Disability Policies and Practices in the Rural United Kingdom

Debra A. Harley, Allison R. Fleming, Sherri L. Greer, and Patricia Mundt

Overview

The official name of the United Kingdom (UK) is the United Kingdom of Great Britain and Northern Ireland. The United Kingdom is located northwest of the European continent between the Atlantic Ocean and the North Sea. It has a total land area of 244,100 km², of which 99% is inland and the remainder inland water. The UK is comprised of four geographic regions – England, Scotland, Wales (which together make up Great Britain), and Northern Ireland. The capital of the UK is London. The people of the UK are called British; however, they have different nationalities (*Encyclopaedia Britannica*, 2016). The UK is one of the world's leading business locations and is one of the top ten manufacturers in the world. In addition, the UK has the largest industries in Europe for life sciences, the Incorporated Television Company (ICT), and the creative art industries (British Council, n.d.). The country-side ranges from green meadows and woodland to rugged moorland and mountains. The UK is a country with great geographical diversity. As such, it is not our intention to assume that the broad views expressed in this chapter are representative of the UK. Furthermore, it is beyond the scope of this chapter to include all areas of the UK; however, throughout this chapter, reference is made to specific regions of the UK.

According to the Department of Work and Pensions (2014), there are over 12 million people in the UK with disabilities, and approximately one in five people (19%) has at least one disability. This figure has remained relatively constant over time. The distribution of disability is fairly evenly spread across the UK. Across the EU member states, an estimated 25% of the population aged 16 and over have a disability. Aggregation of this percentage reveals the disability prevalence rate is lowest in Malta (12%), Sweden (16%), and Ireland (17%) and highest in Croatia (335), Slovakia (34%), and Slovenia (36%). The rate is 21.5% in the UK (Academic Network of European Disability Experts, 2013). Yet many people who have rights under the disability provision of the Equality Act do not consider themselves as having a disability (Heslop, 2013).

There is a consensus among unions, employers, insurers, and healthcare professionals regarding the need to improve rehabilitation in the UK (Department of Work and Pensions [DWP], 2004). The three main diagnostic or disability groups that

D.A. Harley (✉)
Department of Early Childhood, Special Education, and Rehabilitation Counseling, University of Kentucky, Lexington, KY, USA
e-mail: dharl00@email.uky.edu

S.L. Greer • P. Mundt
ESDRC Department, University of Kentucky, Lexington, KY, USA

A.R. Fleming
Rehabilitation and Human Services, Pennsylvania State University, University Park, PA, USA

account for the majority of sickness and invalidity (known as Supplemental Security Income and Social Security Disability Insurance in the USA) in the UK are musculoskeletal disorders, mental health disorders, and cardiorespiratory disorders (Gobelet & Franchignoni, n.d.). These three disorders account for approximately two-thirds of sickness absence, long-term incapacity, and ill-health retirement (disability) (Waddell & Aylward, 2005; Waddell & Burton, 2004). In fact, musculoskeletal conditions are a major cause of work absence and loss of work productivity in the UK (Black, 2008). Approximately 40% of people with rheumatoid arthritis (RA) stop working within 5 years of diagnosis (Young, Prouse, & Williams, 2009) because the onset of RA occurs most frequently at the prime employment age. However, people with mental health disorders, learning disabilities, or psychological impairments are less likely to be employed than are people with physical disabilities (Malo & Garcia-Serrano, 2001).

Healthcare coverage in the UK is universal. That is, "all those 'ordinary residents' in England are automatically entitled to health care that is largely free at the point of use through the National Health Service" (The Commonwealth Fund, 2016). Although healthcare has a key role in the treatment of illness and injuries, vocational rehabilitation also has a key impact in the outcomes of workers returning to work. According to Waddell, Burton, and Kendall (2013), "effective vocational rehabilitation depends on work-focused healthcare and accommodating workplace… Both are necessary: they are interdependent and must be coordinated" (pp. 5–6). Waddell et al. (2013) assert that "vocational rehabilitation should be a fundamental element of Government strategy to improve the health of working-age people" (p. 8).

Learning Objectives
By the end of this chapter, the reader should be able to:

1. Understand the general status of people with disabilities in the UK.
2. Compare legislation and government initiatives for people with disabilities of the UK and the USA.

3. Identify barriers to vocational rehabilitation services in the UK.
4. Identify cross-cultural implications of VR services for the UK.

Introduction

Vocational rehabilitation has many different definitions; however, the core principle is to engage individuals following injury or illness in a process of active change arriving at an improvement in functional ability and greater participation in society (British Society of Rehabilitation Medicine [BSRM], 2003). "In simple language, vocational rehabilitation is whatever helps someone with a health problem to stay at, return to and remain in work" (Waddell et al., 2013, p. 10). Work rehabilitation, also referred to as occupational rehabilitation and vocational rehabilitation, is defined by the UK Department of Work and Pensions (DWP) as "a process to overcome barriers an individual faces when accessing, remaining or returning to work following injury, illness, or impairment" (DWP, 2004, p. 3). Vocational rehabilitation is required both for people who become incapacitated during their working life (job retention) and for those with congenital or early-onset disabilities who require assistance initially to enter the employment market (BSRM, 2003). In the UK, vocational rehabilitation is influenced by multiple entities: charitable organizations, the Department for Education and Employment (DfEE), Department of Health (DOH), Department of Social Security (DSS), Department of Trade and Industry (DTI), and employers and their occupational health resources (BSRM, 2003).

The *Vocational Rehabilitation Standards of Practice* of the Vocational Rehabilitation Association (VRA) UK (2007) purports that several rehabilitation disciplines (e.g., medical, behavioral, vocational) and related process (e.g., case management, work adjustment, job placement) are linked within the central field, and an individual scope of practice may overlap with the central scope of vocational rehabilitation. Within the UK, "the VR professional is required to gain and maintain knowledge, education and profes-

sional experience for compliance with the Disability Discrimination Act (DDA) and specifically with reasonable adjustments" (p. 12). When services outside of the scope of practice of the VR professional are necessary, a clearly written justification for access to specialists is required.

Waddell et al. (2013) contend that key stakeholders need to understand the evidence-based aspects of vocational rehabilitation, specifically what works, for whom, and when. Furthermore, vocational rehabilitation is good business, is cost-effective, increases pathways to work and to return to work rate of benefit claimants, and should be underpinned by education to inform the public, health professionals, and employer about the value of work for health and recovery. The area in which more attention is needed regarding vocational rehabilitation is to improve interventions for mental health disorders, which are the largest and fastest-growing cause of long-term incapacity/disability in the UK (Waddell et al., 2013).

Rural services across multiple domains (e.g., healthcare, commerce, housing, transportation, police services) have been in steady decline over many decades, thereby reducing the ability of available organizations to a more basic level of service and a far smaller range of services than their urban counterparts. In addition, the challenges of services in rural areas are exacerbated by inadequate facilities; higher costs; socioeconomic, cultural, and political influences; and lack of counseling and related services for people with disabilities and their caretakers (Wood, 2004). Wood (2004) emphasized further "marginalization or social exclusion – hardship from low incomes, isolation, the lack of a secure home, difficulties reaching essential healthcare and services, powerlessness and the breakdown of social networks – may exist for groups of rural residents, either as a hidden or visible issue" (p. 10). Clearly, rural poverty has health implications for persons living in rural areas and further disadvantages those with disabilities.

