parents in work

There were no major differences in the types of health problems that lone parents and their children had, between those on IS and those in work. Both groups were similar in terms of: the range in types of health problem; the differing durations of the health problem; in having particular circumstances or triggering events that led to, or exacerbated, health problems; in having links between mental and physical health problems; in having some cases where lone parenthood and health problems are linked; and in terms of the severity of health problems.
However, there are key differences in the benefit histories of those on IS and those in work. Those on IS had more sustained periods of claiming, and more had no previous work history, than lone parents in work. In terms of the attitude that lone parents had towards benefits, both groups are similar, with those on IS and those in work having had very negative experiences of, and attitudes towards, benefits. Most of those on IS would rather be working than claiming benefits, particularly those who felt isolated and lacked support networks, and they did not, therefore, seem significantly different in terms of their attitude towards work, than those already in work.

11.4 How health acts as a constraint to moving into work, and to staying in work

The extent to which health was a constraint differed among lone parents on IS. One group felt that they could not work, another group felt that health problems made working more difficult, and a third group felt that health was not a constraint.

For many lone parents on IS, health was not the key constraint to moving into work. Other constraints were childcare, a lack of work experience, low self-confidence, the perceived attitude of employers to lone parents and health issues, making work pay, finding a job with the right hours, and ESOL needs. In some cases, health interacted with other constraints, with depression leading to low self-esteem and confidence, and childcare being more difficult to access for children with health problems.

For lone parents in work, health can impede their ability to work. Some lone parents were concerned about the sustainability of their employment, with work exacerbating health problems in some cases. In other cases, health had been improved by working.

A key difference between those on IS and those in work seems to be the resilience of those in work, compared to those on IS, who may have similar health problems. Lone parents in work often described themselves as ‘fighting back’ against their health problem, and refusing to let their, or their children’s, health affect them, or prevent them from working. Some spoke of the importance of having ambition and ‘drive’ in order to move into work. Whilst lone parents on IS were not using health to avoid work, many described how it was hard to be resilient and to bounce back after setbacks.

11.5 Using medical support to try and overcome health problems

For those with mental health problems, most had been diagnosed, and many lone parents had been prescribed anti-depressants. A few lone parents had also used counselling and psychiatrists. Some were currently on waiting lists to see counsellors, whilst others had used counselling previously and had not found it useful. Although counselling was not a positive experience for all, the high incidence of depression amongst lone parents, both in and out of work, and the low take-up of counselling, suggest a need for improved awareness and availability of this type of support.

For those with physical health problems, most lone parents were receiving medication and/or treatment, having been diagnosed. All those children with health problems had been diagnosed. Lone parents who had children with health problems had additional caring responsibilities, and some had difficulties getting the support that they needed to look after their child.
For all types of health problems, there were links between health and wider circumstances, eg housing, and for all types of health problems, lone parents were generally aware of what standard medical support was available, although there was some dissatisfaction with GPs, and it was difficult to change them in some areas, particularly London.

The main difference between those on IS and those in work was the ability of those in work to make choices about private medical support. Whilst they had more financial resources to access treatment, not available on the NHS, they also had a wider social network to get advice about alternative treatments or specialist organisations. In contrast, it was difficult for some lone parents on IS to keep up with regular treatment due to transport and childcare problems.

11.6 The support needed and received by lone parents

In terms of health support that lone parents felt that they needed, and health support that they received, there are no obvious differences between those in our sample who were on IS, and those who were in work. For both lone parents on IS and lone parents in work, there was a lot of additional support that some lone parents felt that they needed, that they were not currently receiving, and that friends and family, in particular, are not able to provide.

Having enough information and advice about their, or their children’s, health problems is important for lone parents to be able to manage the health problems. As previously mentioned, some of those with mental health problems felt that being able to access counselling, or to see other mental health professionals, without having to wait for long periods, would help them manage their health problem. This is particularly important for those with severe mental health issues, who felt that they are not currently coping.

For those with physical health problems, and those who had children with health problems, some lone parents suggested that access to practical support would help them manage their, or their children’s, health problems. Enabling lone parents to better manage their health problems may be an important way of enabling lone parents to move into work, and to sustain work.

However, there were a number of lone parents within our sample who felt that they did not need any support. Whilst, in some cases, this was because lone parents were already receiving the support they need, in other cases, it was due to a strong feeling of independence, and preferring to cope with the health problem by themselves, rather than asking for help, or discussing the health problem with strangers. There was also a group of lone parents who felt that the only thing that would help them is if their health problem got better, and who felt that there is no support, that could be offered, to alleviate the problem. Helping these lone parents to start, and stay, in work, will be more difficult.

11.7 What made, or would make, lone parents look for work

Of those lone parents on IS, most wanted to work, except for a small group who felt that they could not work because of their, or their children’s, health problems. Of the remaining lone parents, who were not ruling work out as an option, many did not feel ready to work at the moment. Nevertheless, these lone parents cited a range of things that might attract them into work.

These ‘triggers’ were linked to what they felt were their constraints to work, and included having affordable childcare, having jobs that paid enough so that they were better off in work than on benefits, finding jobs with training and career progression, and their health improving. Some of those
lone parents who felt that they might not be better off in work were not aware of the new tax credits or the broader package of financial help available if they moved into work, suggesting a need for more awareness raising about tax credits and other financial benefits for those who move into work from IS.

Of those lone parents in work, improvements in health did help a small group of lone parents move into work, but this was only the trigger for a few. Another group of lone parents were helped into work by feeling that their health would improve if they were in work, rather than on benefits.

Those in work with recent work histories, and positive memories of work, reported that they had always planned to return to work. Many lone parents cited moving back into work because of the identity, pride and satisfaction they got from working. Others stressed the importance of setting an example for their children and being able to provide their children with extras, whilst others felt that finding the right job had helped move them back into work.

In some cases, improved health provided the motivation to move into work, but overall, it would appear that lone parents with health problems are not necessarily different from lone parents without health problems, in terms of what would attract them into work. Many cited factors that would attract them into work, or that were key in their decision-making process to get into work, which were entirely unrelated to their, or their child’s, health problem.

11.8 What helps lone parents start work, and stay in work

There is no single intervention that would help lone parents with health problems to start, or stay, in work. In many instances, lone parents with health problems are no different to those without health problems, in terms of what would assist them.

Lone parents on IS felt that a number of things would help them move into work: help with job search, a job match service, help building skills and confidence, childcare information, and help with self-employment. These are all available through the New Deal for Lone Parents (NDLP). Not all the lone parents on IS had heard of NDLP, suggesting that NDLP could be more proactively marketed to lone parents on IS with health problems. However, many lone parents on IS had been on NDLP, and still described needing the kind of help to start work that is available to them through NDLP. This suggests that NDLP Personal Advisers (PAs) need to ensure that lone parents on NDLP have access to all of the services that NDLP can provide.

Many of those in work were self-starters, who had not required much help to move into work. Others had help with childcare, or had help to go to college as a step towards work. Some had received help through NDLP, finding the better-off calculation and financial support particularly helpful. In terms of staying in work, in some cases, nothing would have helped lone parents stay in work, as their, or their children’s, health had become too severe. However, in other cases, lone parents could have been helped to find more suitable jobs which they could do despite the health problem - jobs that were less physical, less stressful, and jobs that were with employers who were understanding about the need to take time off because of health problems.

NDLP provides an ‘in work’ service to lone parents. This service could be used to help lone parents who are thinking of having to give up work, to find more suitable jobs rather than having to return to IS. This service could also help with problems that lone parents, who have moved into work, are having and need help with, in order to stay in work. This could be marketed to all those who leave IS for work, to ensure that all lone parents know it exists, whether or not they have ever taken part in NDLP.
This research suggests that there is also a role for employers to play in working with employees with health problems. Employers could encourage employees to discuss their health problems, and could support employees with health problems by making it clear that they could come to them with any problems, through policies such as dependency leave, and by making adjustments to the nature of the work or working hours.

For many lone parents, childcare costs and availability were also major constraints to moving into work, and to staying in work. This research suggests that the issue of providing cheaper childcare and/or providing more financial support with childcare to help lone parents stay in work, also needs to be tackled.

11.9 How existing provision is supporting lone parents

There was a lack of knowledge and confusion about health-related benefits, amongst lone parents in our sample. However, some had applied for health-related benefits in the past and had been turned down after a PCA, and others had been on health-related benefits in the past. Other lone parents had not tried to claim health-related benefits because they did not think they would be eligible, they did not want to be ‘written off’ as sick, they did not see the point if they wanted to move into work, or because they simply chose to stay on IS.

The group of lone parents who felt that they could not work because of their, or their children’s, health, were aware of health-related benefits and were accessing, or had tried to access them. It is, perhaps, surprising that some lone parents who seem to have severe mental health problems are not able to access health-related benefits, some despite repeated attempts.

Most lone parents in our sample had not had a WFI. Those that had one, had either had one when making a new claim, or had children of ages that meant that they were in the target group that WFIs had been rolled out to, at the time of interviews.

Most lone parents on IS had heard of NDLP and many had positive experiences of taking part, although some had not taken part and felt that their health was a constraint to participation. However, none of the lone parents interviewed on IS were on NDLP when interviewed, although many had been in the past. These lone parents need to have more regular contact from PAs to encourage them to continue to engage with the programme, or come back to NDLP when they feel ready. Most lone parents in work had been on NDLP before entering work, and many had found it useful.

Lone parents also suggested that having group sessions with other lone parents who also wanted to move into work would be helpful, particularly for those who felt isolated or had little support. Engaging lone parents who feel comfortable about attending groups may be a first step to moving them closer to the labour market. For lone parents who are not confident enough to attend group sessions or who cannot attend for other reasons, one-to-one support may be more appropriate. Some lone parents also felt that having lone parents who had succeeded in moving into work as mentors would be helpful, as mentors could act as positive role models and help allay fears about moving from benefits into work. On a more practical note, lone parents suggested that Jobcentres could be better designed so that children had somewhere to play whilst interviews were taking place, and so that they could discuss their health issues in private.

Most of the lone parents in our sample had not mentioned their health to anyone at Jobcentre Plus. In some cases, this was because they did not want to discuss it, did not feel it was the business of Jobcentre Plus, or because of the stigma of mental health. However, some lone parents did not know
they could discuss it. One lone parent suggested that Jobcentre Plus could make it clear in advertising material and correspondence with lone parents, that lone parents could talk to advisers and Jobcentre staff about their health problems.

It was suggested by some that lone parents could be asked about their health in interviews with advisers, rather than be expected to bring it up. When lone parents did mention health to their Personal Advisers, they found PAs understanding, but had not received any advice or signposting from PAs, which would have been helpful to some. PAs could support lone parents who do talk about their health problems, by signposting them to specialist organisations, or organisations that could provide support.

When health is discussed, advisers could also discuss work with lone parents rather than assuming that their, or their children’s, health problems mean that they cannot work. Some of those who are not currently on NDLP may have left because they were told that they did not need to think about working because of their health problem. Instead of giving this message, PAs could, instead, help lone parents find work that they could do, despite health problems. NDLP PAs could, perhaps, also be incentivised to help lone parents with health problems, who may be more difficult to move into work, than other lone parents without health problems.

11.10 Summary

This research examined the significant group of lone parents on IS, who report having health problems but are not claiming health-related benefits. It focused on the complex issue of the relationship between health and work for lone parents, examining how health problems affect lone parents’ ability, propensity and likelihood to enter the labour market, their attitudes to work, and their welfare. It also sought to determine whether there is more that can be done to support lone parent families with health problems, in particular, to help them enter the labour market.

This research has found that there were no major differences between those on IS and those in work, in terms of the types, duration and severity of health problems that lone parents and their children reported. However, those on IS had more sustained periods of claiming, and more had no work history than those currently in work. The extent to which health acted as a constraint differed among those on IS: one group felt they could not work, another that health made working more difficult, and another group felt that health was not a constraint. For many on IS, health was not the key constraint to moving into work. For lone parents in work, health could impede their ability to work.

Most lone parents, with both mental and physical health problems, had been diagnosed, and were receiving medication or treatment. The high incidence of depression amongst the sample, and the low take-up of counselling, suggest a need for improved awareness and availability of counselling. For all types of health problems there were links between health and wider circumstances. The main difference between those on IS and those in work was the ability of those in work to make choices about private medical support. In terms of the health support that they felt they needed, there were no obvious differences between those on IS and those in work. Many needed more information, advice and practical support for the health problem. Enabling lone parents to better manage health problems may be an important way of enabling them to enter and sustain work. There was also a group of lone parents who felt that their health getting better was the only thing that would help them. Helping these lone parents start, and stay in work, will be more difficult.

In some cases, improved health provided the motivation to work, but overall, lone parents with health problems are not necessarily different from lone parents without health problems, in terms of what would attract them into work. Some lone parents on IS who felt that they would not be better off in
work, were not aware of the new tax credits, suggesting a need for greater awareness raising about tax credits for those on IS. There is no single intervention that would help lone parents with health problems start or stay in work. There is also a role for employers to play in making adjustments to the nature of work, and working hours, to enable lone parents to continue working. The issue of providing cheaper childcare, or more financial support for childcare, also needs to be tackled.

There was a lack of knowledge and confusion about health-related benefits amongst lone parents in the sample. Most lone parents had not had a WFI. Not all lone parents had heard of NDLP, and not all were aware of all the services that it can provide. Though many had been on NDLP in the past, none of those on IS were on NDLP when interviewed, suggesting the need for PAs to encourage them to continue to engage with the programme, or come back to NDLP when they feel ready. Most lone parents in work had been on NDLP before moving into work, and had found it useful. The NDLP ‘in work’ service could be used to help lone parents thinking of giving up work to find more suitable jobs. NDLP services could be better marketed to those with health problems, both in and out of work. Group sessions and mentors may help some lone parents move into work. PAs could encourage lone parents to talk about health problems and signpost them to organisations that could provide them with support. They could also discuss work with these lone parents, rather than assuming that health problems mean that they cannot work. PAs could, perhaps, be incentivised to help lone parents with health problems, who may be more difficult to move into work, than other lone parents.

This research has shown how health problems affect lone parents’ ability to work and has suggested a number of things that could be done to support lone parent families with health problems, in particular, to help them enter the labour market. Further research could usefully explore how the mental well-being of lone parents, as measured by the GHQ12, changes over time, as they move from benefits into work.
Appendix A
Opt-in letter

DWP
Department for
Work and Pensions

Floor 4
Social Research Division
Adelphi
1-11 John Adam Street
London
WC2N 6HT
Tel: 020 7712 2371
Fax: 020 7962 8542

«Title» «Firstname» «Surname»
«Address1»
«Address2»
«Address3»
«Address4»
«Address5»
Reference Number: «IES_ID»
Date

Dear «Title» «Surname»

We are writing to ask for your help.

We are interested in finding out more about the way in which health acts as a constraint to some lone parents moving into work. This will help the Department for Work and Pensions (DWP) to provide better support to lone parents with health problems and lone parents whose children have health problems. We have therefore asked the Centre for Economic and Social Inclusion (Inclusion) to carry out a research study. Inclusion is a research organisation that is completely independent of government.

Your name has been selected from the DWP records. We would very much like to find out about whether you or your children have had any health problems and if they have had an impact on your ability to work. Your participation in this research is entirely voluntary.
What happens now? If you are willing to take part in this research please fill in the reply form and send it to Inclusion in the reply-paid envelope. Someone from Inclusion may contact you to arrange a time, date and place to speak to you in person for about an hour. Inclusion will thank you with £15 for your time. Everything you tell the interviewer will be treated in complete confidence. Your views will be combined with those of other people, and the report of the research will not identify anyone in person.

I do hope that you will take part in this important research study, as we value your views. But if you really do not want to, then do not send back the reply form. If you have any questions about the research, you can contact Mark Morrin at Inclusion, 89 Albert Embankment, London, SE1 7TP, telephone 020 7840 8345, or contact me. I hope you will enjoy taking part in the research.

Yours sincerely

Angela Donkin
Senior Research Officer, Lone Parents

A large print copy of this letter, a Braille copy and an e-mail copy are available. If you would like one, please call 01273 873582
Appendix B
Lone parent reply form

The impact of health on lone parents’ decisions about work

Information provided in interviews will remain confidential to the Inclusion and IES research team and will not be shared with anyone else. Please complete and return this form to Inclusion, in the reply-paid envelope.

Thank you

1. Have you been feeling generally unwell this year?  
   - Yes  
   - No

2. Are you currently a lone parent?  
   - Yes  
   - No

3. Are you currently claiming Income Support?  
   - Yes  
   - No

4. Are you currently working 16 hours a week or more?  
   - Yes  
   - No

If yes, how long have you been working?  
   - [ ] years  
   - [ ] months
5. Do you have a health problem that has been present for a year or more?

Yes ☐  No ☐

If yes, which of the following health problems do you have?

Please tick any which apply:

- Problems that affect your mobility, e.g. arms, legs, hands, feet, back, neck, arthritis, rheumatism ☐
- Respiratory, e.g. breathing and chest problems ☐
- Mental health, e.g. depression or mental illness ☐
- Other (please say what problem you have below) ☐

...................................................................................................................................

6. Is your child disabled?

Yes ☐  No ☐

7. Does your child have a health problem that has been present for a year or more?

Yes ☐  No ☐

Please provide your contact details:

Name ..........................................................................................................

Address ..........................................................................................................

..........................................................................................................

..........................................................................................................

Tel: ................................................ Mobile: ...............................................

Please return in the reply-paid envelope (to Mark Morrin, Inclusion, 3rd Floor, Camelford House, 89 Albert Embankment, LONDON, SE1 7TP)
Appendix C
Topic guide 1 (lone parents on IS)

Introduction

- introduce yourself
- who project is for – DWP
- aims of the project – finding out more about the health problems of lone parents
- interview will last around an hour
- confidentiality, taping
- incentive payment and effect on savings capital limit

Characteristics

I’d like to start by asking you some background information:

- Children – number and ages, are children attending school?
- What ethnic group would you describe yourself as belonging to? (Ethnic origin codes: Black Caribbean, Black African, Black Other, Indian, Pakistani, Bangladeshi, Chinese, other Asian, White)
- Are you caring for anyone else other than your children?
  - Who? (relative/friend)
  - Does this person have a health problem?
  - What are you doing for them?
  - How much time does this take a week?
  - Is anyone else helping you care for them?
  - Does this have an impact on your ability to work? (details)
Benefit history

I’d like to ask you some information about any benefits you claim or have claimed in the past:

• What benefits do you or your children currently receive? (probe for disabled child premium)

• How long have you been claiming Income Support?

• Have you been on benefits before? If yes:
  - Which benefits?
  - When was that?
  - How long were you claiming for?
  - Why did your circumstances change?

• Are you claiming Income Support Disability Premium (ISDP)?
  - If yes, when did you start claiming?
  - If no:
    - Have you heard of ISDP?
    - Have you ever claimed ISDP?
    - When was this?
    - How long did you claim for?
    - Why did your circumstances change?
    - Have you ever tried to claim ISDP? (details, why/why not?)
    - Have you ever thought about claiming ISDP? (details, why/why not?)

• Incapacity Benefit and Disability Living Allowance:
  - Have you heard of Incapacity Benefit?
  - Have you heard of Disability Living Allowance?
  - Have you or your children ever claimed either IB or DLA? If yes:
    - When was this?
    - How long did you claim for?
    - Why did your circumstances change?
    - Have you ever tried to claim IB/DLA? (details, why/why not?)
    - Have you ever thought about claiming IB/DLA? (details, why/why not?)

• Have you had any specialist help with ISDP, IB or DLA from anyone at the Jobcentre? (details)

• If your child has a health problem, have you ever applied for any financial help to help care for that child?

• How do you feel about being on benefits?
Health problems

I’d like to ask you about the health problem that you or your child has:

• Is it you or your child that has a health problem, or both? (use sections 4.1 and 4.2 as appropriate)

Details of lone parents’ health problem

• Do you have more than one health problem? (If yes, repeat the following questions for each health problem)

• What is your health problem?
• How long has the problem been present?
• Did the problem start before you had children/became a lone parent?
• Has the health problem been diagnosed/identified by any medical professionals?
  – If yes:
  – When was this?
  – What was the outcome of this?
  – Has any medication/treatment been prescribed? (details)
  – If no, why do you think that is?
  – What has your doctor told you about how the health problem may develop?
  – Has your doctor given you advice on how to alleviate the health problem?
  – Has your doctor given you advice on how it affects your ability to work? (Doctor’s note/certificate given? What type or amount of work they can do?)
  – If no:
  – Have you approached any medical professionals for help?
  – If yes, what happened and why? (Prompt for whether doctor was unable to diagnose problem, was unhelpful etc.)
  – If no, why not?

• How severe do you feel that your health problem is?
• How do you cope/live with your health problem?
• What are your treatment and care needs?
• How do you alleviate your health problem?
• Have there been any changes in what you can do since you became ill? (details)
Details of children’s health problem

- How old is the child with a health problem?
- What is their health problem?
- How long has it been present?
- Has the health problem been diagnosed/identified by any medical professionals?
  - If yes:
    - When was this?
    - What was the outcome of this?
    - Has any medication/treatment been prescribed? (details)
  - If no, why do you think that is?
  - What has your child’s doctor told you about how the health problem may develop?
  - Has your child’s doctor given you advice on how to alleviate the health problem?
- If no:
  - Have you approached any medical professionals for help?
  - If yes, what happened and why? (Prompt for whether doctor was unable to diagnose problem, was unhelpful etc.)
  - If no, why not?
- How severe do you feel that the health problem is?
- How do you cope with this health problem?
- What are your child’s treatment and care needs?
- How do you alleviate your child’s health problem?
- Does your child’s health problem influence your own health? (e.g. their mental health)

Impact on their ability to work

- Does your/your child’s health affect your ability to work?
  - If yes:
    - In what ways? (motivation, travel, discrimination, physical ability to work etc.)
    - To what extent?
    - Does it mean you can’t work? Why?
    - Do you need extra support to work?
    - What work can you do?
    - What work can’t you do?
  - If no, why doesn’t it affect your ability to work? (Prompt for not severe enough, have support they need, health problem is managed adequately etc.)
Mental health
We would like to ask you a bit about how you’ve been feeling recently. (Use separate sheet to ask GHQ12)

Work

Work history
• What jobs have you done in the past? For each job:
  – What was the job?
  – Was it full-time (30+ hours) or part-time?
  – When did you do it?
  – Was that before or after you had children/became a lone parent/became disabled?
  – For how long?
  – Why did you leave?
  – Have you had to give up a previous job because of a health problem?
  – Have you managed to continue working in a previous job despite the health problem?
• Have you got any qualifications? (Prompt for: CSEs, GCSEs, ‘O’ Levels, ‘A’ levels, NVQs, GNVQs, degree)

Attitudes to work
I’d like to ask you a few questions about how you feel about work:
• Do you want to work? Why/why not?
• What kind of work do you want to do?
• Have you considered other work that you could do?
• Do you feel ready to work?
• What affects your attitude to work?
• Does your health problem affect your attitude to work?
  – In what ways?
• What would attract you into work?
• What would attract you to join New Deal for Lone Parents?
• Would you be happy to use childcare/respite care to give you a break from caring responsibilities?
  – Why/why not?
  – What types of childcare/respite care, to give you a break from caring responsibilities, would you be happy to use, and why?
**Constraints to moving into work**

I would like to ask you about what constraints you face moving into work:

- What constraints do you face? (prompt for those below)
  - Health/child’s health problem?
  - Attitude of employers to health problem?
  - Not being able to have a break from caring responsibilities?
  - Availability of affordable childcare?
  - Transport – distance to travel, public transport?
  - Not being better off in work – benefit rules, in-work benefits? (probe awareness)
  - Motivation/confidence?
  - Jobs available in the area?
  - Discrimination – race, sex, age, disability?
  - Experience/qualifications?
  - Literacy/numeracy problems?
  - Drug/alcohol issues?
  - Criminal record?
  - Housing?