In a comparison of health confidence in rural, suburban, and urban areas in the UK and the USA, Haven, Celaya, Pierson, Weisskopf, and MacKinnon (2013) found significant differences

between the UK and the USA among residence types and between the two regions within residence types. Levels of health confidence were higher in the UK, and significant differences were found within regions in the USA, but not for the UK. The results of this study are consistent with earlier findings that the UK has one of the highest levels of patient satisfaction among European countries (Coulter & Jenkinson, 2005). Haven et al. suggested:

(a) Confidence in one's individual healthcare and the healthcare system may play a key role in influencing patients' utilization, assessment, and expressed desires regarding their health.
(b) Higher suburban confidence than urban and rural in the USA implies that factors in sub-

---

Research Box 24.1
See Haven et al. (2013).

Objective: This study aimed to determine whether self-reported confidence in healthcare differed between the UK and the USA, as well as by rurality or urbanicity.

Method: A secondary analysis was done of a subset of survey questions regarding self-reported confidence in healthcare from the 2010 Commonwealth Fund International Health Policy Survey. A telephone survey was conducted in participants from the UK and the USA. Participants consisted of 1511 UK residents (688 rural, 446 suburban, 372 urban, and 5 uncategorized) and 2501 US residents (536 rural, 1294 suburban, and 671 urban).

Results: Significant differences were found in self-reported confidence in healthcare between the UK and USA, among resident types and between the two regions within residence types. Reported levels were higher in the UK. Within regions, significant differences by resident type were

found for the USA, but not for the UK. Within the USA, suburban respondents had the highest self-reported confidence in healthcare.

Conclusion: The findings warrant the examination of causes for relative confidence levels in healthcare between regions and among US residence types.

Questions:
1. What are the limitations of this study?
2. How could the definition of rurality have influenced the categories in the UK and the USA?
3. What additional variable would you examine, and how would you redesign this study?

Table 24.1 Relevant legislation

Health and Safety at Work Act (1974)
Sex Discrimination Act (1975)
Race Relations Act (1976)
Access to Medical Reports Act (1988)
Access to Health Records Act (1990)
Employment Rights Act (1996)
Data Protection Act (1998)
Human Rights Act (1998)
Disability Rights Commission Act (1999)
Race Relations (Amendment Act (2000))

Adapted from Barnes, Holmes, and the National Executive Committee of the College of Occupational Therapists Specialist Section – Work (2009) and Sayce and Boardman (2003)

urban resident settings may contribute to a sense of control or reliability.

(c) Lower confidence in rural Americans may be attributable to more than health insurance coverage and other factors such as income, race/ethnicity, age, and sociocultural factors (see Research Box 24.1).

Legislative Framework

The UK ratified the United Nations Convention on the Rights of Disabled People in July 2009. All UK government policies and practices must comply with the convention. The Office for Disability Issues (ODI) coordinates work on the convention on behalf of the UK government (Gov.UK, 2015). The key elements of vocational rehabilitation in the UK are identified as:

1. Assessment of functional, physical, psychological, and cognitive work capacity
2. Vocational assessment and counseling to determine suitable job options
3. Counseling to support adjustment to disability
4. Supervised on-the-job training and/or a short vocational course

5. Fitness and work conditioning programs
6. Confidence-building/self-esteem groups or individual sessions
7. Assessment of workplace suitability
8. Development of skills for job seeking
9. Brokerage and case management
10. Linkage with community-based agencies (Scottish Executive, Co-ordinated, Integrated and Fit for Purpose, 2007, p. 35)

In this section, several select pieces of legislation and government initiatives are discussed (see Table 24.1 for a list of other relevant legislations).

Disability Discrimination Act (DDA) of 1995 The DDA was extended in 2005. The key provisions of the DDA are (a) the definition of who meets the criteria of a disability; (b) protection from discrimination in employment; (c) protection from discrimination in the provision of goods, services, and facilities; and (d) protection from discrimination in education (Sayce & Boardman, 2003). Under the DDA, it is unlawful for organizations to discriminate (i.e., treat people with disabilities less favorably, for reasons related to their disability, without justification) in employment; access to goods, facilities, and services; managing, buying or renting land or property; and education. In addition, businesses must make *reasonable adjustments* (e.g., part-time work, mentor support, work in a different setting) to their policies or practices, or physical aspects of their

premises, to avoid indirect discrimination. Initially, the act was relevant to employers with 15 or more employees. As of 2004, the provisions of the DDA are applicable to nearly all employers, not only those with 15 or more employees. Furthermore, the employment provisions of the DDA cover people with physical or mental impairments that have a substantial and long-term adverse effect on their ability to carry out activities of daily living. Finally, the act provides protection at the recruitment stage as well as for individuals already employed (Sayce & Boardman, 2003).

Status of People with Disabilities in the UK

According to Power and Power (2010), "people with disabilities represent a significant but often overlooked proportion of the British population" (p. 1). In 2012 and 2013, the most common impairments were mobility (57%), stamina/breathing/fatigue (38%), dexterity (28%), and mental health (16%) (Department for Work and Pensions, 2014). The prevalence of disabilities increases with age. According to the Department for Work and Pensions (2014), 7% of children had a disability compared to 16% of adults of working age and 43% of adults over the state pension age. The number of older people with disabilities is estimated to increase to 40% by 2020, if age-related disability rates remain constant (Institute for Public Policy Research, 2007). More women than men have disabilities in the UK. White ethnic groups are almost twice as likely as non-White ethnic groups to have chronic illness or disability (20% compared with 11%; Office of National Statistics, 2014). The occurrence of mental health-related illness is increasing, with estimates that one in four people will experience a mental health issue in any given year (Mind, 2009).

A consensus exists among unions, employers, insurers, and healthcare professionals regarding the need to improve rehabilitation in the UK (Department of Work and Pensions [DWP], 2004). The three main diagnostic or disability groups that account for the majority of sickness and invalidity (known as Supplemental Security Income [SSI] and Social Security Disability Insurance [SSDI] in the USA) in the UK are musculoskeletal disorders, mental health disorders, and cardiorespiratory disorders (Gobelet & Franchignoni, n.d.). These three disorders account for approximately two-thirds of sickness absence, long-term incapacity, and ill-health retirement (disability) (Waddell & Aylward, 2005: Waddell & Burton, 2004). In fact, musculoskeletal conditions are a major cause of work absence and loss of work productivity in the UK (Black, 2008). Approximately 40% of people with rheumatoid arthritis (RA) stop working within 5 years of diagnosis (Young et al., 2009), which is particularly problematic because the onset of RA occurs most frequently at the prime employment age. However, people with mental health disorders, learning disabilities, or psychological impairments are less likely to be employed than are people with physical disabilities (Malo & Garcia-Serrano, 2001).

People with disabilities are more likely to be unemployed, with the UK employment rate for working-age adults with disabilities being 49% compared to 81.8% for nondisabled people. Approximately 45% of working-age people with disabilities are economically inactive (The Annual Population Survey, 2013). Nineteen percent of households that include a person with a disability live in poverty compared to 14% of households without a person with a disability (Department for Work and Pensions, 2014). Of working-age adults with disabilities who are employed, the two most common accommodations are modified hours or days or reduced work hours and tax credits (Office of Disability Issues, 2011). The high rate of unemployment is the primary reason attributed to the observation that many people with disabilities are in low-income households. In addition, people with disabilities are disproportionately more likely to live in substandard housing; there is a shortage of housing that is architecturally or universally designed to meet the needs of people with disabilities (Department for Communities and Local Government, 2009). In fact, the majority

of homes in England do not allow for access for someone using a wheelchair to enter the door without difficulty (Habinteg, 2014).

For people aged 25 to retirement with disabilities living in the UK, approximately one-third is living in low-income households (twice the rate of that for nondisabled adults). The low-income rate for those with disabilities of working-age adults is similar in 2008 but somewhat higher than in the mid-1990s. In addition, the proportion of economically inactive working-age adults who are in relative low income is higher in the UK than in any other EU country, and many of these people have disabilities (Department for Work and Pensions, 2014; Palmer, n.d.). Finally, people with disabilities in the UK identified challenging areas of their life to include health and well-being, money and benefits, leisure, and work and employment (Copestake, Sheikh, Johnston, and Bollen (2014).

In general, the situation for people with disabilities in the UK is characterized by the following:

1. Transportation barriers: pavement and road maintenance, access, and frequency of public transport are the major issues (Transport Research and Innovation Portal, n.d.).
2. Victimized by hate crimes (Home Office, 2014).
3. Reduced participation in the labor market in all European countries. At the EU level, about 47% of people with disabilities are employed, compared to 72% of nondisabled people. The average employment gap is 25% (Academic Network of European Disability Experts, 2013).
4. Higher risk of poverty compared to nondisabled people across all EU member states (Academic Network of European Disability Experts, 2013).
5. The majority of people with a disability acquire their disability later in life (Disability in the United Kingdom: Facts and Figures, 2014).
6. People with disabilities of state pension age are more likely than those of working age to report multiple impairments (Department for Work and Pensions, 2014).

7. People with disabilities of working age are more likely than those of state pension age to report problems with mental health disorders, learning disabilities, and social and behavioral impairments (Department for Work and Pensions, 2014).

For additional information and statistics on disability in the UK, see Disability in the United Kingdom 2014: *Facts and Figures* (2014) available at http://www.base-uk.org/sites/default/files/uk_disability_facts_and_figures_report_2014.pdf. The highest concentration rates of disability and number of life areas (e.g., education, leisure) in which participation is restricted are in the North East, Wales, the North West and East Midlands, which have higher numbers of residents defined as historically poor. This is largely due to a legacy of hard labor industries such as coal mining and shipbuilding (Office for National Statistics, 2013). The lowest rates of disability and restrictions of life areas are in London and the South East and the East England (Department for Work and Pensions, 2014). People living in Wales are most likely to have a limiting chronic illness or disability when compared to other regions of Great Britain (Office for National Statistics, 2013).

Disability and Geography Rural-urban classification defines areas as rural if they fall outside of settlements with more than 10,000 residents (GOV.UK, 2016a). The rate of disability in the UK varies according to geographic region. People with disabilities tend to be concentrated in poorer areas as a result of lower incomes and social allocation policy (OPDM, 2005). In addition to higher rates of disability within economically depressed areas, a general north-south divide with health in the North East is historically poor. A legacy of heavy industries (e.g., coal mining, shipbuilding), lifestyle choices, and other complex factors is attributed as the cause of such higher rates of disability in these areas (Office for National Statistics, 2013). According to the Department for Work and Pensions (2014), the distribution of people with disabilities is fairly even across the UK with the North East at 25%,

Wales at 24%, the North West at 22%, and East Midlands at 22%. Conversely, London and the South East and the East of England have the lowest rates of disability at 14, 16, and 19%, respectively (Office of Disability Issues, 2011). However, residents of Wales are most likely to have a limiting chronic illness or disability when compared within other regions of Great Britain (Office of National Statistics, 2014). The areas with the highest proportions of people living with a limiting long-term health problem or disability are East Lindsey (26%), Blackpool (25.6%), and Tendring (25.5%), while the lowest levels are in Wandsworth (11.2%), Richmond upon Thames (11.5%), and the city of London (11.5%) (Office of National Statistics, 2013).

According to GOV.UK (2016b), the life expectancy is higher, infant mortality rate is lower, and potential years of life lost from common causes of premature death is lower in rural than urban areas. The most common cause of premature death in England is coronary heart disease, followed by cancer and stroke. However, individuals living in rural areas that are economically deprived and have poor health are in the greatest need and have the least opportunity to access services and "are hidden amongst scattered communities of the generally affluent and healthy" (Wood, 2004, p. 22). Although the health outcomes are more favorable for individuals living in rural than urban areas, this does not necessarily mean that they are healthier, rather potentially reflecting unmet need for services. Wood (2004) cautioned against the notion that "rural advantages" make rural areas healthier in which to live when, in fact, a succession of studies have questioned such a notion (p. 10). Furthermore, rural residents may be less likely to present with an illness and tend to seek help at a later stage of the development of an illness (Wood, 2004). Although rural populations face the same range of illnesses, health issues, lifestyle choices, and medical interventions as their urban counterparts, rural residents have fewer choices of primary healthcare providers and range of local services and are more likely to have to travel greater distance to access healthcare services. Unmet need due to service inaccessibility and poor geographical access is a problem in rural areas, presenting a challenge for rural service providers not only to measure needs more accurately but also to respond effectively (Wood, 2004).

Social Attitudes Toward People with Disabilities

The UK has made significant progress in integrating an anti-discrimination agenda into key areas of social life; however, attitudinal and structural change has been considerably slower (Pearson & Watson, 2007). Many people with disabilities in the UK frequently perceive that they do not have freedom of choice and autonomy over their daily lives. Furthermore, people in the general public believe that people with disabilities are less productive than nondisabled people and that people with disabilities need to be taken care of, suggesting a degree of "benevolent prejudice" exists toward people with disabilities (Office for Disability Issues, 2011). A survey by the Multiple Sclerosis Society (2012) found that British adults think people with disabilities need to accept unequal opportunity in their lives and believe individuals often overstate the level of their physical limitations. In both instances, men were more likely than women to hold these views.

Other perceptions of the general public toward people with disabilities in the UK revealed the following actions would positively affect attitudes toward people with disabilities: (a) greater presence of people with disabilities in daily life, (b) greater presence of people with disabilities in the workplace, (c) greater public discussion of issues facing people with disabilities, (d) people with disabilities and nondisabled children in integrated setting both inside and outside school, (e) more politicians with disabilities, and (f) more people with disabilities in the media (ComRes, 2011). Conversely, the following public attitudes would have negative effects on people with disabilities: (a) comedians making jokes about people with disabilities, (b) negative media coverage around people receiving disability benefits, (c) people claiming benefits when they do not have a disability, and (d) people using offensive lan-

guage about people with disabilities (ComRes, 2011). Finally, people with disabilities had a lower engagement rate than nondisabled people in the arts and cultural sectors, in part due to physical barriers, lack of suitable transportation, and lack of communication devices at venues (Arts Council England, 2013; Office for Disability Issues, 2011).

Attitudes toward people with learning disabilities (LD) have become more favorable following greater emphasis on inclusion in educational and social settings in the UK. However, LD appears to be more stigmatized than physical and sensory disabilities but less so than mental health disorders (Scior & Werner, 2015). The fact that discrimination against people with LD is still an everyday reality is illustrated by high rates of unemployment and incidents of bullying and verbal abuse, physical harassment and violence, and hate crimes, seemingly for no reason other than appearing different and less able to defend themselves (Quarmby, 2008, 2011). Wilson and Scior (2015) examined implicit attitudes of adult UK residents toward people with intellectual/developmental disabilities (IDD) and also their association with emotional reactions and contact, which have previously been found to have a significant influence on attitudes and stigma. The results indicated implicit attitudes were not associated with explicit attitudes, social distance, or emotional reactions. Nevertheless, there were small to moderate associations between emotional reactions and explicit attitudes and social distance. Implicit attitudes did not vary according to participants' level of contact with individuals with IDD, type of the contact relationship (voluntary versus involuntary), gender, or educational attainment. Conversely, these participants' characteristics did affect explicit attitudes and social distance. Implicit attitudes toward individuals with IDD were somewhat negative and, unlike explicit attitudes and stigma, did not vary according to participant demographics or contact (Wilson & Scior, 2015).