- Which are the most important constraints? Why? (prioritise using cards)

**Support**

**Contact with Jobcentre Plus**

- Experience of Personal Advisers meetings:
  - Have you ever attended a mandatory meeting with a Personal Adviser as a condition of your IS claim?
  - How many times?
  - What did you see them for?
  - Was it useful? In what ways?

- Experience of NDLP:
  - Have you heard of the New Deal for Lone Parents?
  - Have you ever been asked to see a lone parent adviser for a meeting that was not mandatory?
    - Did you decide to join NDLP/keep seeing the lone parent PA?
    - Why/why not?
- Are you currently on NDLP/seeing a lone parent adviser on a voluntary basis?
- How long have you been on NDLP/seeing the lone parent PA?
- What have you been doing with the lone parent PA?
- Is it useful? In what ways?
- If you have been on NDLP/seen a lone parent adviser on a voluntary basis in the past:
  - When was that?
  - How long was that for?
  - What did you do with the lone parent PA?
  - Was it useful? In what ways?
  - Why did you leave NDLP/stop seeing the lone parent PA?
- Do you feel that your health problem is a constraint to taking part in NDLP?

• Experience of NDDP:
  - Have you ever heard of NDDP?
  - Have you ever seen a disability PA as part of NDDP? (details)
  - Have you ever seen a job broker as part of NDDP? (details)

**Support for health problems**

I’d like to ask you about the support you receive or would like to receive for your health problem:

• What support do you feel you need for your/your child’s health problem?

• Do you have any support for the health problem?

• What support do you have? (probe for counselling if mental health)

• Do you use any organisations for help, information and advice?
  - Which ones?
  - What practical advice/services have they provided?
  - How happy are you with the support they provided?

• Do you have a local support network? What does this consist of?

• Have you ever told anyone at the jobcentre about your health problem? (details)

• Have you had any support for your health problem from the Jobcentre, Personal Advisers or the New Deal for Lone Parents?
  - What did the support consist of? (talking about it, giving advice, referring them to other organisations etc.)
  - Were you happy with the support you received?
Support needed to be able to work

I’d like to ask you about what help you need to be able to work:

- Did you have any support when you worked previously? (details, i.e. with partner then?)
- Has anyone helped you address your constraints to working?
- What would help you look for work? (prompts: help with job search, childcare, transport paid etc.)
  - Which of these are most important? (prioritise)
- What would help you move into work? (prompts: more support for health problem, help with caring responsibilities, better childcare, transport, etc.)
  - Which of these are most important? (prioritise)
- Do you feel that the Jobcentre could do more to support lone parents with health problems to help them move into work?
- Do you feel that Personal Advisers could do more to support lone parents with health problems to help them move into work? (Improve specialist health knowledge of PAs, more frequent contact with PAs?)
- Do you feel that the New Deal for Lone Parents could do more to support lone parents with health problems to help them move into work?
  - How should they do this?
  - What would make your life better in terms of your health problem and work?
  - What plans do you have for the future?

Focus group participation

Are you willing to take part in a focus group?

- explain what this would mean
- incentive payment and effect on savings threshold.

Thanks and close
Appendix D
Topic guide 2 (lone parents in work)

Introduction

- introduce yourself
- who project is for – DWP
- aims of the project – finding out more about the health problems of lone parents
- interview will last around an hour
- confidentiality, taping
- incentive payment and effect on savings capital limit

Characteristics

I’d like to start by asking you some background information:

- Children – number and ages, are children attending school?
- What ethnic group would you describe yourself as belonging to? (Ethnic origin codes: Black Caribbean, Black African, Black Other, Indian, Pakistani, Bangladeshi, Chinese, other Asian, White)
- Are you caring for anyone else other than your children?
  - Who? (relative/friend)
  - Does this person have a health problem?
  - What are you doing for them?
  - How much time does this take a week?
  - Is anyone else helping you care for them?
  - Does this have an impact on your ability to work? (details)
Benefit history

I’d like to ask you some information about any benefits you have claimed in the past:

• Are you currently receiving any benefits? (eg DLA)

• Have you been on benefits before? If yes:
  - Which benefits?
  - When was that?
  - How long were you claiming for?
  - Why did your circumstances change?

• Income Support Disability Premium (ISDP):
  - Have you heard of ISDP?
  - Have you ever claimed ISDP?
    - When was this?
    - How long did you claim for?
    - Why did your circumstances change?
  - Have you ever tried to claim ISDP? (details, why/why not?)
  - Have you ever thought about claiming ISDP? (details, why/why not?)

• Incapacity Benefit and Disability Living Allowance:
  - Have you heard of Incapacity Benefit?
  - Have you heard of Disability Living Allowance?
  - Have you or your children ever claimed either IB or DLA? If yes:
    - When was this?
    - How long did you claim for?
    - Why did your circumstances change?
  - Have you ever tried to claim IB/DLA? (details, why/why not?)
  - Have you ever thought about claiming IB/DLA? (details, why/why not?)

• Have you had any specialist help with ISDP, IB or DLA from anyone at the Jobcentre? (details)

• If your child has a health problem, have you ever applied for any financial help to help care for that child?
Health problems

I’d like to ask you about the health problem that you or your child has:

• Is it you or your child that has a health problem, or both? (use sections 4.1 and 4.2 as appropriate)

Details of lone parents’ health problem

• Do you have more than one health problem? (If yes, repeat the following questions for each health problem)

• What is your health problem?
• How long has the problem been present?
• Did the problem start before you had children/became a lone parent?
• Has the health problem been diagnosed/identified by any medical professionals?
  – If yes:
    – When was this?
    – What was the outcome of this?
    – Has any medication/treatment been prescribed? (details)
    – If no, why do you think that is?
    – What has your doctor told you about how the health problem may develop?
    – Has your doctor given you advice on how to alleviate the health problem?
    – Has your doctor given you advice on how it affects your ability to work? (Doctor’s note/certificate given? What type or amount of work they can do)
  – If no:
    – Have you approached any medical professionals for help?
    – If yes, what happened and why? (prompt for whether doctor was unable to diagnose problem, was unhelpful etc.)
    – If no, why not?
• How severe do you feel that your health problem is?
• How do you cope/live with your health problem?
• What are your treatment and care needs?
• How do you alleviate your health problem?
• Have there been any changes in what you can do since you became ill? (details)
Details of children’s health problem

- How old is the child with a health problem?
- What is their health problem?
- How long has it been present?
- Has the health problem been diagnosed/identified by any medical professionals?
  - If yes:
    - When was this?
    - What was the outcome of this?
    - Has any medication/treatment been prescribed? (details)
  - If no, why do you think that is?
  - What has your child’s doctor told you about how the health problem may develop?
  - Has your child’s doctor given you advice on how to alleviate the health problem?
- If no:
  - Have you approached any medical professionals for help?
  - If yes, what happened and why? (prompt for whether doctor was unable to diagnose problem, was unhelpful etc.)
  - If no, why not?
- How severe do you feel that the health problem is?
- How do you cope with this health problem?
- What are your child’s treatment and care needs?
- How do you alleviate your child’s health problem?
- Does your child’s health problem influence your own health? (eg their mental health)

Impact on their ability to work

- Does your/your child’s health affect your ability to work?
  - If yes:
    - In what ways? (motivation, travel, discrimination, physical ability to work etc.)
    - To what extent?
    - Do you need extra support to work?
    - What work can you do?
    - What work can’t you do?
  - If no, why doesn’t it affect your ability to work? (prompt for not severe enough, have support they need, health problem is managed adequately etc.)
• Is your/your child’s health problem a constraint to working?

• Is the attitude of employers to your/your child’s health problem a constraint to working? If yes, in what way?

• Is the lack of someone to give you a break from caring responsibilities a constraint to working? In what way?

**Mental health**
We would like to ask you a bit about how you’ve been feeling recently. (Use separate sheet to ask GHQ12)

**Work**

**Current job**
• What is the job you are doing at the moment?
  – Employer name? (manual/services, large/small)
  – Job title?
  – When did you start this job?
  – How did you find this job?
  – Can I ask you how much you get paid?
  – Hours – FT/PT, how many per week, what hours (9 to 5, weekends etc.)
  – Are you happy with the hours that you work?
  – Are you using childcare?
    – What type of childcare?
    – For how many hours?
    – How are you paying for it?
  – How do you cope with your/your child’s health problem when you are at work?
  – Does your employer have any family-friendly working practices?
    – If yes, what are they?
  – Have you asked your employer if you can work flexibly?
    – If yes, what was the outcome?
  – Do you feel that this job is secure?
  – Do you feel that you will be able to continue in this job? Why/why not?
  – Are you receiving the Working Tax credit?
Work history

- What jobs have you done in the past? For each job:
  - What was the job?
  - Was it full-time (30+ hours) or part-time?
  - When did you do it?
  - Was that before or after you had children/became a lone parent/became disabled?
  - For how long?
  - Why did you leave?
  - Have you had to give up a previous job because of a health problem?
  - Have you managed to continue working in a previous job despite the health problem?
- Have you got any qualifications? (prompt for: CSEs, GCSEs, ‘O’ Levels, ‘A’ levels, NVQs, GNVQs, degree)

Attitudes to work

I’d like to ask you a few questions about how you feel about work:

- Why did you decide to move into work?
- What factors were important in deciding to move into work? (Probe for: improved health, wanting to get off benefits, a job that fits their needs, availability of childcare, family-friendly employer, WTC, help with finding a job, help with finding childcare)
- Which were the most important factors? (prioritise)
- What affects your attitude to work?
- Does your health problem affect your attitude to work?
  - In what ways?
- Would you be happy to use childcare/respite care to give you a break from caring responsibilities?
  - Why/why not?
  - What types of childcare/respite care to give you a break from caring responsibilities would you be happy to use, and why?

Support

Contact with Jobcentre Plus

- Experience of Personal Adviser meetings:
  - Have you ever attended a mandatory meeting with a Personal Adviser as a condition of your IS claim?
  - How many times?
Appendices - Topic guide 2 (lone parents in work)

- What did you see them for?
- Was it useful? In what ways?

• Experience of NDLP:
  - Have you heard of the New Deal for Lone Parents?
  - Have you ever been asked to see a lone parent adviser for a meeting that was not mandatory?
    - Did you decide to join NDLP/keep seeing the lone parent PA?
    - Why/why not?
  - If you have been on NDLP/seen a lone parent adviser on a voluntary basis in the past:
    - When was that?
    - How long was that for?
    - What did you do with the lone parent PA?
    - Was it useful? In what ways?
    - Why did you leave NDLP/stop seeing the lone parent PA?
  - Do you feel that your health problem was a constraint to taking part in NDLP?

• Experience of NDDP:
  - Have you ever heard of NDDP?
  - Have you ever seen a disability PA as part of NDDP? (details)
  - Have you ever seen a job broker as part of NDDP? (details)

Support for health problems
I’d like to ask you about the support you receive or would like to receive for your health problem:

• What support do you feel you need for your/your child’s health problem?
• Do you have any support for the health problem?
• What support do you have now? (probe for counselling if mental health)
• What support have you had in the past?
• Do you use any organisations for help, information and advice?
  - Which ones?
  - What practical advice/services have they provided?
  - How happy are you with the support they provided?
• Do you have a local support network? What does this consist of?
• Have you ever told anyone at the jobcentre about your health problem? (details)
• Have you had any support for your health problem from the Jobcentre, Personal Advisers or the New Deal for Lone Parents?
What did the support consist of? (talking about it, giving advice, referring them to other organisations etc.)

Were you happy with the support you received?

**Support that helped them move into work**

I’d like to ask you about what helped you move into work:

- What helped you move into work? (prompt for below)
  - Did your health problem get better?
  - Did you get any support that helped you move into work?
    - If yes, what help did you receive and who was the help from?
  - Did a PA meeting/NDLP help you move into work?
    - If yes, how did it help you?
  - If you are using childcare, did you get any help to find it?
    - If yes, what help did you receive and who was the help from?

**Support needed to stay working**

- What would help you stay in work?
- Are you still receiving support to help you stay in work? If yes:
  - What is this support?
  - Who is it from?
  - Will this support continue?
  - Are you worried that this support may end?
- Do you feel that the Jobcentre could do more to support lone parents with health problems to help them move into work?
- Do you feel that Personal Advisers could do more to support lone parents with health problems to help them move into work? (Improve specialist health knowledge of PAs, more frequent contact with PAs?)
- Do you feel that the New Deal for Lone Parents could do more to support lone parents with health problems to help them move into work?
  - How should they do this?
  - What would make your life better in terms of your health problem and work?
  - What plans do you have for the future?
Focus group participation

Are you willing to take part in a focus group?

- explain what this would mean
- incentive payment and affect on savings threshold.

Thanks and close
Appendix E
GHQ12 questionnaire

We would like to ask you about the way you have been feeling over the last few weeks:

Have you recently:

a) been able to concentrate on whatever you’re doing?
   - Better than usual
   - Same as usual
   - Less than usual
   - Much less than usual

b) lost much sleep over worry?
   - Not at all
   - No more than usual
   - Rather more than usual
   - Much more than usual

c) felt that you were playing a useful part in things?
   - More than usual
   - Same as usual
   - Less so than usual
   - Much less than usual

d) felt capable of making decisions about things?
   - More so than usual
   - Same as usual
   - Less so than usual
   - Much less capable
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<th>Question</th>
<th>Options</th>
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<td>e)</td>
<td>felt constantly under strain?</td>
<td>Not at all</td>
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<td>No more than usual</td>
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<td>Rather more than usual</td>
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<td>Much more than usual</td>
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<td>f)</td>
<td>felt you couldn’t overcome your difficulties?</td>
<td>Not at all</td>
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<td>No more than usual</td>
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<td>Rather more than usual</td>
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<td>Much more than usual</td>
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<td>been able to enjoy your normal day-to-day activities?</td>
<td>More so than usual</td>
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<td>Same as usual</td>
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<td>Much less than usual</td>
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<td>been able to face up to problems?</td>
<td>More so than usual</td>
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<td>Same as usual</td>
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<td>Much less able</td>
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<td>been feeling unhappy or depressed?</td>
<td>Not at all</td>
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<td>No more than usual</td>
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<td>Much more than usual</td>
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<td>been losing confidence in yourself?</td>
<td>Not at all</td>
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<td>Not more than usual</td>
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<td>Much more than usual</td>
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<td>been thinking of yourself as a worthless person?</td>
<td>Not at all</td>
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<td>No more than usual</td>
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<td>Much more than usual</td>
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I) been feeling reasonably happy, all things considered?

- More so than usual
- About the same as usual
- Less so than usual
- Much less than usual

Name of interviewee: ....................................................................................................................

City: .............................................................................................................................................

Date of interview: .........................................................................................................................
Appendix F
Focus group discussion guide
– lone parents in work

Note for focus group facilitator: Topics will be discussed openly first, before prompts are used, or lone parents are asked to respond to specific suggestions.

Introduction

• introduce yourself

• who project is for – DWP

• aims of the project (not all participants will have been interviewed)

• discussion will last around an hour and a half (with a break if participants want one)

• confidentiality, taping

• incentive payment and effect on savings capital limit

Support for health problems

• What support do you have? (keep open at first)
  – Family and friends?
  – Health professionals?
  – Employers?
  – Specialist organisations?
  – Other groups?
• What support do you need? (keep open at first)
  – More information and advice? (alleviating, prognosis)
  – Children with health problems?
  – Physical health?
  – Counselling?
  – Other?

Support that helped them move into work
• What factors were important in helping you to move into work? (keep open at first)
  – Improved health?
  – Wanting to get off benefits?
  – Finding the right job?
  – Availability of childcare?
  – Training/education?
  – Supportive employer?
  – WTC?
  – Help with finding a job?
  – Help with finding childcare?
  – NDLP/PA?
  – Other?

Dealing with health at work
• How do you deal with your/your child’s health at work?
• Does your employer know you have a health problem?
• Have they provided you with any support? (made adjustments, changed hours)
• Does any treatment you receive mean missing work? (how do they manage that?)
• Does your employer have any family-friendly working practices?
• Do you feel that you are able to cope with your health problem at work?
• Have you ever had to give up a job because of a health problem?
  – Was your employer aware of problem?
  – Any support from employer?
Support to stay working

- Are you receiving any support to help you stay in work?
- What would help you stay in work? (keep open at first)
  - Help with problems? (rent arrears, tax forms etc.)
  - Cheaper childcare?
  - More childcare availability?
  - Finding more suitable jobs? (better paid, better hours)
  - Finding jobs that they can do with health problems? (time off, less stressful etc.)
  - Understanding employers?
- Do you think that your health is better or worse now that you are in work, compared to when you were on Income Support?

What more could the Jobcentre have done for you?

Facilitator: Ask lone parents how many of them have been in contact with Jobcentre/NDLP before. Explain what the Jobcentre does, and what NDLP is, and what PAs do briefly.
- Would you be happy to discuss health with the PA?
- What more could the Jobcentre have done for you? (keep open at first)
  - Advertise NDLP?
  - Ask about your health problems?
  - Help with finding jobs that they can do despite health problems?
  - Signpost to what support is available?
  - Having staff who speak other languages?
  - In-work support? (finding more suitable jobs, helping with problems)
  - Group sessions with PAs and other lone parents?
  - Seeing lone parent PA, or disability/health PA?
Appendix G
Focus group discussion guide – lone parents on IS

**Note for focus group facilitator:** Topics will be discussed openly first, before prompts are used or lone parents are asked to respond to specific suggestions.

**Introduction**
- introduce yourself
- who project is for – DWP
- aims of the project (not all participants will have been interviewed)
- discussion will last around an hour and a half (with a break if participants want one)
- confidentiality, taping
- incentive payment and effect on savings capital limit

**Support for health problems**
- What support do you have?
  - Family and friends?
  - Health professionals?
  - Specialist organisations?
  - Other?
What support do you need?
- More information and advice? (alleviating, prognosis)
- Support for children with health problems?
- Physical health support?
- Counselling?
- Other?

Support to move into work

What would prevent you from moving into work?
- Health? (need to have regular treatment)
- Childcare?
- Fear of not being better off?
- Confidence?
- Experience/qualifications?
- Housing?
- Other?

Which of the constraints that we have just mentioned do you think is most important to you?

To what extent is health a constraint — does it mean you can't work?

Do you think the job opportunities available to you are restricted because of your/your child’s health? (In what ways would certain jobs make your health worse?)

What do you need to help you move into work?
- Job search help?
- Job matching? (finding job that they can do despite health problem)
- Training/education?
- Confidence-building?
- Information on childcare options?
- Specialist childcare for children with health problems?
- Assurance from doctor?
- Help from/supportive employers?
- Other?

Have you had any help, or tried to get any help, with any of these?
• Have you had to give up a job because of a health problem?
  – Was your employer aware of problem?
  – Any support from your employer?

What could the Jobcentre do to help you?
• Have you heard of the New Deal for Lone Parents? (explain what it is)
• What would attract you to join NDLP?
• Any experiences of NDLP — why did you leave?
• Would you be happy to discuss health with PA?
• Could the Jobcentre do more to help you?
  – Advertise NDLP?
  – Ask about health problems?
  – Help with finding jobs that they can do despite health problems?
  – Signpost to what support is available?
  – Having staff who speak other languages?
  – Group sessions with PAs and other lone parents?
  – Seeing lone parent PA, or disability/health PA?
  – Other?
Part Two – Lone parents on health-related benefits
12 Methodology

12.1 Sampling criteria

In addition to the sampling criteria of female lone parents in London, Newcastle and Leeds/Bradford (see Introduction), there were a number of sampling criteria in Part Two of the research.

Given that the research was designed to focus on lone parents claiming health-related benefits, the sampling criteria included those:

- claiming Income Support with Disability Premium (ISDP);
- claiming Income Support with Disability Premium and Incapacity Benefit (ISDP plus IB); and
- those who stopped claiming Income Support and started claiming Incapacity Benefit when their youngest child turned 16 years old (referred to in this report as ‘movers’).

Lone parents with a child under 16, claiming IB without IS were not included, as Incapacity Benefit administrative data are not reliable for counting the number of lone parents receiving only IB (see Introduction). The sample was designed to include more lone parents claiming ISDP than those claiming ISDP plus IB.

The sample was designed to include lone parents who had been claiming health-related benefits for different periods of time, with an emphasis on those who had been claiming for under two years. The sample was also designed to include lone parents with a youngest child of different ages.

12.2 Recruiting the sample

To recruit lone parents for this research, Income Support data and the ONE database were used. A 100 per cent sample of all female lone parents in selected wards who were claiming the health-related benefits detailed above were requested. Sample One contained 1,891 cases of female lone parents claiming ISDP or ISDP plus IB. Sample Two contained 100 cases of female lone parents who stopped claiming IS and started claiming IB after their youngest child turned 16 years old (movers).

A check was made to see whether any of these lone parents, now on health-related benefits, had recently changed their benefit status, and had, therefore, been included in Part One of the research. It was found that five individuals interviewed as part of the previous study, were now claiming health-related benefits. All of these five lone parents had mental health problems and/or disabilities, and four also had physical health problems and/or disabilities.
Having removed these individuals from the sample, an opt-out procedure was then conducted. An opt-out, rather than an opt-in process, was selected to try and gain access to as many in the sample as possible, and to try and prevent particular groups disproportionately opting-in to the research. An opt-out letter (see Appendix H) was then sent to all the 100 cases of lone parents who had stopped claiming IS and started claiming IB after their youngest child turned 16 years old, and to 1,025 lone parents claiming ISDP or ISDP plus IB. These 1,025 were selected because the database contained telephone numbers that could be used in a telephone recruitment process. Incentives of £15 were offered, to encourage recipients to participate in the research. The opt-out letter also stated, in large print, that versions were available for blind and partially sighted people in large print, Braille, and electronically.

Of the 1,125 lone parents who were sent the opt-out letter, five per cent (58) opted-out. After receiving the opt-out letter, 14 lone parents contacted the research team to say that they would like to take part, and they were interviewed where possible, although in some cases, it was not possible to get hold of them during the recruitment period.

Recruitment was done by telephone. Whilst using telephone numbers to recruit respondents excludes those without telephones, it helped to ensure that the research was accessible to those with disabilities and/or health problems: by allowing respondents to select a time that suited them (for example, that did not conflict with their medication or treatment); by checking whether a respondent would like a support worker, carer, or advocate to be present; and by checking whether they needed a sign language interpreter (or a language interpreter). Using telephone recruitment meant that researchers could speak to family members or support workers where respondents could not speak English, or were unable to use the telephone. The telephone script that was used for recruitment is shown in Appendix I.

In practice, many of the telephone numbers in the Income Support data and the ONE database were incorrect, and although directory enquiries was used to try and find correct numbers, it meant that to achieve 40 interviews, 427 lone parents were selected from those who had not opted-out of the research, and who met our overall sampling criteria.

Recruiting movers was particularly difficult as there were only 100 lone parents in this category in all. It was possible to recruit four lone parents using telephone numbers from the database, and a further letter was sent to lone parents asking them for their correct telephone number, which enabled the recruitment of five more lone parents. A one day trial of doorstep recruitment in London was also undertaken, which achieved one interview. In all, therefore, a total of ten interviews with movers was achieved.

It was decided to recruit an additional ten movers, so another sample was obtained from London, Newcastle and Leeds/Bradford by using additional postcode sectors to the ones used in the original sample. This sample contained 300 lone parents. In response to the difficulties experienced using an opt-out process with the mover group, a letter was sent to all of these lone parents asking them to opt-in to the research. Seventeen lone parents opted-in to the research, of which, ten were interviewed.

12.3 Description of the sample

Fifty-four lone parents were recruited for interview. In two cases, it was discovered during interviews that whilst Income Support data and the ONE database classified these individuals as lone parents, they were not lone parents, and were in fact cohabiting with husbands or partners. In these cases, the
Methodology

interviews were completed, but are not included in the analysis presented in this report. This leaves 52 lone parents whose characteristics are described below.

12.3.1 Area
The sample was split by area, as follows:
- 16 in Leeds/Bradford;
- 18 in Newcastle; and
- 18 in London.

12.3.2 Benefit type
The sample was split by benefit type, as follows:
- 20 ‘movers’;
- 19 claiming ISDP; and
- 13 claiming ISDP plus IB.

12.3.3 Length of claim
The sample was split by length of claim of health-related benefits, as follows:
- 19 had been claiming for less than one year (including ten movers);
- eight had been claiming for between one and two years (including five movers);
- 16 had been claiming for between two and five years (including five movers); and
- nine had been claiming for between five and 12 years.

12.3.4 Age of youngest child
In terms of the age of their youngest child:
- nine lone parents had a youngest child aged under five;
- 12 lone parents had a youngest child aged from five to ten;
- 11 lone parents had a youngest child aged from 11 to 15;
- 20 lone parents had a youngest child aged from 16 to 18 (the ‘movers’).

12.3.5 Ethnicity and age
Whilst ethnicity or age of lone parents were not sampling criteria, a diverse range of ethnic groups, and ages of lone parents, were represented within the sample.

Lone parents were asked to self-define their ethnicity. In the sample there were:
- 31 White lone parents;
- 11 Black lone parents;
- three Pakistani lone parents;
- three Turkish lone parents;
• one Moroccan lone parent;
• one Egyptian lone parent;
• one Arab lone parent; and
• one Mixed Race lone parent.

The ages of lone parents interviewed varied, with:
• 15 being aged 19 to 35;
• 28 being aged 36 to 49; and
• nine aged 50 and over (up to age 57).

12.4 Conducting the interviews

After the interview topic guides were piloted (see Introduction), the main stage interviews were completed. Interviews were conducted in lone parents’ homes, to make it easier for them to take part in the research (except in one case, where a lone parent was interviewed at the office of one of the researchers, at the lone parent’s request). Interviews were recorded and transcribed in full, except in one case where the lone parent requested that the interview was not recorded, and so notes were taken by the interviewer, and these were then analysed along with the transcripts. In one case, a lone parent with cerebral palsy had a support worker present, and the interview was arranged through the support worker.

In a few cases (six in all), interpreters were used in interviews where a lone parent had English as a Second or Other Language (ESOL). In four cases, these were professional interpreters, and in two cases, family members interpreted at the request of the lone parent. Using interpreters worked well, although questions may have been re-phrased by interpreters, and researchers were reliant on interpreters to translate respondents’ answers accurately.

Family members translated the questions for the lone parent and translated their answers. They were not making comments on behalf of the lone parent or giving their own opinions. In some cases, the family member was the child of the lone parent. This raises issues about the extent to which lone parents are happy to discuss their true feelings in front of their children, and the impact on their children of translating issues around, for example, struggling to cope with mental and physical health problems and/or disabilities. It is worth noting that in these cases, children were used to interpreting for their parent; at the Jobcentre or benefits office, at the doctor’s and in other situations, whilst in some interviews with lone parents, whose first language was English, these issues were also discussed in front of children.

In some interviews, lone parents became upset when talking about their health problem and/or disability, and in three cases, described themselves as suicidal. In these cases, researchers ensured that respondents wanted to continue with the interview. In all cases, researchers asked questions sensitively and made it clear that respondents did not have to answer any questions they did not feel comfortable with.
12.5 Focus groups

Participants for focus groups were recruited from both those lone parents that had been interviewed, and also from those who had opted-in to the research but that had not been interviewed. Three focus groups were organised. In London, six lone parents attended the focus group, six attended the group in Leeds, and four attended the group in Newcastle. In both London and Leeds a language interpreter was used: in London a family member interpreted for one lone parent, and in Leeds a professional interpreter was used for one lone parent.

Lone parents were asked about their access needs for focus groups (for example, whether they need support workers, sign language interpreters, or language interpreters to be present). They were given £20 as incentives, and childcare and travel expenses were refunded. However, the nature of focus groups means that some lone parents in our sample will not have been able to participate. Those with health problems and/or disabilities that prevented them from leaving home did not participate, whilst others may have been prevented due to lack of confidence, or due to feeling unable to participate in a group situation. In these cases, where attending a focus group proved too difficult, getting help with moving into work may also be difficult, whilst actually moving into work may be harder still.

The topic guide was developed based on the interview topic guide and feedback from the interim presentation given at DWP, and focused on issues such as attitudes to work, support needs, how health/disability has affected work histories, and what Jobcentre Plus can offer lone parents with health problems and/or disabilities. The focus group topic guide is shown in Appendix K. All focus groups were taped and fully transcribed.

12.6 Analysis

Analysis of the interviews and focus groups was then conducted using the software Atlas.ti (see Introduction for details).
13 The circumstances of lone parents with health problems and/or disabilities

13.1 Introduction

This chapter examines the circumstances of those who took part in the research. It documents the details of the health problems and/or disabilities lone parents have, their work and benefit histories, and their attitudes to work and benefits. The differences between the three benefit groups (ISDP, ISDP plus IB, and movers) are stated where they exist.

It is worth noting that the details of the health problems and/or disabilities presented here are as they were expressed by lone parents themselves. In this research it is not possible to examine lone parents’ health problems and/or disabilities from a medical perspective. The intention is to give an indication of the range of health problems and/or disabilities that were reported within the sample.

13.2 Health problems and/or disabilities

In Part Two of this report lone parents are described as having ‘health problems and/or disabilities’. Defining health problems and disabilities is difficult because of the complex nature and different perceptions of what constitutes a health problem, disability or impairment. The term ‘health problem’ is used as a shorthand for having a health condition or impairment, as it is the term used by DWP in both commissioning this research, and in the research objectives.

Within our sample are lone parents with health conditions or impairments, who may or may not regard themselves as disabled. There are also lone parents who regard themselves as disabled, who may or may not regard themselves as having a health problem. Whether individuals with health conditions or impairments regard themselves as disabled is not clear cut, and it is discussed below whether lone parents in this sample regarded themselves as being disabled.
13.2.1 Types of health problems and/or disabilities

Physical health problems and/or disabilities
Many of the physical health problems and/or disabilities reported were degenerative diseases or hereditary conditions. Auto-immune diseases, such as rheumatoid arthritis, were also common amongst the sample. Few in the sample had a single physical health problem and/or disability. Some multiple health problems and/or disabilities were quite clearly unrelated. However, in some cases, one physical health problem and/or disability led to others, such as epilepsy linked to a previous brain tumour. Some health problems and/or disabilities resulted in other conditions through side-effects of medication.

The level of pain the sample reported was quite striking. Many expressed that coping with the pain was itself debilitating. Some of the sample had conditions which were unpredictable and this meant that they could get worse, and/or cause severe pain at any time. Sometimes this would result in immediate admittance to hospital. In these cases, there was a great fear amongst lone parents of the potential of the health problems and/or disability to suddenly change their lives quite dramatically.

Mental health problems and/or disabilities
The mental health problems and/or disabilities reported were mainly various forms of depression and anxiety. Some cases of psychosis were also reported, such as schizophrenia. Some participants reported self-harming and/or suicide attempts. Many of those who reported mental health problems and/or disabilities were currently, or had been, under psychiatric care, and had either spent time in residential psychiatric care or had been supported by community psychiatric nurses.

Health professionals had formally diagnosed most health problems and/or disabilities. In only a few instances were respondents waiting for diagnosis. A few of those who reported being depressed were not in touch with medical professionals on this health matter, but were so for other health problems and/or disabilities.

The interaction between mental and physical health problems and/or disabilities
Mental and physical health problems and/or disabilities were not necessarily mutually exclusive. Many in the sample reported both a physical and mental health problem and/or disability. Where the physical health problem and/or disability was very debilitating, depression was quite common. It is, however, also worth noting that some with physical health problems and/or disabilities were not depressed. Furthermore, depression was not necessarily linked to the physical health problem or disability. Some conditions, though not debilitating on a long-term basis, could also give rise to depression, for instance, having a mastectomy.

Children with health problems and/or disabilities
Although Part Two of this research was not directly concerned with the health of lone parents' children, it is worth noting that many in the sample had children who had health problems of their own. Having children with health problems, as well as having health problems and/or disabilities themselves, can be an additional constraint to work for lone parents, as shown in the first stage of this research.

There was quite a wide range of child health problems reported, but mental health problems and/or disabilities, and behavioural problems tended to dominate. In a few cases, the child was in contact with a psychologist for issues related to the parent’s health problem and/or disability. In one case, the child had the same health problem and/or disability as the parent due to the hereditary nature of the condition. In another case, where the parent had multiple health problems and/or disabilities, the
children also had health problems and/or disabilities that were very different to that of the parent.

13.2.2 Duration of health problems and/or disabilities
The mental health problems and/or disabilities tended to have been present for a significant number of years. Whilst it is clearly difficult to ascertain precisely how long participants have been living with mental health problems and/or disabilities, some of the sample reported that the health problem and/or disability had been present since childhood. Some lone parents said that they had only recently accepted or recognised that they had a mental health problem and/or disability, or had only recently started to deal with a traumatic event that had occurred in their past. For example:

‘The doctor says everything was just coming to a head. I had stuff from when I was nine and things had happened and I never talked to anybody about it.’

(ISDP)

Overall, health problems and/or disabilities were not always diagnosed or reported as soon as symptoms were apparent. For this reason, the length of time a health problem and/or disability had been diagnosed was not always indicative of how long the health condition had had an impact on the lone parent.

Some physical health problems and/or disabilities had been present since birth. Some others had occurred in childhood but, in the main, health problems and/or disabilities had developed in adult life. In only a couple of instances was the health problem and/or disability related to child-birth, or followed child-birth.

13.2.3 Prognosis of health problems and/or disabilities
Many of the conditions reported by the lone parents were permanent, and were likely to worsen rather than get better over time. For many in the sample, treatment helps them to deal with the symptoms but is not able to alleviate the health problem and/or disability altogether. Some of the health problems and/or disabilities reported included degenerative illnesses, with the changing nature of the health problem and/or disability making coping problematic. Those in the ISDP plus IB group, in particular, had health problems and/or disabilities that were quite rare, and as such, little was known about how to treat them. For example, in the case of a lone parent with a twisted spine, chronic pain syndrome, and a bladder problem:

‘They say there is nothing they can do. They see me every six months but there’s no cure. They don’t know how to treat it.’

(ISDP plus IB)

Those in the movers group seemed to know less about how their health problem and/or disability would develop in the future.

13.2.4 Do these lone parents see themselves as disabled?
The Disability Discrimination Act (DDA) 1995, defines someone as disabled if they have a mental or physical impairment that has an adverse impact on their ability to carry out normal day-to-day activities, where the adverse affect is substantial and long-term (meaning it has lasted for 12 months, or is likely to last for more than 12 months, or for the rest of their life).

The sample were asked whether or not they would describe themselves as disabled. No definition of
disability was offered, as the intention was to gain insights into how they perceived disability. Many did describe themselves as disabled. For some of the sample, the distinction between having a health condition and being disabled was not clear. In some cases, disability was regarded as something that affects only mobility. This was particularly the case for those with mental health problems and/or disabilities: despite the impact their health problem and/or disability had on their day-to-day life, they did not see themselves as disabled. Some of the sample reported that they had become disabled through illness.

For the most part, disability was not considered to be a constant or continual state. Rather, some of the sample reported being disabled some of the time, or from time-to-time. Some reflected the DDA definition of disability by considering themselves disabled because their health problem affected what they were able to do, and doing ‘normal’ things was made more difficult. Conversely, others thought that they were not disabled because, although health problems made life more difficult for them, they were still able to do ‘normal’ things. Many in the sample were more comfortable describing themselves as having a health ‘impediment’, rather than as being disabled.

### 13.3 Work and benefit trajectories

#### 13.3.1 Work and benefit histories

Many in the sample left work and began their first benefit claim when they had their first child. In a few cases, however, work had been sustained during the early years of the first child, and the move to IS occurred at the birth of the second child. Some others began claiming IS from the point at which they became a lone parent and were no longer supported through a relationship. Few had ever claimed Jobseeker’s Allowance (or equivalent at the time). Health-related benefits were rarely the initial benefit received. It was more usual for the health element of the IS claim to have occurred several years after the initial claim for IS.

From the onset of the initial benefit claim, many lone parents in the sample have remained outside the labour market, although a number had moved off benefit for short durations to move into employment. This tended to be part-time and, often for reasons entirely unrelated to health, they subsequently returned to benefit. A few others worked part-time whilst claiming, within benefit regulations. Work histories prior to the initial benefit claim were largely characterised by low-paid work, such as office work, shop work, cleaning, care work, and factory work.

A few in the sample had never worked. There were a number of reasons for this, including having their first child soon after leaving full-time education, being supported by a partner, and in some cases, their health problem and/or disability having always precluded the possibility of work (as reported by respondents).

Within the sample were two lone parents with refugee status. Their initial claim for benefit commenced from the date they were able to claim and these lone parents had not worked in the UK. Some of those lone parents with English as a Second or Other Language (ESOL), who were not refugees, also had no work history in the UK, or at all. In some cases, this was linked to the attitude of their ethnic community towards mothers working.

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6 Although it is possible that there may have been more, as this was not asked directly.
The circumstances of lone parents with health problems and/or disabilities can have an impact on work and benefit histories. This is illustrated in the pen portrait below.

Sonia has two children; a son, 26, and a daughter, six. She and her eldest son have an hereditary disorder. She worked in an administration post for 16 years and has only recently started claiming health-related benefits. Her employer was sympathetic to her health problem; she regularly took extended periods of leave, and attempts were made to accommodate her comfortably in the small office environment. Quite recently she was made redundant, but Sonia believes that they had to let her go because she was not always able to work well. Her condition has become progressively worse and is likely to continue to worsen. She has recently had a hip and both shoulders replaced. Sonia has not always considered herself to be disabled, but she does now due to her poor mobility. She takes regular pain-relieving injections that she is able to administer herself at home. Sonia sometimes feels suicidal, as she does not want to live as she is any more. She has some support from social services, who help with housework and shopping. Sonia would like to work but thinks that it is becoming less of an option as her health deteriorates. She would like more support to cope with her health problem, and her daughter.

13.3.2 Differences in work and benefit histories across the three benefit groups

The ISDP plus IB group tended to have spent less time on benefits than the other two benefit groups. In several cases, work had been sustained throughout parent/lone parenthood, until the onset of the health problem and/or disability. Furthermore, the work histories of this group are characterised by higher-skilled work than the other two groups, though only marginally so.

The movers group reported much longer durations on benefit, overall, than those in the ISDP plus IB group, often lasting more than ten years and, in one case, 30 years. They also appear to have substantially less work history than the other two groups, and had often not worked since they had children.

13.3.3 Attitude to benefits

Perhaps unsurprisingly, the sample had a negative attitude towards benefits, with most wishing that they were not dependent on support from the State. Receiving benefits invoked feelings of worthlessness and even embarrassment and shame. For example:

‘I don’t like it at all. It’s not who I am and how I was raised. It makes you feel like a scrounger.’

(ISDP plus IB)

Benefits were seen as insufficient to support lone parents and their families and meant that they rarely had any money to spare. None could afford what they termed ‘luxuries’, and were keen to point out that there was little financial incentive to remain on benefits.

Not working and claiming benefits was perceived to lead to a great deal of negative social stigma. Focus group participants discussed how there is pride in working, being busy and being productive. Being dependent on state support and being relatively inactive, in many cases not even leaving the house, therefore generated feelings of exclusion and being on the margins of society for some focus group participants. Some focus group participants discussed in-depth that they felt ‘outside’ of...
The circumstances of lone parents with health problems and/or disabilities

society. They felt excluded in a number of ways; financially, through the social stigma of being outside the labour market, and additionally by being disabled.

These feelings of marginalisation can be intensified by the system of social security administration. The process of ‘asking’ for benefits and justifying the claim, whilst appreciated as necessary, was considered to be humiliating. Being so completely dependent on State support was seen, in itself, as demoralising by focus group participants, given that if benefits are stopped, even temporarily, it can have a huge impact, as most in the sample have nowhere else to turn for financial support. For example:

‘It’s not just the fact that you have to take money from somebody else, it’s also the thing about the way you’re treated when you do that. The process of going to the Benefit Agency, of having to explain to somebody – there’s a lot of humiliation around it, especially when they mess up your payment book and you have to say, ‘Look, I’ve got a three year old child, I have no food in the cupboard and no bank account is going to give me an overdraft to pay this. I have nothing’.’

(Focus group participant)

Whilst, without exception, the sample did not relish the idea of being on benefits, both now and in the future, they were considered to be ‘a necessary evil’, and many felt that there was no other alternative for them, given their set of circumstances. Focus group participants were eager to discuss the negative stereotypes in society about lone parents who receive benefits and, in particular, about those claiming health and disability benefits. Some were exasperated by assumptions that they might find being on benefits preferable to work, or even tolerable.

13.4 Summary

Examples of both physical health problems and/or disabilities, and mental health problems and/or disabilities, were reported in the sample. Mental health and physical health problems and/or disabilities were not always mutually exclusive. In many cases, there were several health problems and/or disabilities occurring at the same time. Between the three benefit groups there was no difference in the durations of the health problem and/or disability.

Many in the sample had been given a poor prognosis, though notably, the mover group tended to know less about how their health problem and/or disability would develop, than did the other two benefit groups. These lone parents would benefit from more information about their health problem and/or disability, for example, how it may develop, and advice on how best to manage it.

Not all lone parents in the sample described themselves as being disabled. Disability was often considered to be to do with mobility, and for this reason, some did not consider themselves to be disabled, as their health problem did not affect their ability to walk. Many in the sample explained that they were disabled through illness, rather than ‘born disabled’. Disability was not considered to be necessarily continuous. Many considered themselves disabled from time-to-time, depending on how their health problem changed. Many were more comfortable describing themselves as having a ‘health impediment’ rather than as being disabled.

Many in the sample began their first benefit claim when they had their first child, or when they became a lone parent. Health-related benefits were rarely the initial benefit received: it was more usual for their health element of the IS claim to have occurred several years after the initial claim to IS. From the onset of the initial benefit claim, many had remained outside the labour market, although a number had moved off benefit for short durations to move into employment.
Most of the sample had worked at some point, although a few had never worked. Work histories prior to the initial benefit claim were largely characterised by low-paid work. The ISDP plus IB group had longer work histories, overall, than those in the other benefit groups. This is unsurprising, as they would have had to make enough National Insurance contributions to be eligible for IB. They had also worked in marginally more skilled, and better paid jobs. The sample generally had a negative attitude towards benefits and did not like being dependent on support from the state.
14 How health problems and/or disabilities affect lone parents’ decisions about work

14.1 Introduction

This chapter explores the range of constraints that lone parents claiming health-related benefits experience, and looks at the extent to which the health problem and/or disability is a constraint to work. It considers the impact health problems and/or disabilities have on day-to-day activities (drawing on the subjective accounts of the sample), and looks at the ways in which work aspirations are affected as a result.

14.2 Impact of health problems and/or disabilities on normal day-to-day activities

For most of the sample, health problems and/or disabilities had a significant impact on their ability to carry out normal day-to-day activities. Normal day-to-day activities are defined by the 1995 Disability Discrimination Act (DDA), as:

- mobility;
- manual dexterity;
- physical co-ordination;
- continence;
- ability to lift, carry, or move everyday objects;
- speech, hearing or eyesight;
- memory, or ability to concentrate, learn, or understand; and
- understanding of the risk of physical danger.
Many in the sample reported having difficulty with at least two of these factors. Problems with mobility, in particular, featured strongly, as did manual dexterity and the ability to lift, carry, or move everyday objects. Many reported having difficulty doing housework or shopping because they were unable to carry bags, bend, put force behind the vacuum cleaner, change bed covers and so forth. Standing for long periods or sitting for long periods had an impact on many activities. For example, some focus group participants had to stand up and move around several times within the hour and a half period of the focus group. Manual dexterity, too, was an issue for many in the sample, who experienced difficulty peeling potatoes or writing. In some cases, these difficulties meant that considerable support was required, from either care professionals or family and friends (see Chapter 15).

Mornings were reportedly often the most difficult time of the day. Both those with physical, and those with mental health problems and/or disabilities found that getting out of bed generally took a long time, as did getting washed and dressed. Plainly, there may be quite different explanations for experiencing this difficulty with mornings. However, it is worth noting that both those with physical health problems and/or disabilities, and those with mental health problems and/or disabilities expressed that their difficulty with getting up in the morning was often, in large part, to do with their willingness (or rather a lack of it) to start the day.

Some of the sample had problems with continence which affected their ability to go out. In one case, the respondent had been diagnosed with Fowler syndrome (which leads to the bladder capacity being greatly reduced).

In a few cases, it was expressed that the health problem and/or disability had an impact on their ability to function as a parent as they would like to. For instance, making breakfast, helping the children get dressed and taking them to school, was made difficult and at times impossible by the health problem and/or disability.

Many in the sample reported feeling weak, drained and tired. Though not leaving them physically unable to perform tasks, some health problems and/or disabilities, at times, left respondents feeling too tired to perform ordinary routine tasks. In addition, medication in some cases caused, or contributed to, feelings of fatigue. For those who have quite severe pain, the medication taken for pain relief can result in them being inactive and sleepy for long periods.

The impact of the health problem and/or disability on ability to carry out normal day-to-day activities was set to worsen for many in the sample, who displayed progressive conditions such as arthritis.

The extent to which the health problem and/or disability affects normal day-to-day activities can differ from one day to the next. In many cases, good days and bad days were experienced. Bad days could mean a total lack of mobility, and the need to stay in bed all day. On good days, most normal activities could be accomplished without causing a great deal of strain or discomfort. For example:

‘When it’s OK, I can walk and drive and do housework. It’s when it [back] goes, that it’s bad.’

(ISDP)

Some lone parents in the sample expressed an unwillingness to leave the house. This was often due to fear of experiencing physical pain in public, or being too far away from a toilet, or fear of becoming too weak and experiencing difficulty getting back home. Those with mental health problems and/or disabilities, in particular, had problems with leaving the house, which had a substantial impact on their ability to perform normal day-to-day tasks.
In some cases, the fear of having a panic attack in public was the main concern, whilst some others simply felt unable to be in crowds or visit unfamiliar territory. The home represented ‘safety’ for some and leaving home caused great concern and anxiety. The outside world, with all its potential for unpredictability, was simply not an option for a few cases, who had felt unable to leave their own home for an extended duration. For example:

‘If it was something really important and I had to go out, even if my life depended on it, I couldn’t go out the door.’