Robinson, Martin, and Thompson (2007) examined attitudes toward and perceptions of disability of both people with disabilities and without disabilities. Participants were asked to respond to certain illnesses, conditions, impairments, and injuries and whether people were considered to have a disability. The following responses were perceptions of what constitutes a person having a disability: (a) using a wheelchair (91%), (b) blindness (87%), (c) severe arthritis (81%), (d) Down syndrome (71%), (e) schizophrenia (48%), (f) cancer (44%), (g) older person with hearing aid (44%), (h) severe depression (40%), (i) a broken leg (31%), (j) HIV/AIDS (27%), and (k) severe facial disfigurement (25%). Responses to these same conditions based on whether or not the respondent had a disability were as follows (for having a disability versus not having a disability): (a) 86 vs. 92%, (b) 83 vs. 88%, (c) 84 vs. 80%, (d) 64 vs. 72%, (e) 51 vs. 48%, (f) 56 vs. 41%, (g) 38 vs. 45%, (h) 49 vs. 38%, (i) 31 vs. 32%, (j) 32 vs. 26%, and (k) 28 vs. 25%. Understanding the implicit and explicit attitudes and perceptions held by people toward people with disabilities is important because both may have negative impact on the lives of people with disabilities (Wilson & Scior, 2015). See Table 24.2 for additional findings from Robinson et al. (2007).

In addition to the general social exclusion of people with disabilities, many do not participate in health- and social care because of receiving insufficient support, particularly from social care services, poor experiences of diagnosis/post-diagnosis support, and ineffective joining up between health- and social care services (Copestake et al., 2014). Copestake et al. assert that health inequalities cannot be addressed without tackling social inequalities. The experiences of people with disabilities in health and social care are punctuated by stigma and discrimination and create barriers for them in various spheres of life.

Barriers for People with Disabilities

In the UK, the law mandates accessibility to buildings and accommodation for people with disabilities. Although the law requires that all public service providers make "reasonable adjustments" to ensure their services are avail-

Table 24.2 Attitudes toward and perceptions of people with disabilities

A person who uses a wheelchair and a blind person are most frequently defined as having a disability
A person with HIV/AIDS and a person with a severe facial disfigurement are most frequently not seen as having a disability
Three-quarters perceived there has to be prejudice in society against people with disabilities
It was thought most prejudice exists against people with schizophrenia and HIV/AIDS
Respondents with disabilities consider there has to be slightly more prejudice in society against people with disabilities in general than nondisabled respondents
Most respondents felt comfortable with having contact with a person in a wheelchair, a blind person, or a person who cannot hear without a hearing aid
Respondents were least comfortable with people with mental health disorders
Generally, respondents would feel most comfortable with a person with a disability living next door and least comfortable with a disabled person marrying a close relative
Few respondents with disabilities reported violent, abusive, unfair, or unpleasant behavior
Where acts of violent, abusive, unfair, or unpleasant behavior had occurred, it was mostly on the street
Most respondents had not witnessed violent, abusive, unfair, or unpleasant behavior
Two-thirds of respondents with disabilities were confident with using public transportation
Respondents mostly thought that people in Britain do not think of people as getting in the way or with discomfort and awkwardness, over half the respondents thought that people in Britain thought people with disabilities need to be cared for, and over half thought that people in Britain thought they were the same as everyone else
Fewer respondents themselves thought people with disabilities got in the way and thought of them with discomfort and awkwardness than they thought people in Britain would think in that way
Respondents personally were more likely to think of people with disabilities as being needed to be cared for and more likely to think of them as the same than they thought people in Britain would think
No consistent views from respondents on whether people with disabilities should be expected to work rather than rely on benefits
Majority of respondents thought of people with disabilities as making just as good parents as nondisabled people
Most respondents thought that students with disabilities could do as well as nondisabled students
The majority of respondents thought that a person with a disability should not have to live in a residential home if they do not want to

Adapted from Robinson et al. (2007)

able to people with disabilities, the transportation section is an exception. The London Underground and the UK's national rail system are not readily accessible for people with disabilities. Moreover, public areas such as sidewalks may not be as accessible as well because many of them are narrow and uneven (Country Reports, 2017).

Higgins (2007) identified common barriers to rehabilitation in the UK to include the following:

1. Access to medical treatment due to extended National Health Service (NHS) waiting list
2. Economic factors – generous occupational sick pay or disability benefits
3. Lack of top-level organizational commitment
4. Costs of workplace modifications and availability of suitable alternative duties, particularly for smaller firms
5. Poor communication and lack of a common purpose among key stakeholders
6. Lack of coordinated approach among rehabilitation providers

An additional barrier is the inability of UK healthcare professionals, especially primary care, to initiate or refer for VR services as their clinical management and the provision of sickness certification may initiate prolonged absence from work (NHS, 2008). For example, rheumatologists and hospital-based therapists that focused on physical rehabilitation therapy did not recognize which patients could benefit from referral to a disability employment advisor and the subsequent support that can be offered to working patients (Gilworth, Haigh, Tennant, Chamberland, & Harvey, 2001). A similar barrier was found

among UK community mental health teams (CMHTs) in supporting clients' vocational aspirations. Seebhom and Secker (2003) found CMHTs lacked knowledge about disability benefits or sufficient understanding about certain elements of interprofessional collaboration to enable clients to find and keep employment. The extent of concern was echoed by the Royal College of Psychiatrist, which asserted "CHMTs were ideally placed to take the lead in coordinating the vocational rehabilitation of those with psychiatric disorders, but lacked sufficient expertise in welfare advice and vocational work" (NHS, 2008, p. 15). Other barriers include inadequate access to and/or limited availability of health professionals, personnel's lack of skills to assist people with complex disabilities, and lack of collaboration between government and nongovernment organizations.

Despite increased physical integration, in general, people with disabilities, especially intellectual and developmental, remain socially excluded and vulnerable in the UK (Wilson & Scior, 2015). Since the adoption by the EU of the term social exclusion in the late 1980s, which was an effort to combat stigma attached to poverty and deprivation and subsequently to marginalization and unemployment, people with disabilities have continued to have restricted opportunities to participate in wider social and cultural activities (Rimmerman, 2013). Having sufficient choice and control over one's life is one of the key planks of government policy in the UK. Copestake et al. (2014) found people with disabilities in the UK have a long way to go to fill this aim. Limited self-confidence and self-advocacy interfere with some people with disabilities' capability to gain access to information about their rights or to engage in a legal battle when they are victims of discrimination (Gore & Parckar, 2010).

Government Initiatives to Enhance Opportunities for PWDs

In an effort to address some of these barriers faced by UK residents with disabilities, several programmatic initiatives have been developed, predominately in the areas of employment and return to work services. The following is a discussion of recent initiatives and a comparison to benefits and services that exist in the USA.

Pathways to Work (Pathways) Pathways to Work was originally introduced in 2003. The aim of Pathways is to assist incapacity claimants (PWDs) into, and toward, competitive employment (paid work). Pathways introduced mandatory work-focused interviews (WFI) with specialist incapacity benefit personal advisors (IBPA) and offer a range of services focusing on work and health, including the condition management program (CMP). The CMP provides assistance to customers (clients) to help them manage their health conditions. Services such as the New Deal for Disabled People (NDDP), Work-Based Learning for Adults (WBLA), Training for Work (TfW), and program centers were assembled into a coherent "choice package" that provides systemic work-focused support. In addition, payments have been added for those finding work to act as incentives. Jobcentre Plus is at the core of Pathways to Work. Initially, the mandatory program focused on individuals making a new or repeat claim for incapacity benefits (IB), but in 2005 it was extended to include individuals who had already been claiming IB for 1–3 years. Incapacity benefits is income support with a disability premium and is the UK's largest disability support program (Becker, Hayllar, & Wood, 2010). From a policy perspective, Pathways was initiated to (a) modernize disability policy with other twenty-first-century integration and self-sufficiency goals, (b) increase employment rates across the working-age populations, and (c) reduce the number of claimants receiving benefit (O' Day & Stapleton, 2008).

O' Day and Stapleton (2008) compare and contrast employment support and financial assistance programs for PWDs in the USA and the UK. First, both employment and financial assistance for PWDs in the USA lack the integration for programs in the UK. In the USA, the primary financial disability benefit program (i.e., SSI, SSDI) "require that a person, in essence, be unable to work to qualify for benefits, which lim-

its return-to-work outcomes, and in part, explains why few people leave these programs' rolls" (p. 1). The SSI/DI eligibility focuses upon work limitations. In contrast, the UK's disability support system integrates employment support with financial assistance, especially for people claiming IB. Eligibility for IB is based upon a work capacity assessment that emphasizes a person's work abilities (O' Day & Stapleton). Secondly, the Pathways program integrates employment supports and IB by providing a series of mandatory supports geared to promote employment. Thirdly, universal healthcare is available in the UK. In the USA, universal healthcare is not an option; however, the Affordable Care Act has made subsidized healthcare coverage more readily available.

Employment and Support Allowance In 2008, the UK government implemented the Employment and Support Allowance (ESA), which replaced the IB program. The ESA is a benefit for people who are unable to work due to illness or disability. In comparison to the USA, ESA is the main UK's welfare benefit that provides financial support to individuals having difficulty finding and maintaining employment because of long-term illness or disability. There are two types of ESA. The first is contributed-based ESA in which an individual can receive if he or she has paid enough national insurance. It is a flat-rate benefit. Contributory ESA is not affected by any savings or other income, except for occupational or personal pensions. Unless an individual is placed in the *support group* (SG) (see Table 24.2), payment of contributory ESA will be limited to 12 months. Contribution-based ESA is taxable (AgeUK,

2015; Greaves, 2016). The second is income-related ESA, in which an individual can receive if he or she has no income or a low income. Payment into national insurance is not required nor is it taxable. Income-related ESA is a means-tested benefit. Income-related ESA is calculated based on an individual's needs, including those of a partner, and compared with the money the individual possesses, such as income and savings. Income-related ESA can be paid on its own (if the individual is not entitled to contributory ESA) or as a top-up to contributory ESA (if the individual is entitled). Income-related ESA can include amounts to help toward mortgage interest payments and some other housing cost. Unlike contributory ESA, income-related ESA is not time limited (Greaves, 2016) (Table 24.3).

The major change that accompanied the ESA program is the introduction of the work-related activity group (WRAG) and the support group (SG) for all claimants found not to be "fit for work" (FFW) (Morris, 2014). Morris explains the decision-making process for placement into WRAG and SG as follows:

> Decisions for the WRAG group are based on a score of 15 points or more against the functional descriptors described in the legislation. Those in the WRAG group may also have non-functional impairments, such as suffering from a life threatening disease that is seen as controllable or another recoverable medical condition. Placement in the SG, on the other hand, depends on the existence of a severe condition (e.g., chemotherapy, terminal illness, pregnancy risks, and those who meet functional criteria for severe physical or mental health risks, pp. 6–7).

Work Capacity Assessment (WCA) The WCA is the disability determination process that was

Table 24.3 Support group

If it is decided that an individual has a limited capacity for work-related activity, he or she will be placed in the support group of claimants. If placed in this group, the individual will not have to undertake work-related activities (although he or she can volunteer to do so if desired). The individual will receive a higher rate of ESA than claimants who are placed in the work-related activity group. If the individual is receiving contributory ESA, it can be paid indefinitely (as long as he or she continues to satisfy the conditions for it)

Adapted from Greaves (2016)

introduced in 2008 as an overhaul of the Great Britain disability benefit program. To determine whether an individual is too severely disabled to work, the Department for Work and Pensions has the individual complete a WCA. As part of the WCA, individuals may be asked to answer questions about how their disability affects their ability to work and to complete a medical assessment to determine how the condition affects their life and ability to work. If the individual is determined well enough to work, ESA is denied, and the individual has 1 month to appeal the decision. If ESA is approved, the individual will be placed in WRAG or SG (Greaves, 2016). A printable form of the guide for benefits and credits of ESA is available at https://www.gov.uk/employment-support-allowance/print.

New Deal for Disabled People (NDDP) The NDDP is the major program helping beneficiaries with disabilities (incapacity) get back into the workforce. It is a voluntary program where people with disabilities contact an approved job broker who works as a case manager to find suitable employment (in the USA, a similar model is Ticket to Work). The job broker has no involvement with VR but does assist with potential barriers to working such as mobility issues (NHS, 2008).

Legislation and government initiatives in the UK for people with disabilities are a response to inequalities. The intent is to identify the issues of people with disabilities as relevant and deserving of attention. Maintaining a focus on this population can help to improve the vocational rehabilitation service delivery system.

Vocational Rehabilitation Service Delivery System

Government officials and practitioners of various disciplines (e.g., rehabilitation specialist, occupational therapy) recognize VR does not occur in a vacuum. That is, the current VR environment in the UK reflects what is required of a working population, and as such work is deeply embedded in a political-economic-social context (Barnes et al., 2009). Barnes et al. suggest VR emphasizes having as many people working as possible as the goal, including removal of as many people of incapacity benefits and to create better working opportunities for people with disabilities. Suggested routes to help individuals back into work are through the same employer, different employer, or self-employment (Frank, 2016).

The traditional or medical model of rehabilitation is the dominant course in the UK. The traditional rehabilitation model consists of medical treatment, medical rehabilitation, vocational rehabilitation, and return to work or medical retirement (Waddell & Burton, 2004). The NHS rarely considers or provides vocational rehabilitation services (Waddell and Burton), even though early intervention is crucial in the 6 months before a person enters incapacity benefits, and once receiving incapacity benefits, individuals who receive it for 12 months stay on them for an average of 8 years (Chamberland & Frank, 2004). A pilot service, the Vocational Rehabilitation Service (VR service), which provided support for people with cancer, multiple sclerosis, and inflammatory bowel disease, was delivered between 2011 and 2014. The VR service had a target of engaging 160 clients. At the end of the pilot data, 303 people had used the VR service, 260 had been discharged, and 43 clients were still receiving support. The main referral sources were NHS and self-referrals. Self-referrals were signposted from a range of sources including health professionals. The case managers were successful in raising awareness of the service and encouraging health professionals to refer and signpost. Overall, clients and referrers evaluated the service model positively. The model offered (a) a tiered case management process, (b) specialist support with a strong focus on clients' work needs delivered by case managers who are vocational rehabilitation specialists, (c) client-led support, (d) open access with referrals accepted from a wide range of sources, and (e) links to other services to facilitate referral and signposting (McGregor, 2014).