(mover)

Town centres and shopping centres appeared to present the biggest challenge to lone parents with mental health problems and/or disabilities. These environments could lead to feelings of claustrophobia. For example:

‘If I go shopping, I’m sweating and looking around, and thinking everybody’s looking at me. I leave my shopping and walk out of the shop.’

(ISDP plus IB)

There is no difference between the three benefit groups in terms of the extent to which the health problem and/or disability affects day-to-day activities.

14.3 Constraints to work, other than health problems and/or disabilities

The sample cited several constraints to working, other than health problems and/or disabilities. As might be expected, many in the sample reported lack of childcare, or lack of information about available childcare as a constraint to them moving into work. In some cases, the problem was not just with accessing general childcare but in accessing specialist childcare. As some of the sample had children with health problems, including mental health and behavioural problems, very specific childcare would have to be obtained. Some lone parents wanted childcare for older children, as they did not want to leave them alone after school.

A lack of English language skills was also cited as a constraint to work. Lone parents in this group tended to have a very limited work history, and in many cases had been outside of the labour market for most of their adult life. Not being able to speak English had never really been a major difficulty for them, as they had the support of their extended family and community. For the lone parents in the sample with ESOL needs, there is an awareness, however, that a lack of English would present a significant problem in the labour market. The lone parents with ESOL needs in the movers group felt that, even though their eldest child was 16 or over, work was not a possibility because of their poor English and, moreover, some felt that it was now too late to learn. For example, one family member who was interpreting for a lone parent explained:

‘She says she doesn’t think she will be able to learn English. I tell her to go but she doesn’t want to.’

(mover)
Clearly, a lack of recent work history was a constraint for many of the sample. For example:

‘It [going back to work] would frighten me. I get on with people. It’s just the thought of going back after all these years.’

(ISDP)

This was sometimes linked to age, with older lone parents worrying that they would be discriminated against in the labour market because of their age and lack of recent work experience.

A lack of qualifications and skills was also a constraint. Most of the sample had not engaged in learning since leaving compulsory education, and in some cases, had left without gaining any qualifications. Re-training was also an issue for some, who, although they had some skills in a particular industry, would need to gain new skills in order to work in a job which did not exacerbate their health problem and/or disability.

Making work pay is an issue for many benefit claimants considering moving into work. Focus group participants were concerned about this issue, particularly because of the additional costs they would incur, once in work, due to their health problem and/or disability. Many were unclear about what additional financial support they would get once in work, and whether or not costs such as prescriptions, having grocery shopping delivered, and taxi fares, would be taken into account as part of a ‘better off in work’ calculation. In some cases, it was the less obvious costs associated with the health problem and/or disability that caused concern amongst focus group participants, such as paying friends and neighbours to take their children on outings that they would be unable to attend themselves because of their health problem and/or disability.

Problems with confidence and self-esteem were common in the sample, both for those who reported depression and anxiety, and for those who did not. There was a fear of going into work and a fear of approaching employers at all. In many cases, this fear of work was due to having been outside of the labour market for so long, and is not different from what other long term economically inactive people, who are not lone parents, might also feel (for example, Molloy and Ritchie, 2000). The ISDP plus IB group cited confidence, as a constraint to work, comparably less.

A constraint which is, perhaps, more typical to lone parents with health problems and/or disabilities, is a perceived lack of supportive employers. Many lone parents in the sample thought that employers would be unsympathetic to those with health problems and/or disabilities and would rather employ someone without health problems and/or disabilities, than accommodate them in the workplace. For example:

‘I think it’s employers. Anything else I can always get organised.’

(ISDP)

In the main, a health problem and/or disability was considered to be the main constraint to work, above all other constraints. This was the case even where the other constraints were seen as quite severe.
Interestingly, while these lone parents feel that health problems and/or disabilities are the primary reason for not working, the sample was fairly evenly split when asked whether they considered health/disability or lone parenthood to be the pivotal aspect of their identity. However, it emerged that even where respondents saw themselves first and foremost as lone parents, rather than as someone with a health problem and/or disability, the health problem and/or disability was the factor that resulted in economic inactivity. For example:

‘In terms of being a single parent, there’s a lot of single parents out there, and they manage, and I managed for a while. It’s just the health problem on top that makes it difficult.’

(ISDP)

The extent to which constraints are perceived or actual is almost impossible to ascertain. That said, it would appear that some factors are mentioned as constraints before any attempt has been made to discover what support is available. This is especially the case with childcare. Many in the sample pointed out, correctly, that they would require childcare. Yet this only becomes a constraint when it is discovered that there is a lack of childcare, it is unsuitable, or unaffordable. There is little evidence to suggest that lone parents, in the sample, are knowledgeable about what childcare is available.

The focus groups explored in more depth the extent to which constraints are actual, and whether or not efforts had been made to overcome constraints. Interestingly, some focus group participants cited constraints to work because they had heard that these would be likely to be obstacles which would be difficult to overcome. Indeed, recent television advertisements with strong imagery of lone parents breaking barriers and jumping hurdles in order to gain employment had given some focus group participants the view that moving into work would be difficult. Focus group participants felt that having a health problem and/or disability would present them with an additional constraint. Arguably, for some lone parents, constraints such as ‘lack of confidence’ could be overcome through working. But the extent to which lack of confidence is a perceived or actual constraint to working, will differ from person to person. Indeed, constraints or barriers to working, overall, are subjective, and the same factor may be more or less of a constraint for one lone parent than another.

The perception of unsympathetic employers was not always based on experience. Many in the sample imagined that employers would be unsympathetic to their own set of circumstances. Where respondents considered themselves to be ‘unfit’ for work, they also anticipated that employers would hold the same view.

14.4 Wanting to work and being ready to work

For the sample overall, health problems and/or disabilities were the primary constraint to work. Lone parents felt that their health problems and/or disabilities would affect the type of work that they could do in a number of ways. For example, in terms of the work environment they would need, the tasks they could do, the hours they could work, and needing flexibility when their condition fluctuated. Furthermore, in many cases, lone parents felt that they could not work at all because of the health problem and/or disability. In only a few cases did respondents feel that they could work with support, at the time of interview.

7 The complex interaction between various aspects of identity amongst disabled people has been recently explored in other research (Molloy et al., 2003).
However, many wanted to work, although they did not feel ready to do so because of their health problem and/or disability, and in some cases, were desperately keen to do so. Work was considered to be something that those who lead ‘normal’ lives do, and lone parents felt that there were a number of benefits to working: being financially better off, getting out of the house, being independent, building their confidence and meeting new people. For example:

‘I never go anywhere. It would be nice to meet different kinds of people and get to know them instead of just sitting in the house looking at the four walls or telling your kids off’.

(Focus group participant)

Being unable to work was reportedly very frustrating. At times, some of the sample were visibly upset during interviews because they were not working. However, some did feel that working in the future might be an option, though they gave little indication of when that might be. This was often dependent on their condition improving.

There were a number of cases in which respondents expressed that they did not really want to work. This was primarily due to feeling that they ought to be at home to look after their children. The age of children was a factor here, with those preferring to stay at home having younger children. Others did not want to work because they felt it was too late or too difficult for them to overcome their other significant constraints to employment. This was particularly the case for those who reported basic skills needs and ESOL.

There was another group in the sample who thought that work might be a possibility if they could find the right job. Those who expressed this were mainly concerned with working in a relatively ‘stress free’ environment, and with not taking on a great deal of responsibility. Some of these had previously left jobs because they found the work too stressful.

Plainly, the extent to which work could have a positive impact on health depends very much on both the nature of the health problem and/or disability and the type of work. Overall, though, few in the sample felt that working would improve their health/disability. Where it could, it was thought that working might actually help to build confidence and restore self-esteem. To put it very simply, some felt they would be happier in work. More usually the case though, was the feeling that work would be impossible, and that if a job was taken it would invariably have a damaging effect on health. This was the case among lone parents with both mental and physical health problems and/or disabilities.

Some voiced concern over their ability to sustain work, assuming they were able to take up a job initially. Often, the changeable nature of health problems and/or disabilities meant that whilst work could be manageable on one day, it might not be on another. Focus group participants expressed the view that it is not worth the ‘effort’ to move into work and that there is little point in trying as, more than likely, they would fail in their attempt. Whilst most did want to work, after taking all the complexities of their situation into account, along with the fear that they would have to leave a job after a short period, some focus group participants felt that moving into work might not be worth it. Some were concerned about having to re-apply for benefits if the job did not work out, both because of the process involved and the fear of having a period with no income. Some focus group participants reported that their concerns had not been challenged by advisers they had come into contact with at Jobcentre Plus, thereby, confirming their view that their circumstances were not conducive to working.

In addition, some lone parents were not sure how they should respond to questions around wanting to work, given the mixed messages in the media and society at large about working mothers. Some expressed that even in the absence of the health problem and/or disability, they would be unsure
whether working full-time, for example, would necessarily be the right thing to do for their children. For example:

‘It’s a complete contradiction. On the one hand, we’re told to go out and work because that’s the best example, and on the other we are told to spend more time with our children. Take away the health issue, but at the same time I would still have to be home at a decent time of day to see my child.’

(Focus group participant)

14.5 Work history and health problems and/or disabilities

Across all three benefit groups, lone parents in the sample had left work in the past due to health problems and/or disabilities. Either the health problem and/or disability had begun whilst they were in work, or had worsened, which had an impact on their ability to cope with working. Comparably more in the ISDP plus IB group had left work because of their health problem and/or disability. This may be due, in part, to the fact that they had more extensive work histories than those in the ISDP and mover groups, and therefore, more would have left work due to health problems and/or disabilities than in the other benefit groups.

Some of the sample gave up work from the onset of the health problem and/or disability, or left work to have an operation and then did not return. More commonly, the health problem and/or disability became worse, or it became more difficult to cope with work and the health problem and/or disability, when other factors changed. For example, depression suddenly became worse due to family bereavement, or relationship problems, and therefore work became too difficult to cope with. Some felt that, due to the influence of a number of factors, they had reached a ‘crisis point’, where work was no longer possible.

Among those with physical health problems and/or disabilities, some of the sample had been aware of their condition for some time and had been able to live with it. It appears that where there was very poor prognosis, work was sustained for as long as it was feasible, until such time as the condition, expectedly, deteriorated.

Some of those who had worked with a health problem and/or disability had told their employers about it. Where they had, it would appear that employers had generally been sympathetic and, in some cases, had made a conscious effort to help the person maintain their job. For example:

‘They were really good. Times when I couldn’t go in they’d come and pick me up. They were really understanding.’

(mover)

‘When I started working they would tell me, ‘if you feel too tired, you take a seat and rest a little’.’

(mover)

‘They [employer] made every allowance possible.’

(Focus group participant)
Employers offering support, as reported by the sample, included everything from allowing time off, to making adjustments for them in a workplace designed by and for non-disabled people. In the case of one focus group participant, the employer was initially very helpful in accommodating them in the workplace, but as the working environment and working practices changed, thought was not given to the impact this might have on an employee with a health problem and/or disability.

Others in the sample had opted not to tell their employer about their health problem and/or disability, and simply left their job without discussing it with their employer. In some cases, there was no expectation on the part of the lone parent that the employer could do anything to accommodate them, with instances of this occurring particularly where the job was quite physical, such as cleaning jobs.

In some cases, embarrassment prevented lone parents in the sample from telling the employer about the health problem and/or disability, and so they did not give the health problem and/or disability as their reason for leaving. This was especially the case for those with mental health problems and/or disabilities, who found it difficult to discuss their health problem and/or disability with others. Some focus group participants reported having, in the past, been too depressed to reach out to anyone, least of all to their then boss. In one case, a focus group participant had left work after being unable to carry on in her job without ‘bursting into tears’. Not coping and being unable to deal with stress in the workplace is something that focus group participants said that they would be likely to conceal as far as possible. Not surprisingly, few focus group participants had, in the past, felt able to tell former employers that they were unable to perform well at work because they were frequently emotional and tearful. For example:

‘They were the sort that, ‘If you can’t do the job, we’ll get someone else’.’

(Focus group participant)

Often, it was the individual and not the employer who made the decision to stop working. Even where employers had made allowances and efforts to accommodate an employee with a health problem and/or disability, the job was left because they ‘felt like a spare part’. Many in the sample were keen to feel useful and did not want to feel that they were different from other colleagues, or other working people more generally. It seemed that it was often lone parents themselves, and not employers, who felt that they were not able to do the job ‘properly’.

It is worth noting that in a few cases, the health problem and/or disability had become apparent, coincidentally, at the time of leaving work. For instance, in one case, the respondent had left work because it was no longer financially rewarding, as her husband, who provided the full-time wage, had just left her. Coincidentally, a health condition was diagnosed that she had displayed for some time, and it was recommended that she leave work. Whilst in this case, work would have been discontinued even without the health problem and/or disability, the health problem and/or disability has since become the primary reason for not considering future work. There were also some examples in the sample of lone parents returning to work with a health problem and/or disability, but soon leaving after finding it difficult to cope with.

Some lone parents might have been able to continue working if they had support to stay in work, for example, by employers being more flexible about lone parents’ needs to take time off because of a health problem. Employers could, perhaps, also do more to encourage employees to discuss their, or their children’s, health problems, and to work with employees to make adjustments to the nature of the work, or working hours, for example, to help lone parents continue in work. From 1 October 2004, small employers (those employing 14 people or less), will be brought into the scope of the employment provisions of the Disability Discrimination Act (DDA) 1995. One of the provisions of the
DDA is that employers are obliged to make reasonable adjustments for disabled staff, both in their work, and in the recruitment and selection process. Employers could be encouraged to develop good practice for all employees with health issues, whether or not these employees are defined as disabled under the Act.

14.6 Summary

In summary, health problems and/or disabilities reportedly had a significant impact on lone parents’ ability to carry out normal day-to-day activities. In particular, many in the sample reported difficulty with mobility and manual dexterity. For some of those with mental health problems and/or disabilities in the sample, normal everyday life was affected by fear of leaving the house and the potential for episodes of anxiety in public. Many in the sample reported having good and bad days and, therefore, the extent to perform normal day-to-day activities differed from one day to the next. There were no obvious differences, between the three benefit groups, in terms of ability to carry out normal day-to-day activities.

Health and/or disability was considered to be the primary constraint to working, with health/disability affecting the type of work lone parents could do, and many in the sample feeling unable to even consider the possibility of work, in light of their health problem and/or disability. Several other constraints to work were reported, but it was felt that the health problem and/or disability overshadowed these. All of the constraints, other than health/disability, were typical of those that lone parents without health problems and/or disabilities face, with the exception of the fear of ‘unsympathetic’ employers.

In the main, the sample wanted to work, although many did not feel ready to work because of their health problem and/or disability. There were a few lone parents who did not want to work because they felt that they were unable to overcome constraints other than their health problem and/or disability, and others who felt that they would not work anyway because they wanted to be at home for their children. Some of the sample felt concerned about their ability to sustain work, and there were mixed feelings about the impact working might have on their health problem and/or disability.

Some of the sample had left work in the past due to health problems and/or disabilities, particularly those in the ISDP plus IB group. In some cases, the health problem and/or disability had started whilst they were in work, and in others, the health problem and/or disability had significantly worsened, resulting in their departure from work. Where lone parents in the sample decided to leave work, some had not felt able to discuss their health problems and/or disabilities with employers, whilst others had received support from their employer but resolved to leave anyway, as they did not feel able to carry out their job. This suggests that whilst lone parents with health problems and/or disabilities want supportive employers, they also do not want to be singled out as different, or to feel that they are in any way a drain on their employer. Employers could be encouraged to develop good practice for all employees with health issues whether or not these employees are defined as disabled under the DDA.
15 The support needed and received by lone parents with health problems and/or disabilities

15.1 Introduction

This chapter examines the medication and treatment that lone parents on health-related benefits are receiving, to manage their health problems and/or disabilities. It goes on to examine what support these lone parents receive from professionals as well as from friends and family, and looks at whether, and how, lone parents are coping with their health problems and/or disabilities. It then explores the types of extra support lone parents need to better manage their health problems and/or disabilities, which may also enable them to move closer to the labour market.

There are no major differences in terms of support received and support needs between the three benefit groups, so lone parents in the sample are discussed in this chapter as a single group.

15.2 Medication and treatment

Lone parents on health-related benefits were receiving a wide variety of medication and treatment to manage their health problem and/or disability. Several lone parents had had operations (for conditions including cancer, gallstones, hysterectomies, joint replacements, and amputations), and others were currently waiting for operations. Lone parents were also receiving medication for a variety of conditions, including: depression, heart problems, tuberculosis, epilepsy, arthritis, diabetes, high blood pressure, and under-active thyroids, and were taking sleeping tablets, painkillers and hormone replacement therapy, and were using creams or inhalers.

As well as operations and medication to help manage their health problems and/or disabilities, lone parents also received injections for pain and arthritis, attended pain clinics for pain management, had physiotherapy and osteopathy, had been through drug treatment programmes, used wheelchairs, and in one case, had a guide dog. Some lone parents in the sample had received diet advice (such as eating more fruit and vegetables) and exercise advice (although some found doing the recommended
exercise too painful). Others had been advised to stop smoking. A group of lone parents in the sample had regular hospital appointments, and for mental health problems and/or disabilities, lone parents used mental health services such as counselling, and in a few cases, psychiatric in-patient care.

15.3 Support received

As well as having a wide variety of medication and treatment, lone parents on health-related benefits had support from a wide range of medical and social care professionals. Medical professionals seen included general practitioners (GPs), health visitors, physiotherapists, occupational therapists and attendance at pain clinics. For mental health problems and/or disabilities, lone parents had access to psychiatrists, counsellors, mental health teams and crisis teams. Many in the sample found this support helpful. For example:

‘I feel better talking to a stranger. I can bring out things I have not been able to bring out before.’

(mover)

However, some of the sample found it difficult to access the support when they needed it, and had to turn to friends and family whilst they waited to access formal help. For example:

‘They’ve got this support system, when things get really bad there’s a crisis team you can turn to, and they take forever. Because I was feeling so desperate and I could see myself, again, threatening to take my life, a friend came down and stayed with me for the whole day.’

(ISDP)

Support from social care professionals included support from day centres, community nurses, social services, social workers and home carers. The types and intensity of the support provided by these professionals varied.

One lone parent who used a wheelchair had a community nurse who came to her home daily, in the morning and evening. Lone parents received help from social services that included mobility training, putting in banisters, seats for baths, and installing showers in homes. Social workers provided support to lone parents individually and through family support groups. Home carers provided support to some lone parents in the sample daily, and others weekly or fortnightly, which many in the sample felt they could not manage without, as it meant that they did not get so tired or depressed, and meant that they were able then to spend more time with their children. The importance of this type of support is illustrated in the examples below:

‘I got a lot of help from the community nurse to find out about, when I was really bad, about my wheelchair and equipment I needed, and what things I would have to use.’

(ISDP)

‘I couldn’t manage without it [home carer support]. It takes away some of the guilt with my friends and family helping me.’

(ISDP)

Some of the sample used Disability Living Allowance (DLA) to pay for someone to help around the home, whilst others had support for their health problem and/or disability from disability organisations (such as the Guide Dogs for the Blind Association), or from support groups for people with their health conditions (such as epilepsy and arthritis). For example:
The support needed and received by lone parents with health problems and/or disabilities

As well as support from health and social care professionals, and disability organisations, lone parents received a great deal of support for their health problem and/or disability from friends, neighbours, former partners, family members and their own children. This support included: being taken out of their homes, having letters read for them, shopping, decorating, gardening, housework, cooking, childcare, personal care (such as bathing and dressing), emotional support, and in one case living with relatives. Lone parents often felt embarrassed or guilty at having to receive such a lot of support from family and friends, and their own children, who often helped a lot with personal care. For example:

‘It’s embarrassing asking an 11 year old boy, ‘can you come and help me because I’m stuck in the bath?’ I can’t bend down and get my trousers on, and the bairns have to help in that way.’

(ISDP plus IB)

It is worth noting though that a few lone parents reported being alone, without any family or friends to support them. In the case of one lone parent with depression, taking part in the focus group was the only occasion that she has had to talk to anyone at all about her health problem. She explained that since her husband had left her she had, ‘built my own world inside the house because people laughed at me’. English is not her first language and she left her extended family and friends in Turkey several years ago, making the possibilities for informal support even more difficult.

For some focus group participants with mental health problems and/or disabilities, reaching out to friends and family for support becomes difficult when the friends and family do not understand the nature of their problem, and feel that the lone parent should simply ‘cheer up’. Furthermore, some focus group participants felt that other people have their own problems and so may not want to offer support to someone with depression. For example:

‘Going to someone’s house to talk about it gets them all down. People don’t want to see you moaning.’

(Focus group participant)

15.4 Coping with health problems and/or disabilities

Most of the sample received a lot of practical support to manage their health problem and/or disability. As well as asking the sample about the support they received, they were also asked whether they felt they were coping with their health problem and/or disability.

Some of the sample did not feel that they were coping, or were finding it very hard to cope. They felt that their health problem and/or disability was ‘getting them down’ and worried about coping. Others felt that they had to cope and just had to ‘get on with it’. For example:

‘I’ve got to cope. I’m not going to sit in a corner and cry about it.’

(ISDP plus IB)
‘You just get on with it. I do have help - my sister, and family, and doctor, but at the end of the day it’s down to me to try and push myself and do what I can.’
(ISDP)

‘I cope because I’ve got a daughter of 12. I’ve got to get on with my life.’
(ISDP plus IB)

Others had developed coping strategies, and had learned to manage their health problem and/or disability and were now coping better than they had in the past. Coping strategies included taking each day at a time, not planning ahead, going straight home if they developed a panic attack, lying down, keeping warm, relaxation tapes, and running their hands under cold water when they were thinking of self-harming. In some cases, medication is the key to enabling them to cope. For example:

‘I can cope with everyday life. Before I couldn’t.’
(ISDP)

One lone parent said that smoking helped her cope, whilst another got satisfaction from setting herself small achievable tasks:

‘On a practical level, when I accomplish tasks I just take satisfaction, or I’ll do tasks that I can instantly achieve, like dusting.’
(ISDP)

15.5 Extra support needed

Some of the sample felt that they had all the support they needed or wanted, or that they did not think any additional support could help them. For example:

‘I don’t know what anyone else could do.’
(mover)

‘I used to have someone taking the children to and from school, I had the shopping, ironing. I’m the one who decided to stop it. I feel I’ve been robbed of my independence. I want to do things for myself and I’ve got the children, when they get older, they’re more independent.’
(ISDP)

‘It doesn’t come naturally to me to reach out.’
(ISDP plus IB)

However, despite the high level of professional support, and support from family and friends that lone parents are already receiving for their health problems and/or disabilities, many in the sample felt that they still needed a wide range of additional support for their health problems and/or disabilities. Some of the sample did not know what support was available and would have liked more information on support. More information on support is particularly needed when lone parents first develop a health problem or become disabled. For example:
‘The people who should tell you about those things don’t tell you. When you first become ill you see a doctor, they do the tests and they can see how you are. They should introduce you to social services so you can get the help you need.’

(ISDP)

Some of those with mental health problems and/or disabilities, and in particular, those with depression, reported very limited help from medical professionals and felt that there was a need for more information and support. One focus group respondent reported that she had been given tablets but was then ‘left to languish’ without any idea of what to expect in the future or who else she could contact for support.

As well as more information, lone parents cited a wide range of additional support that they needed, support that, in some cases, other lone parents in the sample were already receiving. This included: help with moving to housing where they could live independently or did not have to climb stairs, equipment in their homes such as hand rails and electric tin openers, access to home carers, and help with housework, decorating and shopping. For example:

‘I would like somebody who could help me because I get tired and have to sit.’