In a review of the state of vocational rehabilitation in the UK, Frank and Thurgood (2006) concluded that close collaboration between the

employment and health sectors is required to maintain an active and healthy workforce. Furthermore, to facilitate this collaboration, a group of trained health professionals is required. Greer (2011) contends allied health professionals (AHPs) are valuable in contributing to vocational rehabilitation in mental health services because they "have access to a range of models of practice and associated assessment and outcome measure tools which can support the development, implementation and evaluation of vocational rehabilitation practice" (p. 19). Models of vocational rehabilitation for mental health service users include supported employment, social firm (small business which provides support paid or unpaid work opportunities for individuals with mental health (MH) difficulties alongside other employees), clubhouse, transitional employment, supported education, and prevocational skills for work (Greer, 2011). According to Bond, Drake, and Becker (2008), evidence-based supported employment (EBSE) (e.g., individual placement and support model) is clearly demonstrated as the most effective means of supporting people with severe and enduring MH problems to gain and maintain employment. The enhancing the quality of life and independence of persons disabled by severe mental illness through supported employment (EQOLISE) project compared EBSE with other vocational rehabilitation services using pre-vocational models in six European countries and concluded the following: (a) EBSE clients were twice as likely to gain employment (55 vs. 28%) and worked significantly longer, (b) the total costs for EBSE were generally lower than standard services over the first 6 months, (c) clients who had worked for at least 1 month in the previous 5 years had better outcomes, and (d) individuals who gained employment had reduced hospitalization rates (Burns et al., 2007). Recent UK-MH policy recommends the use of EBSE as an important element of a comprehensive vocational rehabilitation service and centers of excellence (Greer, 2011, see p. 51–52 for a summary of key Scottish and UK policy relating to vocational rehabilitation and MH).

The social model emphasizes the societal barriers that people with disabilities face, rather than people having a disability because of their impairments. However, adhering to the social model does not mean ignoring these impairments because condition and impairment management is an important resource and part of life for people with disabilities (Copestake et al., 2014). However, Crawford (2012) asserts although the social model of disability has informed much of the research in the UK, evidence suggests this approach may not inform practice, particularly at the local level.

Table 24.4 Comparison of UK to other countries

USA
Assessment and rehabilitation have been, for many years, a more systematic and sophisticated process
Work samples and computerized occupational information are used extensively. There are several "systems" of work samples, of which Valpar and the key system are perhaps the most widely used in the UK. Valpar is rarely used against the standardized employment information of the American system
Rehabilitation (referred to as work preparation in the UK) is also more systematic in the USA. In the USA, it is called work adjustment, and an important part of the assessment (evaluation) process is to identify the "critical work behaviors," which individuals may need to achieve their vocational aspirations and to determine whether there is a "shortfall" with regard to any of these
The USA has a much greater extent of proper professional training. Both rehabilitation counselors and vocational evaluators have their own professional organization, each with its own rigorous procedures for accreditation
The USA has several federal agencies (i.e., Rehabilitation Services Administration [RSA], National Institute on Disability, Independent Living, and Rehabilitation Research [NIDILRR]) with budgets that support personnel preparation, training, and research to develop new approaches in medical, social, and vocational rehabilitation
In the USA, rehabilitation facilities are accredited. This is done by the Commission on Accreditation of Rehabilitation Facilities (CARF), and much of the funding provided by the RSA is contingent on meeting CARF standards

Table 24.4 (continued)

Evaluation standards and performance indicators for the state vocational rehabilitation services program seek to reflect the importance of placing the clients of rehabilitation programs not just in work but also in work that is matched to their abilities
Australia and New Zealand
Vocational rehabilitation services in both Australia and New Zealand are also based on a strong emphasis on professional training of staff. Each Australian state has a university-based, postgraduate training program in rehabilitation counseling. These receive financial support from the Commonwealth (federal) Rehabilitation Service, which has also commissioned from one university (Sydney), a distance-learning version of their program
Services in both Australia and New Zealand rejected the conservative approach to both policy and staffing that were once based on Beveridge-type assumptions. In both Australia and New Zealand, more radical changes were implemented service objectives and funding
The New Zealand solution was based on the introduction of a "no-fault" compensation scheme, one aim of which was to ensure cost containment through the earliest possible referral to rehabilitation (all types of medical, social, and employment rehabilitation). To implement that policy and program, rehabilitation *BSRM Working Party Report 59 International Perspectives Vocational Rehabilitation – The Way Forward*
Counselors were recruited and trained with a continuing commitment to the expansion and academic underpinning of research and development. In Australia, similar decisions were reached to replace the inherited UK model by more professional services. Workers' Compensation Fund money was used to finance the development of new services
To reduce longer than necessary absence from work (and undue delay in referral for rehabilitation), a review of policy and services developed a radically different approach based on alternative principles. Early intervention to ensure earliest possible resumption of work after illness or injury required the timely availability of relevant services and their funding as well as an effective system of referral. To that end, new initiatives included the early review of all sickness absence, ensuring (in certain circumstances) mandatory referral for rehabilitation. To support that aim, it was necessary to: Invest significantly in the training of therapists and other relevant professions who would be involved in the provision of such services Stimulate a market in which those services were provided on a "fee-for-item" basis Create a new role for persons to work alongside patients in order to ensure proper assessment of need and delivery of services and to liaise with employers over return to work – the "case manager role"
Australia has also examined the feasibility of developing an occupational database, similar to that of the USA
Germany
In Germany, rehabilitation tends to be equated with vocational training. A countrywide network of centers exist, and they are extremely well resourced. Courses usually last 18 months and lead to a vocational qualification which is the same, in all respects, to that obtained by nondisabled people completing a more traditional apprenticeship training
Sweden
The Scandinavian countries – especially Sweden and Norway – have for some time pursued more "active labor market" policies, directed at getting people with disabilities back to work. New legislation has been introduced requiring employers "to submit a rehabilitation enquiry to the local insurance office within 8 weeks (of sickness absence)." It is also responsible for initiating and financing interventions aimed at work resumption, while the social security agency is responsible for the coordination and supervision of rehabilitation measures
Sickness absence in Sweden is certified by an occupational physician
The legislation mandates "firms to provide commensurate work to employees who have become disabled in their current jobs." These mandates in principle are more far reaching than the mandates imposed on firms by the Americans with Disabilities Act in the USA
The Netherlands
There are a number of similarities between Sweden and Holland, including the provision of a partial disability benefit, which is however seldom realized in practice
For many years though, the very high numbers of people receiving disability benefits led to talk of the "Dutch disease." Over the last two decades, the government has gradually tightened up its system, and now reference is sometimes made to the "Dutch miracle," reflecting a relatively higher number of people returning to work
One particularly interesting feature of Dutch provision is the system, developed by the Joint Medical Service for matching job requirements to individual functional abilities and disabilities. The Joint Medical Service maintains an occupational database of around 10,000 jobs, and this is used to assess the extent of an individual's disability – i.e., the loss of earnings arising from their disability – and thus the level of partial benefit needed. The database can also be used to help identify redeployment opportunities or new career possibilities

Adapted from British Society of Rehabilitation Medicine (2003)

International Perspectives

Over two decades ago, Floyd (1996) speculated that the UK might follow the USA in professional training and development of employment and vocational rehabilitation personnel. According to the British Society of Rehabilitation Medicine (BSRM, 2003), vocational rehabilitation has been taken very seriously in many other countries in contrast to the UK (see Table 24.4 for comparison to other countries). In comparison to the UK, vocational rehabilitation services and education and training for practitioners are much more developed in many countries, including the USA and Australia (NHS, 2008; Organization for Economic Co-operation and Development, OECD, 2003). For example, a small number of courses are available in varying format (e.g., degree, certificate, diploma, short courses) that addresses a range of levels of educational need. In addition, university and private providers offer specialist courses. In Scotland, however, provision of courses is limited (NHS, 2008). The BSRM suggests that other countries that have more effective rehabilitation services than the UK are countries that have invested resources into creating well-developed services, conducted assessment of the scale of demand for vocational rehabilitation services, hired staff with professional qualification, and are supported by an academic base for research. Rehabilitation facilities in the USA already have standards and regulations to follow (i.e., the Commission on Accreditation of Rehabilitation Facilities, CARF), providing service users and government officials with some idea of the standard of rehabilitation they might expect. Conversely, very few rehabilitation facilities have gone this route in the UK (Barnes et al., 2009).