(mover)

Some of the sample also wanted access to counselling, day centres and psychiatric nurses, and parenting support. Lone parents also felt that they needed additional financial help, particularly to enable them to buy fruit and vegetables. For example:

‘The Government says five pieces of fruit and veg a day. It’s impossible on benefits.’

(mover)

‘My consultant swears that if you could eat healthy it would improve your health – five bits of fruit and veg a day. I don’t think that when you’re claiming benefits they take that into consideration.’

(ISDP)

As well as more information about support, and the need for various additional types of support, the timing of support is also important, with lone parents needing different types of support at different times. Some of the sample explained that they needed more help on leaving hospital, and that waiting for appointments to see health professionals when a health condition gets suddenly worse meant that support often came too late (an issue in all three study areas). Support needs to be flexible so that lone parents can access it when they need it. For example:

‘There have been times when I’ve been really bad and I’ve needed to speak to the consultant, but sometimes you can’t get to see him, and when you do get to see him, you’re OK.’

(ISDP)
Because of how it affects me I can’t plan. I could say, ‘Can I have someone to come round once a week and do my shopping?’ Say they agreed to that every Wednesday, but it’s not every Wednesday I’d need it. And when I can do it I want to be independent. I’d like to be able to ring up someone if I woke up and I was ill or felt weak. I’d like to be able to ring up and say, ‘I need help today.’

(ISDP)

Some of the sample had found that they had to fight to get or keep support for their health problem and/or disability, and found this very stressful. Going through appeals in order to be awarded Disability Living Allowance was seen as unnecessary stress by a number of lone parents, whilst others were worried that their home care support could be removed. For example:

‘They try to take it away at every opportunity.’

(ISDP)

‘I used to have a social worker when the children were littler and I had them for a good few years, and all of a sudden it stopped, and at the minute I’m fighting to get help now.’

(ISDP)

15.6 Summary

Lone parents on health-related benefits were receiving a wide variety of medication and treatment to manage their health problem and/or disability. This included operations, taking medication, and various treatment options. As well as having a wide variety of medication and treatment, lone parents on health-related benefits had support from a wide range of medical and social care professionals, and in some cases, from disability organisations. This support was in addition to a great deal of support provided by family, friends and lone parents’ own children. In most cases, it was felt that lone parents could not manage without receiving this support from professionals, and friends and families.

However, not all lone parents felt that they were coping with their health problem and/or disability. Some of the sample had developed coping strategies, but there was still a need for a wide variety of additional support. This ranged from more information and advice about what support was available, to the types of practical support that some of the sample were already receiving. The need for support to be flexible and to be available when lone parents needed it, both at the start of medical conditions, and when they got worse, and throughout the condition, was also key. Lone parents felt that fighting to get or keep support added unnecessary stress for them to cope with.
16 Helping lone parents with health problems and/or disabilities to start work

16.1 Introduction

This chapter examines what would help lone parents, who claim health-related benefits, move into work. It also explores what help, if any, the sample have sought, or would turn to, if they were looking for help and support to move into work.

The extent to which those with health problems and/or disabilities, particularly of a long-term and degenerative nature, could work with help, cannot be assessed on the basis of this research alone. What is presented here are the accounts and perceptions of those who took part in the research. The study gathered the subjective and personal views of lone parents, and whilst respondents recalled the advice of medical professionals, we are not able to provide the medical knowledge required to substantiate the views of the lone parents themselves.

16.2 What would help lone parents with health problems and/or disabilities to start work?

One of the first elements of this question to be addressed is what is meant by ‘work’. During the focus groups, lone parents were keen to point out that they are engaged, first and foremost, in caring for their children. For many, this constituted working. Some focus group participants felt that working full-time would be impossible, but they could feasibly do several hours work a week and build this up if they were able to, provided this did not leave them in an insecure position financially.

Q. Does anyone think they can’t work because of their health problem?

A. ‘What do you mean by work? If you’re talking about nine to five, five days a week then I’d say yes, if I were to do that I’d end up very ill again quickly. If you’re saying being able to do 16 hours a week or less and building up slowly then I could work, and I’d jump at the chance.’

(Focus group participant)
The extent to which their health problem and/or disability impacts on a lone parent’s ability to carry out normal day-to-day activities (see Chapter 14) does not necessarily affect their views of the help they would need to move into work. The extent to which a lone parent is incapacitated by their health problem and/or disability does not necessarily reflect the extent to which they require assistance to move into work.

The help that lone parents felt they needed to enable them to start work reflects what they felt were their constraints to working (see Chapter 14). In terms of the perceptions of the respondents overall, the main factor that they felt would help them move into work was the alleviation of, or significant improvement in, their health problem and/or disability. The sample generally held the view that there was little that could be done to move them into work, given the extent of their health problem and/or disability, and the impact they felt it has on their day-to-day lives. Some of the sample felt that their health problem and/or disability alone precluded the possibility of work at the time of interview, and in some cases, in the future.

It was clear that whilst other factors, particularly circumstances related to lone parenthood, could exacerbate their overall disadvantage in the labour market, the health problem and/or disability itself overshadowed all of these.

For many in the sample, the question of what would help to move them into work was a hypothetical one, as they could not imagine being employed with their health problem and/or disability. This was not for reasons to do with coping at work, or finding a sympathetic employer, but because they felt that they were unable to work due to the health problem and/or disability. Though some of the sample felt that nothing except overcoming the health problem and/or disability would move them into work, others were able to discuss what kind of interventions they would need to move into work.

In many senses, these interventions are not very different from what would help other lone parents, without health problems and/or disabilities, into work. Help with finding, arranging, and affording childcare would be useful for some of the sample. In addition, some of the sample believed that they needed to get qualifications or take up training before they could work, or needed ESOL help. A key concern for many in the sample was coping with the benefit-to-work transition, and in particular, coping in the absence of Housing Benefit. For example:

‘If the Jobcentre could find me a job suitable to me, so that I could claim Housing Benefit, I’d be gone tomorrow.’

(ISDP)

But the most frequently cited request for help was with confidence and self-esteem. Given that so many in the sample, overall, have depression and anxiety, it is perhaps not surprising that help with raising confidence and building self-esteem was considered to be key to moving into work.

Given that lone parents with health problems and/or disabilities share many of the same constraints to working as other lone parents, and indeed other long-term economically inactive adults, they clearly require help with addressing these to start work. However, due to their health problem and/or disability and the nature of their benefit claim, they are likely to be out-of-touch with various initiatives which might help them to overcome these constraints.

Whilst most of the sample felt very strongly that their health problem and/or disability prevented them from working at the time of research, many felt that they may be able to work in the future. A primary concern, therefore, is the distance they will be from the labour market when they reach that point. Some lone parents felt that despite not being able to take up full-time paid work they could be
engaged in activities which would help them keep or improve their skills and self-confidence, and prevent them from moving further away from the labour market. For example:

‘Why can’t the government accept that those of us who can go and do a couple of hours voluntary work a week, that’s a way of keeping our skills up? It’s the difference of being in the home to going out and having to deal with people as you do in a job, it’s huge, and there must be ways that we can keep our skills and confidence up, so when our health problems are low enough to go and work, we have the confidence to do that, rather than having to go right back down to the bottom and work our way up again.’

(Focus group participant)

What was undoubtedly distinctive about lone parents claiming health-related benefits, compared to lone parents without health problems, in terms of what is needed to help them move into work, was the request for supportive employers. Few in the sample thought they would be able to work without finding an employer with whom they could be honest with about their health problem and/or disability, and who would be able to see the contribution they could make. For example:

‘How could you go to a new employer, to an interview, sell yourself for a job, and say you get panic attacks?’

(ISDP plus IB)

‘How many employers are going to be understanding if you’re sick and can’t come in?’

(ISDP)

Supportive employers were defined by lone parents as having several key characteristics, including:

- understanding the need for time off;
- being sympathetic to the unpredictable nature of health problems and/or disabilities;
- allowing flexible working hours and varied shift patterns; and
- being prepared to change the work environment to accommodate health problems and/or disabilities.

The question of what is meant by the term ‘equal opportunities employer’ was raised in the focus groups, with some participants believing that if employers state that they are an equal opportunities employer, then they should be able to accommodate lone parents with health problems and/or disabilities in the workplace. Some focus group participants were quite sceptical about how committed some employers are to making their equal opportunities statements into a reality.

Some of the sample felt that work would be more of an option if they could work in occupations that did not aggravate their health problem and/or disability. For example, finding jobs where it was possible to work sitting down, not having to lift, or not having to type a great deal. In some cases, this would require a change in career from what they previously did when they last worked.

Those who had a child who also had a health problem and/or disability, felt that even if they were well enough to work, they would still need to be at home in order to provide enough support to their child.
16.3 Differences between the benefit groups

There were a few notable differences between the three benefit groups in terms of what help they needed to move into work. The ISDP group frequently cited ‘help with childcare’ as necessary to help them move into work. Interestingly, the ISDP plus IB group, despite having children of comparable school age as the ISDP group, hardly mentioned requiring help with childcare. Instead, the ISDP plus IB group emphasised the importance of finding a supportive employer who would understand their need to sometimes take time off work, or who would enable them to have a suitable working environment and/or the equipment they would need at work.

This reflects the fact that some of this latter group had given up work because of their health problem and/or disability. However, there is little evidence to suggest that the employment they left was unsupportive. It is perhaps more likely that some of this group were already acquainted with the forms of childcare available to them, and what routes to take to obtain it.

The movers felt that they required more training than did the other benefit groups in the sample. In particular, help with ESOL would be necessary for some of the sample who have never worked in the UK. In some cases, these lone parents were quite reluctant to seek help with ESOL, as they did not feel able to work because of their health, and saw no immediate necessity to address their language barrier.

16.4 Accessing help to move into work

In terms of where the sample would go to get help to move into work, assuming that they felt able to, few had a clear idea of where to turn. A few simply did not know what help they would need in order to move into work. It was expressed that being out of the labour market for so long had left them unfamiliar with employers’ expectations.

The Jobcentre was mentioned, by some of the sample, as the first point of contact, but interestingly, the main reason for going to the Jobcentre would be to seek help with job search, and not with the kinds of help identified above. Very few in the sample were able to say where they would turn for help with childcare, or training, for example.

When asked where they would go to seek help in moving into work, many in the sample said that they would simply look in the newspaper for jobs and then apply. It would seem that, for some of the sample, the notion of getting help with moving into work is not well understood. Despite identifying a need for help, few expected that they would find it. In addition, many in the sample expressed ways in which they would simply help themselves. Proactively looking in newspapers, or in a few cases, looking for a course, might facilitate finding work, but for many in the sample it would not necessarily mean sustaining work.

Almost without exception, the Jobcentre was considered only to provide a job brokering service for people who are ready and available to work. When asked what the Jobcentre could offer, many in the sample did not know, or just thought it was a place to look through job vacancies. Some of the sample had gained employment or been on training schemes through the Jobcentre in the past, often many years ago. The idea of visiting the Jobcentre as a person with a health problem, and/or a disability, seemed peculiar to many in the sample.

In this research, only lone parents in Newcastle lived in an area where the Jobcentre Plus model had been rolled out. Most still thought of the Jobcentre as being distinct from the benefits office.
‘I don’t regard the Jobcentre as anything to do with me.’

(ISDP plus IB)

One lone parent felt that the Jobcentre provided help for those who are able to work full-time or for those who are disabled, but not for those with other health problems or impairments.

Even as a job brokerage service, the Jobcentre was not always deemed to be the right place to go, depending on the kind of work lone parents wanted. The Jobcentre was not perceived to be as useful if more skilled and better-paid work was sought. For example:

‘They tend to want you to do things like bar work, when I’ve had experience in the voluntary sector that would allow me to do other things.’

(ISDP)

Some of the sample suggested seeking the help of voluntary organisations, and in a couple of cases, specialist disability groups would be first point of contact. There were no noticeable differences between the three benefit groups in terms of where they would go to seek help to move into work.

16.5 Summary

Many lone parents in the sample felt that overcoming the health problem and/or disability was the main factor that would help them to move into work. Many in the sample were only able to talk hypothetically about the possibility of work, although others felt that they could build up their hours over time.

Other than an improvement in their health problem and/or disability, the help that lone parents claiming health-related benefits needed, to move into work, was not radically different from the kind of help that other lone parents, and indeed, other economically inactive groups, would need. Help with childcare, training, benefit-to-work transition, and confidence-building were all considered to be necessary. The ‘movers’ group, in particular, wanted help with training and some needed help with ESOL, and the ISDP group reported a greater need for assistance with childcare. Some of the sample suggested that it would be useful to engage in activities whilst on benefits which would help them improve their skills or confidence, so they are not too far removed from the labour market by the time that they do feel ready to work.

Some of the sample emphasised the need for supportive employers, and thought that they would have to find a supportive working environment in order to sustain work. This was especially the case for the ISDP plus IB group.

Overall, the sample were not clear on where they would access the kinds of help they had identified as needing to move into work. There was no notable difference between the three benefit groups in terms of where they would go to seek help in moving into work. Whilst some of the sample suggested ‘the Jobcentre’, very few were aware of how the Jobcentre might help them, or the full range of services that Jobcentre Plus could offer.
17 How existing provision delivers, or could deliver, support to lone parents with health problems and/or disabilities wishing to enter work

17.1 Introduction

This chapter examines whether health-related benefits, Work Focused Interviews (WFIs), the New Deal for Lone Parents (NDLP) and the New Deal for Disabled People (NDDP) are delivering support to lone parents with health problems and/or disabilities. It examines what more Jobcentre Plus could do to support these lone parents and help them move closer to the labour market or into work.

17.2 Health-related benefits

In this section, the three benefit groups are examined separately, so that the groups can be easily compared in terms of what they think they are claiming and how they found out about health-related benefits.

17.2.1 What benefits do lone parents on health-related benefits think they are claiming?

Whilst almost all of the lone parents in our sample were aware that they were claiming a health-related benefit as well as Income Support, there was some confusion among individual lone parents about exactly which health-related benefits they were claiming. This, perhaps, reflects the lack of strong branding of health-related benefits, and a lack of clear information explaining the relationship...
between, and eligibility for, Income Support, Disability Premium, Incapacity Benefit, and Disability Living Allowance.

**Lone parents on ISDP**
There were 19 lone parents in our sample who were claiming ISDP, according to DWP records. They were asked what they thought they were claiming and 11 of them were also claiming Disability Living Allowance (DLA) as well as ISDP, of which, two were also claiming Severe Disablement Allowance (SDA).

All of these lone parents were aware that they were claiming health-related benefits, but described what they were claiming in different ways:
- six said they were claiming IS plus DLA;
- four said they were claiming ISDP;
- four said they were claiming ISDP plus DLA;
- three said they were claiming IS plus IB;
- one said she was claiming IS plus IB plus DLA; and
- one said she was claiming IB.

**Lone parents on ISDP plus IB**
There were 13 lone parents in our sample who were claiming ISDP plus IB, according to DWP records. They were asked what they thought they were claiming and four of them said that they were also claiming DLA.

All of these lone parents were aware that they were claiming health-related benefits, but described what they were claiming in different ways:
- seven said they were claiming IS plus IB;
- four said they were claiming IS plus DLA; and
- two said they were claiming IB only.

**Movers**
There were 20 lone parents in our sample who had moved from IS onto health-related benefits when their youngest child reached 16, according to DWP records. When asked what they thought they were claiming, one said she was also claiming DLA.

Five lone parents were unclear that they were now claiming health-related benefits:
- one thought she was claiming only IS;
- one was unsure whether she was on IS or IB;

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9 Other research has shown how the benefits provided for people who are incapacitated on health grounds are poorly branded, and that many recipients of such benefits simply talk about receiving ‘sickness benefit’ (Hedges and Sykes, 2001).
• one thought that she had applied for IB but had been refused;
• one had been told that she did not have enough NI contributions for IB and so thought that she was only on IS; and
• one had applied for IB, had a Personal Capability Assessment (PCA) 18 months previously, and thought she was still waiting to hear the outcome.

The other 15 lone parents knew they were now on health-related benefits. Of these:
• five said they were claiming IS ‘with sickness’;
• three said they were claiming IS plus IB;
• three described themselves as waiting to have a PCA, and taking sick notes to the benefits office in the meantime (these lone parents will be claiming short-term IB, which is available for the first 28 weeks of illness, after which a claimant has to have a PCA to get long-term IB);
• two said they were claiming IB only;
• one said she was claiming IS plus DLA; and
• one said she was claiming ISDP.

Compared to the other two benefit groups, the movers were the only group where not all lone parents were aware they were claiming health-related benefits, and where some who were aware that they were claiming health-related benefits described what they were claiming as ‘IS with sickness’, rather than being clear about the benefit name.

17.2.2 How did lone parents find out about health-related benefits?

**Lone parents on ISDP**

Lone parents claiming ISDP found out about health-related benefits in a wide variety of ways. For some of this group, local benefits offices suggested that if they had a health problem and/or disability, and felt that they, therefore, could not work, they contact their doctor and make a claim for health-related benefits. Some of this group first heard about health-related benefits from their doctors, whilst a range of other health and social care professionals suggested claiming to other lone parents in our sample. These professionals included:

• health visitors;
• staff at psychiatric hospitals (in three cases); and
• social workers (including when lone parents were hospital in-patients).

Two lone parents first heard about health-related benefits through disability organisations: the Sickle Cell Society and a local disability charity. Others found out about claiming from local advice centres (including the Citizens Advice Bureau, welfare rights offices and local community centres), from leaflets in the Post Office, from local councils, employers, and friends and family.

**Lone parents on ISDP plus IB**

A similar pattern emerged among lone parents claiming ISDP plus IB. For some of this group, it was at the benefits office they first heard about health-related benefits, whilst others heard about them from health professionals, including GPs, counsellors and a drug rehabilitation centre, or social care
professionals such as a care manager of a hostel, where one lone parent was then living, and social services. Others heard from Disability Action, local ‘One Stop’ centres, family (including one lone parent whose mother worked at a Jobcentre), and one lone parent whose employer told her about IB when she was claiming Statutory Sick Pay.

**Movers**
Ten movers had heard about health-related benefits from the Jobcentre or benefits office. Six had heard about them from doctors, two had heard about them from friends and family, and two from advice centres.

Compared to the other two benefit groups, movers were more likely to hear about health-related benefits from Jobcentre Plus. This is due to first finding out about health-related benefits when their youngest child turned 16 and they were no longer eligible for IS. Chapter 18 discusses more fully the transitions lone parents make at this time.

### 17.3 How Work Focused Interviews deliver support

Work Focused Interviews (WFIs) are mandatory for lone parents making new and repeat claims for Income Support. They have also been introduced for existing (stock) claimants by the age of lone parents’ youngest child:

- from April 2001 to April 2002, WFIs were introduced for those with a youngest child aged 13 to 15 years old;
- from April 2002 to April 2003, WFIs were introduced for those with a youngest child aged nine to 12 years old;
- from April 2003 to April 2004, WFIs were introduced for those with a youngest child aged five to eight years old; and
- from April 2004 to April 2005, they will be introduced for those with a youngest child aged nought to five years old.

WFIs aim to encourage lone parents to join NDLP, although participation in NDLP remains voluntary. This section examines each benefit group in turn to compare what contact they had with Personal Advisers.

When lone parents in the sample were asked whether they had had a WFI (by describing what a WFI is), most said that they had not had one. Given that 21 of the lone parents in the sample had a child ten or younger, if they were existing (stock) claimants, they may not yet have been required to attend a WFI. Only 15 lone parents in the sample said that they had had a WFI: six of those on ISDP, or ISDP plus IB, and nine of the movers. Other lone parents whose youngest child’s age means that they were required to attend may have been granted waivers or deferrals.

For the six lone parents on ISDP who had had a WFI, five had had a WFI when they made a claim for Income Support, the sixth had a meeting recently (she had a youngest child of ten years old). At WFIs, eligibility for benefits was discussed for those making a claim for Income Support, and work history and health problems and/or disabilities were also discussed. These lone parents found PAs helpful and sympathetic and were told by the PAs to get back in touch when they felt ready to work. For example:
‘[They said] I’m here if you want to discuss anything if you do eventually go back to work.’
(ISDP)

‘He said that if I was ready to go back into work, go back to the Jobcentre and they would do everything for me.’
(ISDP)

Of the nine ‘movers’ that had had a WFI, most had one when their youngest child was approaching 16:

- One had a WFI when her youngest child was turning 16, and was referred to NDLP, which she then joined.
- One had a WFI when her youngest child was turning 16 to discuss what she was going to claim when her IS claim ended.
- One had a WFI when her youngest child was turning 16, told the adviser about her health problem, and was advised to claim health-related benefits.
- One had a WFI when her youngest child was turning 16 but could not remember what was discussed.
- One had two WFIs when her youngest child was approaching 16, and chose to wait until her child was 16 before claiming health-related benefits.
- One had a WFI when her youngest child was 15, and she was at that time caring for her mother. She was told the adviser would contact her again in a year.
- One had a WFI when she was on Income Support, without health-related benefits, when she was about to have an operation, and was told she did not have to look for work.
- One had a WFI when making a new claim for Income Support, and just discussed processing her benefit with the adviser.
- One had a WFI, but could not remember what they talked about or exactly when it was.

Some of the sample who had not had WFIs had a letter requesting that they attend one. After explaining their health problem and/or disability, however, they were told they did not have to attend (having presumably been granted waivers or deferrals). Two lone parents found even the request to attend a WFI worrying or stressful. For example:

‘I had a letter about it a year or so ago. It was lone parents receiving Income Support and it was a back to work meeting. It just so upset me. At the time, the people who sent the letter didn’t know I was in receipt of Disability Benefit and I was devastated. I was going through a phase of not coping very well with being so poorly and to receive that through my door. I had to ‘phone up and explain, it was awful.’
(ISDP)
However, other research has shown that whilst some lone parents with health problems and/or disabilities view WfIs as irrelevant or inappropriate, WfIs appear to play a considerable role in increasing their self-confidence and raising optimism with regard to their perceived limitations (Thomas and Griffiths, 2003).

17.4 How the New Deal for Lone Parents (NDLP) and the New Deal for Disabled People (NDDP) deliver support

Lone parents who are claiming health-related benefits and have a child under 16 are eligible for both the New Deal for Lone Parents (NDLP) and the New Deal for Disabled People (NDDP). Those who are making a new claim for IS, or whose child age means that they are required to attend WfIs (unless they are granted a waiver or deferral), are likely to be offered NDLP. Whether lone parents on health-related benefits will have received NDDP mail-shots will depend on whether they live in an area where Jobcentre Plus has been rolled out (only Newcastle in this research)10.

17.4.1 New Deal for Lone Parents

Of the lone parents in this sample, 34 had heard of NDLP but had not taken part, 15 had not heard of it, and only three had actually taken part in the programme. Other research has shown that PAs do not mention NDLP by name and that they introduce the programme to lone parents in many different ways, so some lack of awareness of NDLP may be due to this (Thomas and Griffiths, 2003).

Those that had heard of NDLP had found out about it through television advertisements, letters from Jobcentre Plus, or from WfIs. When asked why they had not taken part in the programme, lone parents explained that they lacked knowledge of what the programme actually consisted of or what it offered them. Other research has shown that amongst lone parents with limited English skills, there was often a very limited awareness and understanding of NDLP (Pettigrew, 2003).