Summary

People with disabilities in the UK face many challenges similar to those in the USA. Information on inequalities and discrimination is representative of the population with disabilities and does not distinguish significantly between those residing in rural and urban areas. Although the UK had implemented legislation to improve the quality of life of people with disabilities, many facets of healthcare delivery and social attitudes remain riddled with barriers. Furthermore, there is considerable variation by type of impairment. The remaining challenge for people with disabilities in the UK is for the public as a whole and service providers to have a better understanding of their medical, psychosocial, financial, and employment challenges.

Resources

Disability Discrimination Act of 1995 (c.50): http://www.equalrightstrust.org/ertdocument-bank//DDA1995.pdf

Office for Disability Issues: https://www.gov.uk/government/organisations/office-for-dosability-issues

Rehabilitation Council: http://www.rehabcouncil.org/uk

The European Blind Union: http://www.euroblind.org

United Kingdom Rehabilitation Council: http://www.rehabcouncil.org/uk

Vocational Rehabilitation Association UK: http://www.vra-uk.org

Learning Exercises
Self-Check Questions

1. How do vocational rehabilitation services in the UK compare to that of other countries?
2. What are the barriers to health and social care services in the UK for people with disabilities?
3. What are the distribution rates of disability based on geography in the UK?
4. How effective is the social model in addressing challenges for people with disabilities?
5. What are the key elements of vocational rehabilitation services in the UK?

Experiential Exercises

1. Conduct an interview or survey with a rehabilitation counselor in the UK to determine service delivery challenges and barriers.
2. Compare and contrast disability legislation in the UK and USA.

If given the opportunity to redesign the vocational rehabilitation system in the UK, what major recommendations would you make?

References

Academic Network of European Disability Experts. (2013). *European comparative data on Europe 2020 and people with disabilities*. Retrieved from http://www.disability-europe.net/theme/comparative-data/reports-comparative-data

AgeUK. (2015, May 22). *Employment and support allowance*. Retrieved from http://www.ageuk.org.uk/money-matters/claiming-benefits/employment-support-allowance/what-is-employment-and-support-allowance/

Art Council England. (2013, August). *Understanding disabled people as audiences 2012–13*. Retrieved from http://www.nck.pl/media/study/understanding_disabled_people_as_anudiences.pdf

Barnes, T., Holmes, J., & The National Executive Committee of the College of occupational Therapists Specialist Section – Work. (2009). *Occupational therapy in vocational rehabilitation: A brief guide to current practice in the UK*. Southwark, London: College of Occupational Therapists.

Becker, E., Hayllar, O., & Wood, M. (2010). *Pathways to work: Programme engagement and work patterns – Findings from follow-up surveys of new and repeat and existing incapacity benefits customers in the Jobcentre Plus pilot and expansions*. Norwich: Department for Work and Pensions. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_dta/file/214423/rrep653.pdf

Black, C. (2008). *Working for a healthier tomorrow*. London: The Stationery Office.

Bond, G., Drake, R., & Becker, D. (2008). An update on randomized controlled trails of evidence-based support employment. *Psychiatric Rehabilitation Journal, 31*, 280–290.

British Council. (n.d.). *UK key facts.* Retrieved from http://www.educationuk.org/global/articles/uk-key-facts

British Society of Rehabilitation Medicine. (2003). *Vocational rehabilitation – The way forward*. Retrieved from http://www.bsrm.org.uk/downloads/vrthewayforward2nded-final-revised-text-30-11-03.pdf

Burns, T., Catty, J., Becker, T., Drake, R., Fioritti, A., Knapp, M., et al. (2007). The effectiveness of supported employment for people with severe mental illness: A randomized controlled trail. *The Lancet, 370*, 1146–1152.

Chamberland, M. A., & Frank, A. O. (2004). Congratulations but no congratulations: Should physicians do more to support their patients at work. *Clinical Medicine, 4*(2), 102–104.

ComRes. (2011, December). *Scope NDPP Survey*. Retrieved from http://sss.comres.co.uk/polls/Scope_DPP_tables_25_July_2012.pdf

Copestake, P., Sheikh, S., Johnston, S., & Bollen, A. (2014). Removing barriers, raising disabled people's living standards. Retrieved from https://www.opm.co.uk/up-content/uploads/2014/Removing-barriers-raisingliving-standards.pdf

Coulter, A., & Jenkinson, C. (2005). European patients' views on the responsiveness of health systems and healthcare providers. *European Journal of Public Health, 15*(4), 355–360.

Country Reports. (2017). *Disability access in United Kingdom: Accessibility*. Retrieved from http://www.countryreports.org/travel/UnitedKigdom/accessibility.htm

Crawford, C. (2012). *Youth with disabilities in Transition from school to work or post-secondary education and training: A review of the literature in the United States and United Kingdom*. Retrieved from https://irisinstitute.files.wordpress.com/2012/01/youth_in_transition_iris_cr.pdf

Department for Communities and Local Government. (2009). *English house condition survey 2007*. Retrieved from http://www.esds.ac.uk/doc/6449/mrcod/df/6449ehcs_annual_report_2007.pdf

Department of Work and Pensions. (2004). *Building capacity for work: A UK framework for vocational rehabilitation*. London: Author.

Department of Work and Pensions. (2014, July). *Family resources survey 2012/2013*. Retrieved from https://www.gov.uk.government/uploads/system/uploads/attachment_data/file/325491/family-resources-survey-statistics-2012-2013.pdf

Disability in the United Kingdom. 2014: *Facts and figures*. Retrieved from http://sss.base-uk.org/sites/default/uk_disability_facts_and_figures_report_2014.pdf

Encyclopedia Britannica. (2016, July 13). *United Kingdom*. Retrieved from https://www.britannica.com/place/United-Kingdom

Floyd, M. (Ed.). (1996). *Vocational rehabilitation and Europe*. London: Jessica Kingsley.

Frank, A. (2016). Vocational rehabilitation: Supporting ill or disabled individuals in (to) work: A UK perspective. *Healthcare, 4*(46). doi:10.3390/healthcare4030046. Retrieved from https://www.ncbi.hih.gov/pmc/articles/PMC5041047/pdf/healthcare-04-00046.pdf.

Frank, A., & Thurgood, J. (2006). Vocational rehabilitation in the UK: Opportunities for healthcare professionals. *International Journal of Therapy and Rehabilitation, 13*(3), 126–134.

Gilworth, G., Haigh, R., Tennant, A., Chamberland, M., & Harvey, A. (2001). Do rheumatologists recognize their patients' work-related problems? *Rheumatology, 40*(11), 1206–1210.

Gobelet, C., & Franchignoni, F. (n.d.). *Vocational rehabilitation*. Retrieved from http://eknygos.lsmuni.it/springer/482/3-16.pdf

Gore, E., & Parckar, G. (2010). *Rights and realities: Disabled people's experience of accessing goods and services*. London: Leonard Cheshire Disability.