Some of the sample had not taken part because, whilst they had seen the advertisements, they had not been directly asked to take part. In some cases, a lack of confidence was preventing them from taking part. Others felt that they might be interested in taking part in NDLP in the future when they felt ready to work (if their health problem and/or disability got better than at present, and/or their children were older). For example, one lone parent described what she had been told about NDLP at a WFI:

“She was very nice and it sounded like it was a structured scheme with all sorts of benefits, rather than just going down to the Jobcentre which can be a bit daunting. You can say, ‘I’ve been suffering from depression and I’ve got a little boy.’ They go through all the jobs for you so I think that’s really good... They said, ‘when you feel up to it, come back and see us.’ It was an environment where you’d want to go back and see them.’

(ISDP plus IB)

Three lone parents had taken part in NDLP but were not currently on the programme. The first lone parent was on ISDP and had wanted to do Teacher Training, and it was explained that training within NDLP only goes up to NVQ Level 3, and normally only to NVQ Level 2. She was advised by the PA that

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10 The rollout of Jobcentre Plus areas will be completed in 2006, whilst the rollout of WfIs (which is based on child’s age rather than area) will be completed in 2005.
she could be a classroom assistant instead, which she found patronising, as she had three ‘A’ levels. However, she was given advice about the self-employment option within NDLP, which she was also interested in, but decided not to pursue it as she was worried about what would happen to her if she started a business that was not a success.

The second lone parent who had taken part in NDLP was claiming ISDP plus IB and was working for five hours a week (allowed under the permitted work rules), which Jobcentre Plus was aware of. She had the initial meeting about a year before the interview but said they had not asked to see her again. At the initial meeting, the lone parent adviser told her about in-work benefits, but did not look at any specific jobs or discuss other NDLP options, such as training or job search help. She wanted to work for more than five hours a week, but had not said that to the adviser, and felt that the adviser was happy to let her continue to work for five hours a week.

The third lone parent who had been on NDLP was a ‘mover’. She had ESOL needs and had been sent on a language course at a college that was quite far from where she lived, and she found she was unable to sit from 9am to 4pm during the course, because of her health problem. When she explained the problem to her PA, they suggested that she make a claim for health-related benefits, which she did.

**17.4.2 New Deal for Disabled People**

Of the lone parents in our sample, only 11 had heard of NDDP and none had taken part. Those that had heard of NDDP had found out about it through leaflets in the Post Office or through letters from Jobcentre Plus, but none felt ready to take part at the moment because of their health problem and/or disability, or because of the age of their children.

One lone parent who was blind was aware of NDDP and said she would use it when her son was older and she was ready to go back to work. She would like to use the help available through NDDP to find a supportive employer, after her previous experience of working where her employer was not willing to make adequate adjustments to the work to enable her to do it (this was before the Disability Discrimination Act was passed).

One lone parent was currently on ‘progress2work’, a programme designed to help former drug misusers into employment.

**17.4.3 Choosing between seeing lone parent advisers or Disability Employment Advisers**

In Section 13.2, it was outlined how some, but not all, of the sample described themselves as disabled, with others being more comfortable describing themselves as having a health condition or impairment, rather than as being disabled. Section 14.3 showed that most respondents saw themselves first and foremost as lone parents, rather than as someone with a health problem and/or disability, but that the health problem and/or disability was the main factor that they felt affected their ability to work.

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11 Although this is, perhaps, not surprising, as NDDP is deliberately not marketed as a strongly branded programme, in the way that NDLP is.
Lone parents were asked whether they would rather see a Disability Employment Adviser (DEA)\textsuperscript{12} or a lone parent adviser to get help in moving back to work. Of those that answered this question, 26 lone parents said they would rather see a DEA, three said they would rather see a lone parent adviser, and eight said they wouldn’t mind seeing either, or would like to see both. Two did not know which they would rather see.

The fact that the majority would rather see a DEA reflects the fact that disability and/or health problems were seen as a bigger constraint to work than being a lone parent. Almost all of the movers said they would rather see a DEA, as most did not feel like they are lone parents any more, now that their youngest child is aged over 16.

Some of the sample felt that seeing a DEA meant they would get help with finding employers willing to employ disabled people, or that advisers might be able to talk to employers first and explain the disability before interview stage. For example:

‘They would probably know of employers who were offering positions to disabled people.’

(ISDP)

Lone parents who wanted to see a lone parent adviser often did not see themselves as being disabled, whilst lone parents who wanted to see a DEA said that they wanted to see an adviser who would understand their health problems and/or disabilities. Some of the sample stressed the importance of seeing someone who understands both issues. For example:

‘I need someone to understand about being a lone parent and about being disabled.’

(ISDP)

Some did not want to be considered as a lone parent, or as someone with a health problem and/or disability. Instead, they wanted a service that could be holistic. For example:

‘I hate being seen as a lone, disabled parent. I’m a whole person’.

(Focus group participant)

All lone parents were also asked whether they would be happy to discuss their health problem and/or disability with someone from Jobcentre Plus, and the vast majority said that they would be. These lone parents argued that it would not be possible to get the help they needed without discussing their health problem and/or disability. For example:

‘I would have to in order for them to help me.’

(ISDP)

‘If it would help me get the job I wanted.’

(ISDP)

‘I've no problems discussing my health problem with anybody. I'm not ashamed.’

(ISDP plus IB)

\textsuperscript{12} We asked them whether they would rather see a lone parent adviser, or an adviser ‘specialising in disability or health’, as not all lone parents in our sample thought of themselves as disabled.
However, a few lone parents in the sample did not want to discuss their health problem and/or
disability with anyone from Jobcentre Plus. They found being contacted by Jobcentre Plus stressful,
did not think it was the business of Jobcentre Plus, or was relevant, or were not sure if they would be
happy about discussing it. For example:

‘I’m not sure. Would they be sympathetic? Have they got that awareness?’

(ISDP)

‘That’s my problem, not theirs. I don’t like discussing it at the doctor’s. I shouldn’t have to go
somewhere to explain my life to nobody.’

(ISDP)

17.5 What more can Jobcentre Plus do to help?

In Chapter 15, the additional support that lone parents need for their health problems and/or
disabilities was outlined. Whilst, in most cases, this support would need to be provided by health or
social services, Jobcentre Plus could have a signposting role in directing lone parents to this support
when they first start claiming health-related benefits. Other research on WFIs has shown that lone
parents are offered the option of a referral to a DEA. Only very small numbers are taking up this offer,
although some particularly appreciated specialist referrals to help address their barriers, such as being
referred to a DEA (Thomas and Griffiths, 2003).

Many lone parents in the sample first heard about health-related benefits from Jobcentre Plus staff
(see Section 17.2) but were not signposted to other support for their health problem and/or disability,
and were not offered any help to bring them closer to the labour market or to move into work. For
those who have moved onto health-related benefits, having given up work, signposting them to
support for their health problem and/or disability could help the rehabilitation process, and could
make the period out of the labour market a shorter one. For those lone parents who claim health-
related benefits, after already being out of the labour market for a considerable period, signposting
them to support for their health could be a first step towards moving into work.

For those who do not feel ready to work at the moment because of their health problem and/or
disability, signposting them to support for their health problem and/or disability, and then providing
them with help to move into work, may change some lone parents’ perceptions of whether they are
ready to work. This signposting could take place alongside the provision of clearer information to lone
parents about benefits and how to access them, for example, help in accessing DLA.

In Chapter 15, the research showed how lone parents in the sample describe support they would need
to move into work that is actually already available through NDLP or NDDP (support such as help with
confidence, training, finding suitable jobs and supportive employers, better-off calculations, explaining
in-work benefits, and financial help for the transition into work). However, many in the sample did not
think of the Jobcentre as a place to go to get such support and were unaware of the services that
Jobcentre Plus provided.

In this chapter, the research has also shown how many in the sample would be happy to discuss their
health problem and/or disability with someone from Jobcentre Plus, and that many in the sample
would prefer to see a DEA than a lone parent adviser, but that few had heard of NDDP, or were aware
that there were DEAs at the Jobcentre. This shows a clear need for lone parents on health-related
benefits to receive more information about NDDP and DEAs. A mechanism whereby lone parents
automatically see a DEA and are notified about NDDP, and encouraged to visit a job broker when they
first make a claim for health-related benefits, would ensure that they were all aware of the support available to them.

There seems to be a need for Jobcentre Plus to be more proactive in contacting those on health-related benefits, and ensuring that they are aware of all the services Jobcentre Plus provides. Indeed, more proactive contact was suggested by a number of lone parents, who stressed the importance of advisers offering support without being too ‘pushy’. For example:

‘If they got in touch with you by ‘phone as a friendly chat, not pushing you into going out to work, saying, ‘I’m here and I can do this for you, I can come out and have a chat with you, you can have a chat with me and we can talk about what problems there are and how we can help.’ If they did that and not be pushy about it.’

(ISDP)

‘They should be a bit more proactive, instead of you having to look for the information. A situation where a person who’s on the sick has to make the first step - that’s wrong. I know people are horrified if they get a letter saying they’ve got to go in for an appointment [at the Jobcentre/Benefits Office], but I think once you’re there, and if you’ve got a nice adviser who’s not pushing you into anything, just explaining the options, that would help.’

(ISDP plus IB)

Some of the sample, particularly those not able to easily get to the Jobcentre, also felt that having home visits from advisers would be helpful, whilst others felt that a play area at the Jobcentre would make it easier for them to use.

Focus group participants suggested the need for having WFs at stages that were appropriate for them, rather than every year or every six months. Other focus group participants suggested the need to try work and build up their hours over time. This can be done through the ‘permitted work rules’ which, these findings suggest, need wider publicity.

**17.6 Summary**

Whilst most lone parents in the sample were aware that they were claiming a health-related benefit, there was some confusion about exactly what benefits they were claiming, reflecting a lack of strong branding of health-related benefits, and a lack of clear information explaining the differences between, and eligibility for, different types of health-related benefits. Lone parents in the sample found out about health-related benefits in a variety of ways, with many finding out from their doctors, or Jobcentre Plus staff. Movers were less clear about what they were claiming, and were more likely to find out about health-related benefits from Jobcentre Plus staff at the point when their youngest child turned 16 and they were no longer eligible for IS.

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13 The permitted work rules have been developed to support the Government’s commitment to removing barriers to work for people with long-term health problems who want to take steps back to work. They strengthen the aim of work as a stepping stone off benefit and into employment. They remove the requirement that the work must be therapeutic. The new rules allow customers to work for less than 16 hours a week, on average, and earn no more than £67.50 a week for 26 weeks (the Permitted Work Higher Limit or PWHL). This can be extended if it is agreed that an extension will help increase a customer’s capacity towards work of 16 hours or more a week.
Few lone parents in the sample had had WFls, although almost half of the mover group had had one as their youngest child was approaching 16. Few had taken part in NDLP, although most had heard of it. There was much less awareness of NDDP and DEAs. This is despite the fact that most of the sample would rather see a DEA than a lone parent adviser if they wanted help to move into work, reflecting the fact that health problems and/or disabilities were the main constraint to work for many in the sample.

Jobcentre Plus could do more to signpost lone parents to support for their health problems and/or disabilities when they first claim health-related benefits, and to ensure that lone parents are aware of the benefits and services that Jobcentre Plus can provide them with. A mechanism whereby lone parents automatically see a DEA and are notified about NDDP, and encouraged to visit a job broker when they first make a claim for health-related benefits, would ensure that they were all aware of the support available to them.

Jobcentre Plus could also be more proactive in contacting those on health-related benefits, offering advice on support available for health problems and/or disabilities, and providing support to help them move into work. For some lone parents on health-related benefits, this may be best delivered through home visits from DEAs. Some of the sample suggested the need for adviser meetings at stages that were appropriate to their circumstances, whilst others suggested the need to try work, and to build up their hours over time, which can be done through the ‘permitted work rules’, which perhaps need more publicity.
18 Moving from Income Support to health-related benefits when the youngest child reaches 16

18.1 Introduction

This chapter focuses on the group of lone parents who move from Income Support onto health-related benefits when their youngest child reaches 16 (called ‘movers’ in this report). Nationally, 23 per cent of lone parents leaving Income Support when their youngest child reaches 16, move onto health-related benefits. Whilst research has been conducted examining those that move from Jobseeker’s Allowance (JSA) to health-related benefits (Hedges and Sykes, 2001, and Ashworth et al., 2001), little is known about why some lone parents move onto health-related benefits from Income Support when their youngest child reaches 16, and why they have not claimed health-related benefits before.

This chapter examines the experiences of this benefit transition for the ‘movers’ interviewed in this research, who, according to DWP records, stopped claiming IS and started claiming health-related benefits after their youngest child reached 16. Recruiting this group to this research was more difficult than for the other two benefit groups, as this group is much smaller than the group on health-related benefits with children under 16 (see Introduction). Twenty, in all, were interviewed, five of whom were interviewed through interpreters as they had English as a Second or Other Language (ESOL).

Whilst it would have been preferable to sample for characteristics within this group, even if there had been larger numbers in the sampling frame it would have been difficult, as there is little information on characteristics of this group within DWP records. It must be stressed, firstly, that this chapter covers only 20 lone parents, and secondly, that a particular type of ‘mover’ may have been unwittingly attracted in the recruitment process.
18.2 The transition from IS to health-related benefits

Jobcentre Plus contacts lone parents as their youngest child approaches 16, alerting them to the fact that they will be unable to claim IS as a lone parent when their youngest child reaches 16. Lone parents are encouraged to then contact their local benefits office or Jobcentre to discuss this change. The move to health-related benefits for the movers in our sample started when they were contacted in this way by Jobcentre Plus.

Figure 18.1 briefly outlines the transition to health-related benefits as described by each lone parent in the movers group in the sample, from the point of being informed by Jobcentre Plus that their benefit status would change, to the point of making a claim for health-related benefits.

**Figure 18.1: The transitions to health-related benefits for movers in the sample**

<table>
<thead>
<tr>
<th>No.</th>
<th>The transition from being informed about change in benefit status to claiming health-related benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Initially moved onto JSA, told Jobcentre Plus about health problems/disabilities and was advised to get a sick note from the doctor.</td>
</tr>
<tr>
<td>2</td>
<td>Went to local advice centre, who explained that she did not have to work because of her health problems/disabilities, and helped her to make claim for health-related benefits.</td>
</tr>
<tr>
<td>3</td>
<td>Told Jobcentre Plus about health problems/disabilities and was advised to get a sick note from the doctor.</td>
</tr>
<tr>
<td>4</td>
<td>After IS claim ended went to her doctor and got a sick note. After a gap with no benefits, the claim for health-related benefits started.</td>
</tr>
<tr>
<td>5</td>
<td>Told Jobcentre Plus about health problems/disabilities and was advised to make a claim for health-related benefits.</td>
</tr>
<tr>
<td>6</td>
<td>Heard about health-related benefits from friends who were claiming and made a claim for health-related benefits.</td>
</tr>
<tr>
<td>7</td>
<td>Told Jobcentre Plus about health problems/disabilities and was advised to make a claim for health-related benefits.</td>
</tr>
<tr>
<td>8</td>
<td>Initially moved onto JSA, and was advised by doctor to make a claim for health-related benefits.</td>
</tr>
<tr>
<td>9</td>
<td>Helped by family to make claim for health-related benefits.</td>
</tr>
<tr>
<td>10</td>
<td>Initially moved onto JSA, and moved into work for one week but was unable to cope. Returned to the Jobcentre to explain that she was unable to work and was advised to make a claim for health-related benefits.</td>
</tr>
<tr>
<td>11</td>
<td>Told Jobcentre Plus about health problems/disabilities and was advised to make a claim for health-related benefits.</td>
</tr>
</tbody>
</table>

continued
Initially moved onto JSA, applied for lots of jobs unsuccessfully. Felt that being unsuccessful and worrying about moving into work had made her depression worse. Advised by doctor to make a claim for health-related benefits.

Initially moved onto JSA and was worried about not being able to work. Advised by doctor to make a claim for health-related benefits.

Told Jobcentre Plus about health problems/disabilities and was advised to make a claim for health-related benefits.

Initially moved onto JSA but did not feel able to work so told Jobcentre Plus about health problems/disabilities and was advised to make a claim for health-related benefits.

After IS claim ended went to her doctor and got a sick note. After a gap with no benefits, the claim for health-related benefits started.

Told Jobcentre Plus about health problems/disabilities and was advised to make a claim for health-related benefits.

Made a claim for health-related benefits when informed that benefit status was going to change.

Went to doctor and got a sick note and made a claim for health-related benefits.

Initially moved onto JSA, told Jobcentre Plus about health problems/disabilities and was advised to make a claim for health-related benefits.

Whilst DWP records show that these lone parents stopped claiming IS and started claiming health-related benefits after their youngest child reached 16, the benefit transitions described by the movers group were not all straightforward. Some of the movers initially moved from IS onto JSA and then onto health-related benefits, some moved onto JSA and into work before claiming health-related benefits, some were left with a gap between claiming IS and the new claim for health-related benefits, and some experienced a straightforward transition from IS onto health-related benefits.

Whilst all movers in the sample began the transition to health-related benefits after being informed by Jobcentre Plus that their benefit status would change, not all first heard about health-related benefits from Jobcentre Plus. Ten first heard about health-related benefits from Jobcentre Plus when they went to the Jobcentre and explained that they had a health problem and/or disability and were advised to claim health-related benefits, whilst the remaining ten heard about them from doctors, friends and family, and advice centres (as also shown in Chapter 17).

Chapter 17 examined what benefits ‘movers’ thought they were claiming. Although all movers described the transition after their youngest child turned 16 (as shown in Figure 18.1), five movers were unclear that they were now claiming health-related benefits: they either thought they had been refused health-related benefits or were still waiting to hear the outcome of their claim, thought they were now claiming IS again, or were unsure whether they were claiming IS or IB. The other 15 lone parents knew they were now claiming a health-related benefit, although not all were clear about exactly what they were claiming or what it was called (see Chapter 17). This shows that whilst movers
in the sample were aware that their benefit status had changed when their youngest child reached 16, not all were clear on what they were now claiming.

18.3 Is extra help needed when making the transition?

Movers are being advised to claim health-related benefits by Jobcentre Plus, doctors, friends and family, and advice centres. Nine movers had also had a WFI, most when their youngest child was approaching 16 (as shown in Chapter 17). These WFLs discussed what the lone parents would do when their youngest child reached 16 and they were no longer eligible to claim IS, and in one case led to a lone parent joining NDLP.

However, some movers in the sample would have liked more help at the point of making the transition off IS onto other benefits. Some movers would have liked more information about what was going to happen and more preparation for the transition off IS. This was particularly the case where lone parents were left with no income between the IS claim ending and a new claim beginning. The need for more information is illustrated by two lone parents below:

‘We have no help or information. We don’t know where to go. They’re very distant.’

(mover)

‘They could have [given me] more information in claiming the right benefit’.

(mover)

In one case, a lone parent who had made this transition said she would have liked to have been told about NDDP and to have seen a DEA, as she wanted to do some training and be helped to find suitable jobs. She felt that it would have been helpful if someone could have come to her home, as her health condition made it difficult for her to go out on her own. In another case, a lone parent who went onto JSA would have liked more help in finding work and to have someone to sit down and talk to about work. She felt that being unsuccessful in many job applications made her depression worse, and she was then advised to claim health-related benefits by her doctor. Another lone parent noticed a sign for a DEA in the Jobcentre only by chance and went to see them, and was then advised to claim health-related benefits.

These findings suggest that some lone parents need more information and preparation for the change in their benefit status when their youngest child reaches 16. All lone parents could be made aware of DEAs and NDDP when their youngest child is approaching 16, so that they can access these services if appropriate at the time of transition off IS. Lone parents who decide to make a claim for health-related benefits when their youngest child reaches 16 could perhaps be automatically seen by a DEA to ensure they receive the help they need at the point of transition. The DEA could then signpost them to support for their health problem and/or disability, and give them information about NDDP (these lone parents will no longer be eligible for NDLP once their youngest child reaches 16). In some cases, these meetings would be best delivered through home visits, and in some cases, interpreters would be needed.
18.4 Why had these lone parents not tried to claim health-related benefits before their youngest child turned 16?

Movers in the sample were asked why they had not tried to claim health-related benefits before their youngest child reached 16. The main reason for not claiming health-related benefits before their youngest child reached 16 was that movers’ health problems and/or disabilities had got worse in the period leading up to their youngest child turning 16, and that they felt that their health problems and/or disabilities had not been severe enough to claim health-related benefits prior to this. This was the case for seven of the movers.

Four movers said that they had not claimed health-related benefits before their youngest child reached 16 because coming off IS was the first time that they had been required to work, and they did not feel able to work because of their health problem and/or disability. It is worth noting that as well as their health problem and/or disability, movers in the sample also have other significant constraints to employment. Chapter 13 showed that the movers reported much longer durations on benefit than those in the other benefit groups, often lasting more than ten years and, in one case, thirty years. They also appear to have substantially less work history than the other two groups, and had often not worked since they had children. As well as having a lack of work experience as a constraint to work, Chapter 14 showed that movers with ESOL needs felt that work was not a possibility because of their poor English and that it was now too late to learn. Some lone parents in the movers group also felt that their age was a constraint to working. These additional constraints to working may also have an impact on the decision of movers to make a claim for health-related benefits the first time they are required to work. This is, perhaps, an area for further research.

Four movers had not tried to claim health-related benefits before because they were unaware of them prior to having to come off IS. Two movers said they had just not thought about it before. Of the remaining three movers, one had thought about claiming health-related benefits before, but had not had the courage to go to the benefits office alone as she had ESOL, and her son did not always have the time to go with her. One had not tried to claim before because she thought the amount of benefits she would receive would be ‘more or less the same amount’. One thought that as she had to change benefits when her youngest child reached 16 that it made sense to change to health-related benefits at that point, rather than making a claim for health-related benefits before her youngest child turned 16.

Some movers (both those who initially went onto JSA, and those who went straight onto health-related benefits) expressed concern about having to move onto JSA or into work, as they felt that they were not able to work because of their health problem and/or disability.

There is a lack of information about the existence of health-related benefits amongst some of the movers, and a lack of knowledge about the financial incentive to claim health-related benefits as soon as their health problem and/or disability develops or becomes worse (lone parents with a child under 16 claiming health-related benefits receive a larger amount of money than lone parents with a child under 16 claiming IS without health-related benefits).

More knowledge about health-related benefits might lead some movers to make a claim before their youngest child reached 16, although some may feel that it is easier to remain on IS whilst their youngest child is under 16 and they are not required to work, than to go through the process of claiming health-related benefits. This is perhaps something that could be explored in further research.
18.5 Summary

Whilst DWP records show that these lone parents stopped claiming IS and started claiming health-related benefits after their youngest child reached 16, the benefit transitions described by the movers group were not always straightforward. Some movers initially moved from IS onto JSA and then onto health-related benefits, some moved onto JSA and into work before claiming health-related benefits, some were left with a gap between claiming IS and the new claim for health-related benefits, and some experienced a straightforward transition from IS onto health-related benefits.

Some movers in the sample would have liked more help at the point of making the transition off IS onto other benefits. Some would have liked more information about what was going to happen and more preparation for the transition off IS, others would have liked more information about DEAs and NDDP. These findings suggest that some lone parents need more information and preparation for the change in their benefit status when their youngest child reaches 16. All lone parents could be made aware of DEAs and NDDP when their youngest child is approaching 16, and those who then decide to make a claim for health-related benefits could be seen by a DEA to ensure they receive the help they need at the point of transition.

The main reason for not claiming health-related benefits before their youngest child reached 16 was that movers’ health problems and/or disabilities had got worse in the period leading up to their youngest child turning 16, and that they felt that their health problems and/or disabilities had not been severe enough to claim health-related benefits prior to this. Other reasons for not claiming previously included it being the first time they had been required to work, and being unaware of health-related benefits prior to coming off IS. Some movers in the sample expressed concern about having to move onto JSA or into work, as they felt that they were not able to work because of their health problem and/or disability.

There was also a lack of information about the existence of health-related benefits amongst some of the movers in the sample, and a lack of knowledge about the financial incentive to claim health-related benefits as soon as their health problem and/or disability develops or becomes worse. More knowledge about health-related benefits might lead some movers to make a claim before their youngest child reaches 16.
19 Conclusions

19.1 Introduction

This research aimed to help unpack the complex issue of the relationship between health and work for lone parents, and to determine whether there is more that could be done to support lone parents on health-related benefits, in particular, to help them enter the labour market.

Through interviews with 52 lone parents claiming health-related benefits, the research examined: the circumstances of these lone parents; how their health problem and/or disability affects their ability to work; whether their support needs are being met; what would help them start work; whether existing provision is delivering support to this group; and why some lone parents start to make a claim for health-related benefits for the first time when their youngest child reaches 16. The key findings on each of these themes are set out below.

19.2 The circumstances of lone parents with health problems and/or disabilities

Many in the sample began their first benefit claim when they had their first child, or when they became a lone parent. Health-related benefits were rarely the initial benefit received; it was more usual for their health element of the claim for Income Support to have occurred several years after the initial claim for Income Support. From the onset of the initial benefit claim, many in the sample have remained outside the labour market, although a number had moved off benefit for short durations to move into employment.

For the most part, the sample had worked at some point, although a few had never worked. Work histories prior to the initial benefit claim were largely characterised by low-skilled work. The ISDP plus IB group had longer work histories, overall, than those in the other benefit groups. This is unsurprising as they would have had to work enough to make sufficient National Insurance contributions to be eligible for IB. They had also worked in marginally more skilled, and better paid, jobs. The sample had a negative attitude towards benefits and did not like being dependent on support from the state.
19.3 How health problems and/or disabilities affect lone parents’ decisions about work

Health problems and/or disabilities reportedly had a significant impact on lone parents’ ability to carry out normal day-to-day activities. Health and/or disability was considered to be the primary constraint to working, with many in the sample feeling unable even to consider the possibility of work, in light of their health problem and/or disability. Several other constraints to work were reported, but it was felt that the health problem and/or disability overshadowed these. All of the constraints, other than health/disability, were typical of those that lone parents without health problems and/or disabilities face, with the exception of the fear of ‘unsympathetic’ employers.

In the main, the sample wanted to work, although many did not feel ready to work because of their health problem and/or disability. Some of the sample felt concerned about their ability to sustain work and there were mixed feelings about the impact working might have on their health problem and/or disability.

Some of the sample had left work in the past due to health problems and/or disabilities, particularly those in the ISDP plus IB group. In some cases, the health problem and/or disability had started whilst they were in work, and in others, the health problem and/or disability had significantly worsened, resulting in their departure from work. Where lone parents in the sample decided to leave work, some had received support from their employer but decided to leave anyway, as they did not feel able to carry out their job. Employers could be encouraged to develop good practice for all employees with health issues whether or not these employees are defined as disabled under the Disability Discrimination Act (1995).

19.4 The support needed and received by lone parents with health problems and/or disabilities

Lone parents on health-related benefits were receiving a wide variety of medication and treatment to manage their health problem and/or disability. This included operations, taking medication, and various treatment options. As well as having medication and treatment, they had support from a number of medical and social care professionals, and in some cases, from disability organisations. This support was in addition to a great deal of support provided by family, friends and lone parents’ own children. In most cases, it was felt by these lone parents that they would not be able to manage without receiving this support from professionals, and friends and families.

However, not all lone parents in the sample felt that they were coping with their health problem and/or disability. Some of the sample had developed coping strategies, but there was still a need for a wide range of additional support. This ranged from more information and advice about what support was available, to the types of practical support that some of the sample were already receiving. The need for support to be flexible and to be available when lone parents needed it, both at the start of medical conditions, when they got worse, and throughout the condition was also key. Lone parents felt that fighting to get or keep support added unnecessary stress for them to cope with.
19.5 Helping lone parents with health problems and/or disabilities to start work

Other than an improvement in their health problem and/or disability, the help that lone parents, claiming health-related benefits, needed to move into work, was not radically different from the kind of help that other lone parents, and indeed, other economically inactive groups, would need. Help with childcare, training, benefit-to-work transition, and confidence-building were all considered to be necessary. The ‘movers’ group, in particular, wanted help with training, and some needed help with ESOL, and the ISDP group reported a greater need for assistance with childcare.

Lone parents on health-related benefits emphasised the need for supportive employers, and thought that they would have to find a supportive working environment in order to sustain work. This was especially the case for the ISDP plus IB group. Some of the sample suggested that it would be useful to engage in activities whilst on benefits which would help them improve their skills or confidence, so they are not too far removed from the labour market by the time that they do feel ready to work.

Overall, the sample were not clear on where they would access the kinds of help, they had identified as needing, to move into work. There was no notable difference between the three benefit groups in terms of where they would go to seek help in moving into work. Whilst some of the sample suggested ‘the Jobcentre’, very few were aware of how the Jobcentre might help them, or the full range of services that Jobcentre Plus could offer.

19.6 How existing provision delivers, or could deliver, support to lone parents with health problems and/or disabilities wishing to enter work

Whilst most lone parents in the sample were aware that they were claiming a health-related benefit, there was some confusion about exactly what benefits they were claiming, reflecting a lack of strong branding of health-related benefits, and a lack of clear information explaining the differences between, and eligibility for, different types of health-related benefits. Lone parents in the sample found out about health-related benefits in a variety of ways, with many finding out from their doctors, or Jobcentre Plus staff. Movers were less clear about what they were claiming, and were more likely to find out about health-related benefits from Jobcentre Plus staff at the point when their youngest child turned 16 and they were no longer eligible for IS.

Few lone parents in the sample had had WFls, although almost half of the mover group had had one as their youngest child was approaching 16. Few had taken part in NDLP, although most had heard of it. There was much less awareness of NDDP. This is despite the fact that most lone parents in the sample would rather see a DEA than a lone parent adviser if they wanted help to move into work, reflecting the fact that health problems and/or disabilities were the main constraint to work for many in the sample.

Jobcentre Plus could do more to signpost lone parents to support for their health problems and/or disabilities when they first claim health-related benefits, and to ensure that lone parents are aware of the benefits and services that Jobcentre Plus can provide them with. A mechanism whereby lone parents automatically see a DEA and are notified about NDDP, and encouraged to visit a job broker when they first make a claim for health-related benefits, would ensure that they were all aware of the support available to them.
Jobcentre Plus could also be more proactive in contacting those on health-related benefits, offering advice on support available for health problems and/or disabilities, and providing support to help them move into work. For some lone parents on health-related benefits, this may be best delivered through home visits from DEAs. Some of the sample suggested the need for adviser meetings at stages that were appropriate to their circumstances, whilst others suggested the need to try work and to build up their hours over time, which can be done through the permitted work rules, which perhaps need more publicity.

19.7 Moving from Income Support to health-related benefits when the youngest child reaches 16

The benefit transitions described by the movers group were not always straightforward. Some movers initially moved from IS onto JSA and then onto health-related benefits, some moved onto JSA and into work before claiming health-related benefits, some were left with a gap between claiming IS and the new claim for health-related benefits, and some experienced a straightforward transition from IS onto health-related benefits.

Some movers in the sample would have liked more help at the point of making the transition off IS onto other benefits. Some would have liked more information about what was going to happen and more preparation for the transition off IS, others would have liked more information about DEAs and NDDP. These findings suggest that some lone parents need more information and preparation for the change in their benefit status when their youngest child reaches 16. All lone parents could be made aware of DEAs and NDDP when their youngest child is approaching 16, and those who then decide to make a claim for health-related benefits could be seen by a DEA to ensure they receive the help they need at the point of transition.

The main reason for not claiming health-related benefits before their youngest child reached 16 was that movers’ health problems and/or disabilities had got worse in the period leading up to their youngest child turning 16, and that they felt that their health problems and/or disabilities had not been severe enough to claim health-related benefits prior to this. Other reasons for not claiming previously included it being the first time they had been required to work, and being unaware of health-related benefits prior to coming off IS. Some movers in the sample expressed concern about having to move onto JSA or into work, as they felt that they were not able to work because of their health problem and/or disability.

19.8 Summary

This research has shown that for lone parents claiming health-related benefits, their health problem and/or disability is their main constraint to moving into work. Although many in the sample want to work, many do not feel ready to work at the moment. More support is needed for lone parents to help them manage their health problem and/or disability, and more help is also needed to help them move into work. Lone parents on health-related benefits also need clearer information about health-related benefits and more information about what NDLP, NDDP and DEAs can offer them. Providing such information and support may change some individuals’ perceptions of whether they are ready to work. Those who move onto health-related benefits, when their youngest child reaches 16, do so for a range of reasons, and might benefit from seeing a DEA at this point to discuss their options.
Whilst there are, therefore, clear ways where support for lone parents on health-related benefits could be improved, it is important to note that even with such support, not all lone parents on health-related benefits would be able to move into work. The costs of providing intensive support to those in this group who are furthest from the labour market may, in some cases, be high. Decisions need to be made by policy makers about to what extent these individuals have a right to help to move into work whatever the cost, and to what extent services should be provided to support those who may feel that they cannot ever work, to address their wider issues of social exclusion.
20 Comparative conclusions

20.1 Introduction

These two pieces of research have examined the impact of health problems on lone parents’ decisions about work. They were commissioned as two separate pieces of work: Part One compared lone parents with health problems on Income Support (IS) to lone parents with health problems who have moved into work having been on Income Support, and Part Two examined lone parents on health-related benefits.

They were also qualitative studies that did not, therefore, aim to be representative of all lone parents in these groups. Rather, they aimed to examine in-depth the issues faced by lone parents in these situations and to begin to test out some ideas of what extra support could be provided to help lone parents with health problems and/or disabilities, and particularly to help them move into, or closer to, the labour market. This is not an area where much research has previously been done, and this research was, therefore, intended to be exploratory.

Although this was not designed as a single comparative study, it is possible to present some overall findings and issues by discussing the key research themes that cut across both studies. This is, therefore, what this chapter aims to do, drawing from and building on Chapter 11 (where the findings of Part One of this research are presented) and Chapter 19 (where the findings of Part Two of this research are presented). Suggestions are made, based on the research findings and our interpretations of them, about what more could be done to support lone parents with health problems and/or disabilities.

This chapter examines a number of key themes:

- health problems and/or disabilities;
- benefit and work histories;
- attitudes to benefits and work;
- how health is a constraint to work;
- health support;
- help to start work;
- help to sustain work;
- existing provision, and
- transitions onto health-related benefits for movers.
20.2 Health problems and/or disabilities

In Part One of the research a lot of detail was collected on lone parents’ health problems and/or disabilities and the GHQ12 was also used. This was designed to provide a more detailed picture than had been given in previous research about what kinds of health problems lone parents on Income Support (or in work having been on Income Support) experienced. In Part Two of the research, less detail about health problems and/or disabilities was collected, as these lone parents with health problems and/or disabilities were claiming health-related benefits, and in most cases would have been through the Personal Capability Assessment (PCA) process and been judged as meeting the threshold for receiving health-related benefits.

Although it is not possible or useful to compare directly the types of health problems and/or disabilities that different groups of lone parents in Part One and Part Two had, the research generates some interesting findings about health problems and/or disabilities among lone parents. Across all three groups (lone parents on IS, in work and on health-related benefits) there was a high incidence of multiple health problems which, for the most part, included both a mental and physical health problem and/or disability.

To examine mental health in more depth, in Part One of the research, the GHQ12 set of questions was used, alongside the identification of mental health problems and/or disabilities by respondents, to explore the mental well-being of lone parents in the sample. Lone parents in the sample were worse off than the general population in terms of mental well-being (see Chapter 3 for a discussion on the use and limitations of the GHQ12 in this research).

Child health problems were also explored in this research: in Part One, child health problems were explicitly examined, and, although some lone parents in Part Two also had children with health problems, this was not a sampling criterion in Part Two. In terms of the child health problems reported in Part One, in the main, child health problems reported were asthma, eczema, and behavioural problems, such as Attention Deficit Hyperactivity Disorder (ADHD). There were also a few cases of physical disabilities. In Part Two, where lone parents raised the issue of child health problems, mental health problems and behavioural problems tended to predominate.

Other interesting findings included the impact of poor housing on health, and whether lone parents identified themselves as being disabled. In Part One of the research, the relationship between health and poor housing conditions was raised, in relation to how poor housing can have a negative impact on conditions such as asthma, as well as child behavioural problems. In Part Two of the research, lone parents claiming health-related benefits were asked if they considered themselves to be disabled. Many did describe themselves as disabled, although for some, disability was regarded as something that only affects mobility (a perception documented in other research on disability).

There are a number of implications of these findings about health problems and/or disabilities. The high incidence of multiple health problems was present in the samples amongst those claiming IS and those in work, as well as amongst those claiming health-related benefits. Multiple health problems included lone parents who had a combination of mental and physical health problems and/or

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14 The General Health Questionnaire set of 12 questions (GHQ12) is used in the English Health Survey, commissioned by the Department of Health, and is used in the British Household Panel Survey to assess mental well-being. See Chapter 3 for discussion of the use and findings of the GHQ12 in this research.

15 See, for example, Hurstfield et al., 2004.
disabilities, and in some cases also had children with health problems. This provides additional
evidence that some lone parents not claiming health-related benefits are experiencing poor health, as
has been found by previous survey evidence (see Introduction), and may be experiencing multiple
health problems.

When examining what can be done to support lone parents with health problems and/or disabilities,
poor housing is an issue that needs examination as it can exacerbate health conditions. As some lone
parents on health-related benefits identified themselves as being disabled, there may be a need to
provide services to this group that take into account their needs and identification as disabled people
as well as their needs and identification as lone parents.

20.3 Benefit and work histories

In examining benefit and work histories, the research found that the different groups of lone parents
within the two samples differed in terms of the length of time that they had been on benefits and
whether they had any previous history of working.

In terms of benefit history, lone parents on IS had often begun claiming when they first became lone
parents, although in other cases they had been ‘on and off’ IS since becoming lone parents; moving
between work, benefits and education. Lone parents on IS did, however, have more sustained
periods of claiming than those in the sample in work. In terms of work history, the sample of lone
parents on IS included those who had never worked, or not worked since becoming a lone parent, as
well as those with more substantial work histories that were often made up of low-skilled, service-
sector jobs.

In contrast, lone parents in work (having previously been on IS) tended to have spent less time claiming
IS overall than had those currently on IS. It was more common among the ‘in work’ group to have
worked before having children, and to have used IS for short periods of time, sometimes between jobs
or immediately after the birth of children. It was less common for these lone parents to have no prior
work history before they moved off IS and into work in their current job. Lone parents currently in
work were employed in a wide range of sectors, mainly working in low paid and low-skilled
occupations, at the minimum wage or slightly above (although there were a few lone parents in
managerial and professional occupations earning over £20,000 a year).

Lone parents claiming health-related benefits differed between those who were claiming Income
Support with Disability Premium (ISDP) plus Incapacity Benefit (IB) (who had, in most cases, built up
National Insurance contributions through work to be eligible for IB), and those claiming ISDP, or those
who had moved onto health-related benefits when their youngest child reached 16 (movers). The
ISDP plus IB group tended to have spent less time on benefits than had the movers and ISDP groups,
and their work histories were characterised by somewhat higher skilled work. The movers group
reported much longer durations on benefit than those claiming ISDP plus IB, and had substantially less
work history than those claiming ISDP, or ISDP plus IB, and had often not worked since they had
children. Most of those claiming health-related benefits had worked at some point in the past, mostly
in low-paid work.

These findings about work and benefit histories suggest that some lone parents with health problems
and/or disabilities may also face a lack of work history, which may act as a constraint to moving into
work. They may, therefore, need additional help in starting work.
20.4 Attitudes to benefits and work

Lone parents from all three groups (on IS, in work, on health-related benefits) were almost unanimous in their dislike of being a benefit claimant. A key reason for this was the struggle to make ends meet on benefits, as well as finding claiming benefits to be stigmatising, humiliating and demoralising. Being on benefits was described as leading to boredom, isolation and exclusion from ‘normal life’. Being on benefits was often considered to be a ‘necessary evil’ and not something that individuals would actively choose to do. Some lone parents felt that being on benefits had a detrimental effect on their mental health.

Many of those in the sample, in work, had very strong ‘work ethics’ and substantial work histories, and had very positive attitudes towards work. Those in work described getting a sense of identity, pride and self-respect from work and felt that working set a good example for their children. Lone parents on IS and on health-related benefits did, in the main, want to work. Work was seen as leading to financial independence and as providing social contact with other adults and enabling them to build their confidence, to be self-sufficient and to provide a better life for themselves and their children. Where lone parents did not want to work, this was due to feeling that their children were too young or that they needed to stay at home for their children, or because they felt that their constraints were too difficult to overcome.

The fact that lone parents in the sample on IS and on health-related benefits did not want to be on benefits and wanted to work, means that there is a great deal of potential for services to be offered and developed that enable them to move into work.

20.5 How health is a constraint to work

The biggest difference between Part One and Part Two of this research was not the type of health problem or disability that lone parents had, but the impact that it had on their day-to-day activities and ability to work, and the prominence of the health problem and/or disability compared with other constraints to work.

In both parts of the research, the types of health problems and/or disabilities and the impact of these were self-reported. Attitudes about the impact of a health problem or disability are subjective. Health problems are experienced in different ways by different people, and similar health conditions may have a different impact on different individuals, or interact with their other constraints in different ways. In some cases, the view of lone parents about the impact of their health problems and/or disabilities might be quite different from a medical perspective on their impact.

Amongst lone parents on IS, three groups emerged who differed in terms of how they perceived health to be a constraint. The first group felt that their health problem and/or disability meant that they were not able to work. The second group felt that their health problem and/or disability did not prevent them from working, but would make working more difficult. A third group did not feel that health and/or disability was a constraint on moving into work. Among those on IS, in many cases, health or disability was not felt to be the key constraint on moving into work. However, it often made it harder for lone parents to deal with any of their constraints effectively.

In contrast, for the sample claiming health-related benefits, overall, health and/or disability was the key constraint on moving into work. Health problems and/or disabilities had a significant impact on the ability of lone parents to carry out their normal day-to-day activities as well as on their ability to work. Although lone parents on health-related benefits felt that health problems and/or disabilities
were the primary reason for not working, the sample was fairly evenly split when asked whether they considered health/disability or lone parenthood to be the pivotal aspect of their identity. However, it emerged that even where respondents on health-related benefits saw themselves first and foremost as lone parents, the health problem and/or disability was the factor that resulted in economic inactivity.

Common across lone parents on IS and lone parents on health-related benefits were the other constraints that they faced alongside health/disability. These other constraints included: childcare, a lack of work experience, a lack of confidence, the perceived attitude of employers to health problems and/or disabilities, concerns around making work pay, needing flexible employment, a lack of qualifications and skills, and in a few cases, having English as a Second or Other Language (ESOL) needs. In most cases, these are similar to the constraints faced by lone parents without health problems or disabilities, except, perhaps, for the perceived lack of employers who would be supportive to people with health problems and/or disabilities.

These findings suggest that health seems to act as a bigger constraint for those on health-related benefits than for those with health problems on IS. This suggests that for those on IS, health needs to be taken into account when providing support to help lone parents move into work, as it operates as an additional constraint that may make it harder, overall, for a lone parent with other constraints to move into work. It may, however, not always be the key constraint for this group. For those on health-related benefits, health/disability may be the key constraint for many. The help offered to this group could perhaps be focused firstly on the health problem/disability as a constraint, and secondly on the other constraints they face as lone parents.

Lone parents also felt that the attitude of employers to people with health problems and/or disabilities was negative and would make it harder for them to find work. This suggests that work needs to be done both with employers to change attitudes to health and disability, and with lone parents to ensure that they are aware of support available to find employers that are supportive to employing people with health problems and/or disabilities.

20.6 Health support

Most lone parents in the three groups (on IS, in work, on health-related benefits) had seen a doctor, had had their health problem and/or disability diagnosed and had been prescribed medication and/or treatment where relevant. A wide range of support for health/disability was received. This included practical and emotional support from family and friends and from lone parents’ children, as well as a range of external support that included counselling, diet advice, pain clinics, and osteopathy. However, a few lone parents were not receiving any support for their health problems and/or disabilities.

The main difference between those in work and those on IS related to the ability to make choices, often financial, about the type and frequency of support necessary to help their situation. Those in work had access to a wider social network and there were instances where work colleagues had offered information and advice about treatments that they had had, or were aware of. Those in work also had more financial resources to access treatment not available on the National Health Service (NHS). In contrast, lone parents on IS, particularly those with mental health problems, had less access to wider social networks, which limited their awareness and access to alternative or additional medical support. It was also difficult for some to keep up with regular treatment due to transport and childcare problems.
Comparative conclusions

Lone parents in the sample on health-related benefits had access to a wider range of support from medical and social care professionals than did lone parents on IS or in work. These included psychiatrists, occupational therapists, counsellors, mental health teams, crisis teams, community nurses, social workers, social services, and home carers.

More support was needed for health problems and/or disabilities across all three groups. Lone parents often needed more information and advice on the health problem/disability itself as well as on the support available to them. There was a lack of awareness of specialist organisations that could help with a particular health problem and/or disability. A wide range of additional support was needed, and this was often support being received by others in the samples, such as equipment in homes, counselling, and help around the home, for example. Extra financial help was also needed, particularly to afford to buy the fresh fruit and vegetables recommended to many by their doctors.

Support also needed to be flexible and timely so that individuals could access it when they needed it. Lone parents needed different types of support at different times, such as help on leaving hospital and wanting not to have to join waiting lists for counselling or appointments with specialists.

While, in most cases, this support would need to be provided by health or social services, Jobcentre Plus could have a signposting role in directing lone parents to this support when they first start claiming health-related benefits, or, in the case of those on IS, when they see Personal Advisers (PAs) as part of the Work Focused Interview (WFI) process, or as part of the New Deal for Lone Parents (NDLP). Signposting them to support for their health problem and/or disability could help the rehabilitation process, and could make the period out of the labour market a shorter one for some lone parents.

20.7 Help to start work

The help that lone parents in our samples on IS and on health-related benefits needed to start work is, in many cases, similar to what lone parents without health problems and/or disabilities would also need to start work. Lone parents expressed a need for help with job search and interview preparation, as well as help with confidence, training, information on childcare options, help with self-employment, and in some cases ESOL help. This kind of support to start work would help to tackle some of the constraints other than those health cited above. However, some of the help that the samples felt that they needed was more specific to having health problems and/or disabilities: needing a job matching service to help find jobs that they could do despite their health problems and/or disabilities, and needing help with finding employers who would be supportive to employing those with health problems and disabilities.

Across lone parents in the three groups, there was a lack of awareness of services that were already available to them which could provide these kinds of support. Even where lone parents were aware of services such as the NDLP, they were not always familiar with the range of options these services provided. In terms of where individuals would go to get help to move into work, few had a clear idea of where to turn. The Jobcentre was mentioned by some as the first point of contact, but the main reason for going to the Jobcentre would be to seek help with job search, and not with the other kinds of help identified as necessary. In many cases, these lone parents had not had much or any contact with the Jobcentre, and were unaware of the changing services available through the Jobcentre Plus model.
Lone parents on health-related benefits differed from those in the samples on IS or in work, in that the main thing that they felt would help them start work was the alleviation of, or significant improvement to, their health problem and/or disability. A common feeling among this group was that little could be done to help them start work given the impact that the health problem and/or disability had on their day-to-day life.

For these lone parents in particular, although also for others who did not feel ready to go back to work, there is a need for activities to keep them close to the labour market until they feel ready to work. These activities might include help to find voluntary work, or a slow re-introduction to work (for example, through the use of the permitted work rules). Condition management approaches (as being used in the ‘Pathways to Work’ pilots) could also be used to help individuals find ways to move into work with their health problem and/or disability, rather than waiting until their health is better, or feeling unable to work because of their health problem/disability.

There are, therefore, a number of ways in which additional support could be provided to help lone parents with health problems and/or disabilities to start work. These include publicising support that is already available, as well as making services such as condition management programmes more widely available.

20.8 Help to sustain work

There was concern among some of those in work in the sample that the work they were doing was not sustainable, for example, because the nature of the work was too physical, because jobs were too stressful, or because employers were unhappy about their need to take time off. NDLP provides an ‘in-work’ service to lone parents. This service could be used to help lone parents who are thinking of having to give up work to find more suitable jobs, rather than having to return to benefits. This could be marketed to all lone parents on benefits, to ensure that all lone parents know it exists, whether or not they have ever taken part in NDLP.

In some cases, lone parents in work were reluctant to discuss their health problems and/or disabilities with their employers. It was felt that bringing up health or disability at the recruitment stage would ‘put employers off’, but individuals then felt unable to discuss it with employers if they had not brought it up at recruitment. In the case of mental health problems, some lone parents were embarrassed to discuss it with their employers. There was also a feeling that taking too much time off work for health problems/disabilities would lead to them getting the sack, while some feared being treated differently from other employees if their health problem and/or disability was known about.

Those in work who had understanding or supportive employers felt that they could be more open and honest about their health problem and/or disability. Supportive employers were defined as being those that understood the need to take time off, were sympathetic to the unpredictable nature of some health problems and/or disabilities, enabled flexible working patterns, and were willing to make changes in the work environment and work practices to accommodate them.
Where lone parents on IS or on health-related benefits had negative perceptions of employers, these were often based on negative experiences in employment in the past, for example, in some cases having experienced pregnancy discrimination. For those who had been out of the workforce for some time, these perceptions may now be outdated, and there may be a need for lone parents to be given examples of supportive employers when they come into contact with Jobcentre Plus, as well as, perhaps, being targeted by supportive employers, as has happened to lone parents generally through programmes such as Ambition Energy.16

Employers clearly have a role to play in working with employees with health problems and/or disabilities. Employers could encourage employees to discuss their health problems, and could support employees with health problems by making it clear that they could come to them with any problems, through policies such as dependency leave, and by making adjustments to the nature of the work or work environment to help lone parents continue in work. From 1 October 2004, small employers (those employing 14 people or less) will be brought into the scope of the employment provisions of the Disability Discrimination Act (DDA) 1995. One of the provisions of the DDA is that employers are obliged to make reasonable adjustments for disabled staff, both in their work, and in the recruitment and selection process. Employers could be encouraged to develop good practice for all employees with health problems whether or not these employees are defined as disabled under the Act.17

20.9 Existing provision

There was a lack of awareness and confusion about health-related benefits among lone parents on IS and in work in the sample. Not all of these lone parents had heard of health-related benefits, and some who had did not think they would be eligible, for example, unless they were ‘registered disabled’.18 For those in the sample claiming health-related benefits, there was also confusion about what health-related benefits they were claiming. This confusion suggests the need for clearer information about the relationship between, and eligibility for, health-related benefits and, perhaps, clearer branding of them.

Most lone parents on IS, in work and on health-related benefits in the sample had not had a Work Focused Interview (WFI), although a number of movers had had one as their youngest child approached 16. The roll-out of WFIs by age of youngest child19 means that not all lone parents in the two samples will have been eligible for a WFI by the time of interview, and some may have been granted waivers or deferrals.

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16 Ambition Energy is part of the Ambition initiatives developed by the National Employment Panel. It aims to place 4,500 customers in work over three years in a number of energy sector occupations. It was launched in June 2002, and particularly targets lone parents, ethnic minorities and ex-offenders.

17 Under the DDA, it is often unclear whether an individual meets the definition of the Act, until this is tested in an employment tribunal. Hence, it makes sense for employers to develop good practices for all people with health problems, as many of them could turn out to be covered by the Act.

18 Since the introduction of the DDA, there is no such thing as ‘registered disabled’.

19 Work Focused Interviews (WFIs) are mandatory for lone parents making new and repeat claims for Income Support. They have also been introduced for existing (stock) claimants by the age of the lone parents’ youngest child. See Chapter 17.
Most lone parents on IS had heard of NDLP and many had been on the programme in the past and had had positive experiences. Of those lone parents in work in the sample, most had been on NDLP before moving into work. These lone parents found ‘better-off’ calculations, benefit run-ons, and help with claiming tax credits particularly useful. Lone parents on IS felt that PAs needed to be more proactive in keeping them engaged with the programme. Lone parents on health-related benefits are eligible for both NDLP and the New Deal for Disabled People (NDDP). They are likely to be offered NDLP through WFs or when making a new claim. Most lone parents in the sample on health-related benefits had heard of NDLP but very few had actually taken part, and there was a lack of knowledge about what the programme actually consisted of. This research suggests that there is a need for more information to be given to all lone parents, detailing all of the services that NDLP can provide.

Whether lone parents on health-related benefits receive information about NDDP may depend on whether they live in an area where Jobcentre Plus has been rolled out. Few had heard of NDDP (although this is, perhaps, not surprising as NDDP is deliberately not marketed as a strongly branded programme in the way that NDLP is, and local names for the programme may vary) and none had taken part. This research suggests the need for these lone parents to receive information about NDDP and to be encouraged to visit an NDDP job broker. Lone parents on health-related benefits were asked whether they would rather see a Disability Employment Adviser (DEA), or a lone parent adviser, and most said they would rather see a DEA, reflecting the fact that this group saw health/disability as their biggest constraint on moving into work. This suggests that all those making a new claim for health-related benefits could be seen by a DEA. Proactive contact could then be made by advisers throughout the claim, at stages appropriate for individual clients.

Not all lone parents across the three groups were happy to discuss their health problem and/or disability with staff from Jobcentre Plus. However, some thought it would be helpful to do so and had not realised that they could talk to PAs about it. It was suggested that lone parents could be asked about their health in interviews with advisers, rather than being expected to bring it up. Lone parents on IS and in work had found that when they mentioned their health problem to a PA, the PA was understanding, and often suggested that the lone parent stay on benefits until their youngest child reached 16.

This research suggests that rather than just advising lone parents with health problems to stay on benefits, PAs could offer support to these lone parents, as well as to those on health-related benefits, such as signposting them to organisations that might be able to help, and helping them to find jobs that they could do despite their health problems. Signposting lone parents to support for their health problem and then providing them with help in moving into work may change some lone parents’ perceptions of whether they are ready to work. PAs could, perhaps, be incentivised to work with lone parents with health problems and/or disabilities, who may be more difficult to move into work than lone parents without health problems.

As a result of taking part in focus groups during this research, some participants on IS and on health-related benefits suggested that group sessions with other lone parents would be helpful as a first step in moving them closer to the labour market, particularly for those who felt isolated or had little support. However, this would not be appropriate for all lone parents, as some did not feel able to attend focus groups due to a lack of confidence or the nature of their health problems and/or disabilities. It was also suggested that the Jobcentre environment could be improved to make it easier for lone parents with health problems and/or disabilities to use, by, for example, having more areas where discussions could take place in private, areas for children to play, and toilets for the public.

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20 Only Newcastle in this research.
There is a need for lone parents with health problems to be made aware of all the different services that Jobcentre Plus can provide them with. Different types of provision may be needed for different groups, for instance, through a choice of seeing Disability Employment Advisers or lone parent advisers. Provision may need to be delivered at stages and in ways most appropriate to the individual lone parents: for example, home visits may be a better mode of contact for some, or telephone calls and meetings to explain services, rather than, or as well as, letters.

20.10 Transitions onto health-related benefits for movers

Part Two of this research included those who had left IS for health-related benefits when their youngest child reached 16 (movers) as part of the sample. The main reason for not claiming health-related benefits before their youngest child reached 16 was that movers' health problems and/or disabilities had got worse in the period leading up to their youngest child turning 16, and that they felt that their health problems and/or disabilities had not been severe enough to claim health-related benefits prior to this. Other movers made a claim at this time because it was the first time they had been required to work and they did not feel able to because of their health/disability and other constraints. Not all had been aware of health-related benefits prior to their child turning 16, or were aware that they had a financial incentive to claim health-related benefits rather than just IS before their youngest child turned 16.

Their benefit transitions began when they were informed by Jobcentre Plus that their benefit status would change and the transitions ended with a claim for health-related benefits. The transitions described by movers were not straightforward, with some moving initially onto Jobseeker's Allowance (JSA) and then onto health-related benefits, and some experiencing a gap between claims. Some movers would have liked more help at the point of making the transition off IS, particularly having more information about what was going to happen and more preparation for making the transition. All lone parents could be made aware of DEAs and NDDP when their youngest child is approaching 16, so that they can access these services if they have a health problem and/or disability. Lone parents who first make a claim for health-related benefits at this time could, perhaps, be automatically seen by a DEA.

20.11 Conclusions

Lone parents on IS with health problems are different from other lone parents on IS who do not have health problems. Health problems often act as an additional constraint to entering work and these lone parents need additional support to the mainstream support available to all lone parents on IS.

Lone parents on health-related benefits have health/disability as their main constraint to entering work but also face constraints common to those lone parents not on health-related benefits. These lone parents need support to ensure that they can move into work if and when it is appropriate for them to do so.
Appendix H
Opt-out letter

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WC2N 6HT
Tel: 020 7712 2371
Fax: 020 7962 8542

«Title» «Firstname» «Surname»
«Address1»
«Address2»
«Address3»
«Address4»
«Address5»
Reference Number: «IES_ID»
Date
Dear «Title» «Surname»

I am writing to ask for your help in some important research that is being carried out among lone parents. We are interested in finding out more about lone parents’ experiences of being on health-related benefits. This will help the Department for Work and Pensions (DWP) to provide better support to lone parents with health problems. The Department has asked the Institute for Employment Studies (IES) to carry out a research study. IES is a research organisation that is completely independent of government.

Your name has been randomly selected from DWP records and your participation in this research is entirely voluntary. Your benefits will not be affected in any way.

A researcher from IES will contact you in November to arrange a time, date and place to speak to you in person. The interview will last for about an hour. Everyone who is interviewed will be given £15 as
a small token of thanks for their help. After we have met you in person, you may then be asked if you would like to take part in a focus group, with around six other lone parents in your area. The focus groups will last for about an hour and a half. Everyone who takes part in a focus group will be given £20 as a token of thanks.

Anything you say to the researcher will be strictly confidential; your name and personal details will not be passed on to any government department or anyone else. Please let us know if there is anything we can do to make it easier for you to take part. The researcher who contacts you will also be glad to talk about any requirements you may have or arrangements that would be helpful.

I do hope that you will take part in this important research study, as we value your views. But if you do not wish to take part, you can contact Jo Casebourne at IES, Mantell Building, University of Sussex, Brighton, BN1 9RF, or on 01273 873582, before 28th November, giving the reference number from the top of this letter, and your name will be taken off the list of people we will contact. Please contact Jo Casebourne, or contact me, Victoria Petrie, on 020 7962 8510 if you have any questions about the research.

Yours sincerely

Victoria Petrie,
Research Officer, Lone Parents

A large print copy of this letter, a Braille copy and an e-mail copy are available. If you would like one, please call 01273 873582
Appendix I
Telephone script

Recruiting lone parents – Telephone script

Introduction
Hi, my name is full name and I am ‘phoning from/on behalf of the Institute for Employment Studies about the research that we are doing on lone parents and health problems for the Department for Work and Pensions.

What the research is about
You will have been sent a letter from the Department for Work and Pensions telling you about this research.

I’ll just briefly explain again what it is that we are doing. What we are doing is interviewing lone parents who are claiming benefits, to ask about how health problems affect their decisions about work. We have been asked to do this research as the Government wants to do more to support lone parents with health problems.

The interview
What it would involve is an interviewer visiting you at home, or at another place if you prefer, for about an hour, to ask you about your experiences. The interviewer will ask about your health, your work history, any support that you have received with your health or to help you move into work, and what more you think the Government could do to help you.

Your participation is entirely voluntary, and whether or not you choose to participate will not affect your benefits.

Everything you tell the interviewer will be treated in complete confidence. Your views will be combined with those of other people, and the report of the research will not identify anyone in person.

If you would like to take part we will give you £15 as a thank you.
Arranging the interview

Are you willing to take part?

If no:

Thank you for your time. **Terminate call.**

If yes:

The name of the interviewer is **Name**. She will be in your area on **DATES**. Are any of those dates suitable for you?

We would like to make sure we make this research accessible to everyone who would like to take part. Can I just check your access needs:

• Do you need a language interpreter? (we can provide, or would you like a family member/friend present to translate?)

• Are you happy with the interview taking place in your home?
  – If yes, check address details and bus routes.
  – If no, agree alternative venue they would like.

• Is there a particular time of day that suits you best? (fix time and date of appointment – morning/afternoon/early evening)

• Would you like to receive the original letter about the research in large print or Braille or by email?

• Would you like a carer or another individual (friend/family member/advocate) to be present? (if yes, can we take their name and contact details so we can send them the information about the project)

• Do we need to make any adjustments to the length of the interview? (normally one hour long) we can plan a short break if required.

• Do you have any other needs we should be aware of?

If you need to cancel or re-arrange the interview for any reason, please let me know. My name is **insert full name** and my number is **insert telephone number**. Please feel free to call if you have any more questions about the research.

**Confirm time and date of appointment and name of interviewer.** We will also be sending a letter/Braille letter/email to you confirming this.
Appendix J
Topic guide

Note to interviewers: Please check before interview whether respondent receives ISDP and/or IB, or moved onto IB when youngest child reached 16. Please ask all questions sensitively. If a respondent becomes distressed, please ask if they are happy to continue with the interview.

Introduction

• introduce yourself
• who project is for – DWP
• aims of the project – finding out more about the health problems of lone parents on benefits
• interview will last around an hour
• confidentiality, taping
• incentive payment
• would you like a rest break during the interview?
• please let us know if you would rather not answer a question
• you can stop the interview at any time

Characteristics

• How many children have you got and how old are they?
• What ethnic group would you describe yourself as belonging to?
Benefits

Claiming health-related benefits

In this study we are talking to lone parents who are claiming health-related benefits: either Income Support with a Disability Premium, or Income Support with Incapacity Benefit, or just Incapacity Benefit.

- What benefits do you currently receive? (after they have answered this, if they are confused, say what they receive according to DWP records)
- How did you find out about Disability Premium/Incapacity Benefit?
- Have you ever been given any information about Disability Premium/Incapacity Benefit from anyone at the Benefits Agency or the Jobcentre?
- Have you ever had any help with claiming Disability Premium/Incapacity Benefit from anyone? (Jobcentre, health professionals etc.)

Only for IB movers:

- Did you try claiming Disability Premium/Incapacity Benefit before your youngest child reached 16?
- Why/why not?
- What happened?
- Why did you decide to claim Incapacity Benefit when your youngest child reached 16?
- Were you concerned about the thought of moving onto Jobseeker’s Allowance, or moving into work when your youngest child reached 16?
- Is there anything the Jobcentre/Benefits Agency could have done, when your youngest child reached 16, to help you?
- Would seeing someone from the Jobcentre/Benefits Agency at that time have helped you?

Benefit history

- How long have you been on benefits?
- What age was your youngest child when you started claiming Income Support?
- What age was your youngest child when you started claiming Disability Premium/Incapacity Benefit?
- Before this current period on benefits, have you been on benefits before? If yes:
  - Which benefits?
  - When was that?
  - How long were you claiming for?
  - Why did your circumstances change?
- How do you feel about being on benefits?
Health problems/impairments

Details of health problems/impairments
- Do you consider yourself to be a disabled person or to have a disability or impairment?
- What are your health problems/impairments?
- How long has the health problem(s)/impairment(s) been present?
- Did you have it before you had children/became a lone parent?
- Has the health problem(s)/impairment(s) been diagnosed by any medical professionals?
- Have any medical professionals told you about how the health problem(s)/impairment(s) may develop?
- Have any medical professionals given you advice on how to manage your health problem(s)/impairment(s)?
- How does your health problem(s)/impairment(s) impact on your ability to carry out normal day-to-day activities?
- How do you cope with your health problem(s)/impairment(s)?

Support for health problems/impairments
- What types of support do you have for your health problem(s)/impairment(s)?
- Who provides this support? (professional carers, family members, friends, your children)
- What types of additional support do you need?

Work

Work history
- What kind of jobs have you done before?
- Have you worked whilst you had your health problem/impairment?
- Have you had to give up a previous job because of a health problem/impairment? (Was employer aware of health problem/impairment? Did you get any support from employer?)

Attitudes to work
- Do you want to work? Why/why not?
- Does your health problem/impairment affect the type of work you can do? (hours, work environment, self-employment, job)
- Does your health problem/impairment mean you can’t work?
- Do you feel ready to work?
- Do you think working would make your health problem/impairment better, make it worse, or would not have any impact?
• Other than your health problem/impairment, what kinds of things make it difficult for you to move into work? (childcare, transport, making work pay, employer attitudes to lone parents/disabilities, confidence, qualifications etc.)

Help to move into work
• If you felt able to work, what kinds of help do you think you would need to help you move into work?
  - Confidence-building?
  - Training/education?
  - Information on childcare?
  - Information about financial help available?
  - Help with finding a job?
  - Finding a supportive employer?
• Which of these are most important?
• Do you know where you would go to try and get help in getting back to work?

Contact with Jobcentre Plus
• What do you think the Jobcentre can offer you?

Experience of Personal Advisers meetings
• Have you ever attended a mandatory meeting with a Personal Adviser as a condition of your IS claim?
  - When was that?
  - What did you talk about?
  - What did the adviser say to you about work?
  - What did you think about this meeting?

Experience of New Deal for Lone Parents
The New Deal for Lone Parents (NDLP) is a voluntary programme to help lone parents into work:
• Have you heard of NDLP?
• Have you ever been asked to take part in NDLP?
• Are you currently on NDLP? (what done, useful?)
• Have you been on NDLP in the past? (when, how long, what done, useful, why left?)
• What would attract you to join NDLP?
Experience of New Deal for Disabled People

The New Deal for Disabled People (NDDP) is a voluntary programme to help disabled people into work:

- Have you ever heard of the NDDP?
- Have you ever been asked to take part in NDDP?
- Are you currently on NDDP? (what done, useful?)
- Have you been on NDDP in the past? (when, how long, what done, useful, why left?)
- What would attract you to join NDDP?

Your health and Jobcentre Plus

- Would you be happy to discuss health with an adviser? Why/why not?
- Do you have any fears or concerns about talking about health with an adviser? (e.g. think your entitlement to benefit will be affected, think you will be forced to work, or think they will assume you are unfit to work?)
- Would you rather see a lone parent adviser or a disability/health adviser?
- Have you ever told anyone at the Jobcentre about your health problem?
  - What did the adviser/staff member say?
  - Did they give you any information/advice?
  - Did you find talking about it with someone from the Jobcentre useful?
  - Did you take up any help offered?
- What more could the Jobcentre do to help you?

Focus group participation

Are you willing to take part in a focus group?

- Incentive payment of £20 plus childcare and transport paid
- Central location with good transport access
- Will last 1½ hours with six to eight other lone parents
- We will ask about your access needs when we contact you.

Thanks and close
Appendix K
Focus group discussion guide

**Note for focus group facilitator:** Topics will be discussed openly first, before prompts are used, or lone parents are asked to respond to specific suggestions.

**Introduction**

- introduce yourself
- who project is for – DWP
- aims of the project (not all participants will have been interviewed)
- discussion will last around an hour and a half
- confidentiality, taping
- incentive payment and travel payments (does not affect benefits)

**Attitude to work**

- Do you want to work? Why/why not?
- What do you think you would gain from working? (keep open at first)
  - Self-esteem?
  - Social networks?
  - Improve health problem and/or disability?
- Would you like to get help in getting back to work?
- How realistic is working at the moment?
- How realistic is working in the future?
- Would it become more realistic if you had support for your health problem and/or disability, and/or help getting back to work?
- Would it become more realistic if your health problem and/or disability improved?
Support to move into work

• If you felt able to work, what kinds of help do you think you would need to help you move into work? (keep open at first)
  – Confidence-building? When and how?
  – Training/education?
  – Information on childcare?
  – Information about financial help available?
  – Help with finding a job?
  – Finding a supportive employer?
• Which of these are most important?
• Do you know where you would go to try and get help in getting back to work?

Support for health problems and/or disabilities

• What support do you have? (keep open at first)
  – Family and friends, children?
  – Health professionals, specialist organisations?
• Have you chosen these types of support, or are you limited to the support that is available?
• What types of additional support do you need for your health and/or disability? (keep open at first)
  – More information and advice?
  – Information on how to manage condition?
  – What types of support?
• Do you know where you would go to try and get help with your health problem and/or disability?

Work history and health problems and/or disabilities

• Have you ever worked whilst you had your health problem/disability?
  – Was employer aware of problem? Why/why not discussed it?
  – Did you receive any support from employer? (details)
• Have you had to give up a job because of a health problem and/or disability?
  – Why did you leave? Their choice or employer decision?
  – What concerns did you have that caused you to leave?
  – Was there anything that would have enabled you to stay? More support, support being given in a different way?
• Do you have any concerns about your ability to sustain work with your health problem and/or disability?
  - What are they? (probe for: employer attitudes, fear that could not do job to required or previous standard, fear of competing with other employees)

• What do you think employers’ attitudes are to people with health problems and/or disabilities?
  - What makes you think that employers have these attitudes? Based on experience? If so, when?

**What could the Jobcentre do to help you**

• What do you think the Jobcentre provides? (probe for just jobs or more than that)

• Would you be happy to discuss health with someone from the Jobcentre/Benefits office? Why/why not? Fears or concerns?

• How would you prefer to be contacted by the Jobcentre? (keep open at first)
  - Letters — Why/why not want these?
  - Telephone calls — Why/why not want these?
  - Home visits — Why/why not want these?

• At the Jobcentre, there are general advisers as well as lone parent advisers and DEAs.
  - Which would you prefer to see? Why?
  - Like to see LP and DEAs?

• Describe NDLp model and ask them whether it would be helpful:

  Having a lone parent personal adviser to help with finding a job, childcare, training, better-off calculation and in-work benefits.

• Describe NDDP model and ask them whether it would be helpful:

  Support to find suitable work, liaising with employers, and support in the workplace from an agency that provides support to people with health problems/disabled people.

• Could the Jobcentre do more to help you? (keep open at first)
  - More information on health-related benefits?
  - Signpost to what support for health problem/disability is available?
  - Help with finding jobs can do with health problems/disabilities?
  - More info about NDLP/NDDP?
  - More info about NDDP?
  - Group sessions with other lone parents?
  - Group sessions with other people with health problems and/or disabilities?


### Other research reports available

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