Gov.UK. (2015, May 8). *Policy paper 2010–2015 government policy: Equality*. Retrieved from https://www.gov.uk/government/publications/2010-to-2015-government-policy-equality/2010-to-2015-government-policy-equality#appendix-10-united-nations-convention-on-the-rights-of-disabled-people

Gov.UK. (2016a, July 21). *Defining rural areas*. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/538957/Defining_rural_areas_Jan_2016_v2.pdf

Gov.UK. (2016b, July 21). *Rural health statistics*. Retrieved from https://www.gov.uk/government/uploads/system/uploads.attachment_data/file/538929/Health_March_2014v2.pdf

Greaves, I. (2016, August 16). *Employment and support allowance overview*. Retrieved from http://www.disabilityrightsuk.org/employment-and-support-allowance-overview

Greer, L. (2011). *Realising work potential – Defining the contribution of allied health professionals to vocational rehabilitation in mental health services: The way forward*. NHS Scotland. Retrieved from http://www.gov.scot/resource/doc/365435/0124266.pdf

Habinteg. (2014). *Habinteg mind the step: An estimation of housing needs among wheelchair users in England*, p. 5. Retrieved from http://www.habinteg.org.uk/mediaFiles/downloads/94842268/Mind_the_step_onlineversion_pdf.pdf

Haven, K., Celaya, M. F., Pierson, J., Weisskopf, A. J., & MacKinnon, N. J. (2013). Comparison of health confidence in rural, suburban and urban areas in the UK and the USA: A secondary analysis. *BMJ Open, 3*, e002640. doi:10.1136/bmjopen-2013-002640. Retrieved from http://bmjopen.bmj.com/content/bmjopen/3/5/e002640.full.pdf.

Heslop, P. (2013, October). *Poverty and social exclusion in the UK. Working paper-Methods Series No. 23. Disabled people and their relationship with poverty*. Retrieved from https://www.poverty.ac.uk/sites/default/files/attachments/WPMethodsNo23-DisabledPeople(Heslop2013).pdf

Higgin, H. (2007). The case for rehabilitation. *Occupational Health, 59*(2), 23–25.

Home Office. (2014). *Hate crimes, England and Wales 2013 to 2014*. Retrieved from https://www.gov.uk/government/statistics/hate-crimes-england-and-wales-2013-to-2014

Institute for Public Policy Research. (2007). *Disability 2020: Opportunities for the full and equal citizenship of disabled people in Britain in 2002*, p. 11. Retrieved from http://www.ippr.org/assets/media/images/media/files/publication/2011/-5-Disability_2020_full_1568.pdf

Malo, M. A., & Garcia-Serrano, C. (2001). *An analysis of the employment status of the disabled persons using the ECHP data*. Report port prepared for EIM on behalf of the European Commission DG V. Retrieved from http://www.researchgate.net/publication/5018586-Disability-and-Labour-Force-Participation-in-Ireland

McGregor, A. (2014, August). *Evaluation of the vocational rehabilitation service pilot: Final report*. Glasgow: University of Glasgow Training & Employment Research Unit.

Mind. (2009). *Facts and statistics about mental health*. Retrieved from http://www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mentalhealth-problems/

Morris, Z. A. (2014, May). *Disability benefit reform in Great Britain from the perspective of the United States*. Retrieved from https://ddp.policyresearchinc.org/wp-content/uploads/2014/07/Morris_Final.C3.pdf

Multiple Sclerosis Society. (2012). *Fight back survey*. Retrieved from http://www.mssociety.org.uk/sites/default/files/Fighting%20Back%20-%20MS%20Week%202012%20report%20-%20spreads.pdf

National Health Service. (2008, March). *Getting vocational rehabilitation working for Scotland: Education needs of staff supporting vocational rehabilitation*. Retrieved from http://www.gov.soct/resource/doc/924/0077375.pdf

O' Day, B., & Stapleton, D. (2008, September). The United Kingdom pathways to work program: A path to employment? *Disability Policy Research Brief, 8*(2). Retrieved from http://ditigalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1277&content=edicollect

OECD. (2003). *Transforming disability into ability: Policies to promote work and income security for disabled people*. Paris: Author.

Office of Disability Issues. (2011). *ODI Life opportunities survey wave one results*. Retrieved from https://www.gov.uk/government/statistics/life-opportunities-survey-wave-one-results-2009-to-2011

Office for Disability Issues. (2011). *Public perceptions of disabled people: Evidence from the British social attitudes survey 2009*. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/325989/ppdp.pdf

Office for National Statistics. (2013). *Disability in England and Wales, 2011 and comparison with 2001*. Retrieved from http://www.ons.gov.uk/ons/rel/census/2011-census/key-statistics-and-quick-sts-tistics-for-wards-and-putput-areas-on-england-and-wales/rpt-disability-shory-story.html

Office for National Statistics. (2014). *Ault health in Great Britain, 2012*. Retrieved from http://www.ons.gov.uk/ons/dcp171778_355938.pdf

OPDM. (2005). *Annual report and accounts, 2005*. Retrieved from http://www.publications.parliament.uk/pa/cm200506/cmselect/cmodpm/559/559.pdf

Palmer, G. (n.d.). *Low income and disability*. Retrieved from http://www.poverty.org.uk/40/index.shtml

Pearson, C., & Watson, N. (2007). Tackling disability discrimination in the United Kingdom: The British Disability Discrimination Act. *Journal of Law & Policy, 23*, 95–120. Retrieved from http://openscholarship.wustl.edu/law_journal_law_policy/vol23/iss1/4

Power, D., & Power, M. R. (2010). The Internet and government disability policy development in the United Kingdom. *Internet, Politics, Policy 2010: An Impact Assessment Conference* (pp. 1–26). Oxford: University of oxford. Retrieved from http://works.bepress.com/mary_power/58/

Quarmby, K. (2008). *Getting away with murder: Disabled people's experiences of hate crime in the UK*. London: Scope.

Quarmby, K. (2011). *Scapegoat: Why we are failing disabled people*. London: Portobello Books.

Rimmerman, A. (2013). *Social inclusion of people with disabilities: National and international perspectives*. Cambridge: Cambridge University Press.

Robinson, C., Martin, J., & Thompson, K. (2007). *Attitudes towards and perceptions of disabled people – Findings from a module included in the 2005 British Social Attitudes Survey*. National Centre for Social Research. Retrieved from http://pf7d7vi404s1dxh27mla5569.wpengine.netna-cdn.com/files/library/robinson-NatCenDisabilityModuleAug2007.pdf

Sayce, L., & Boardman, J. (2003). The disability discrimination act 1995: Implications for psychiatrists. *Advances in Psychiatric Treatment, 9*(6), 397–404.

Scior, K., & Werner, S. (2015)*. Changing attitudes to learning disability: A review of the evidence*. Mencap. Retrieved from https://www.mencap.org.uk/sites/default/files/2016-08/Attitudes_Changing_Report.pdf

Scottish Executive, Co-ordinated, Integrated and Fit for Purpose. (2007). *Framework for adult rehabilitation in Scotland*. Edinburgh: Author.

Seebhom, P., & Secker, J. (2003). Increasing the vocational focus of the community health team. *Journal of Interprofessional Care, 17*(3), 281–291.

The Annual Population Survey. (2013, March). *Annual population survey*. Retrieved from http://www.nomi-sweb.co.uk

The Commonwealth Fund. (2016). *Health care in the United Kingdom*. Retrieved from http://www.commonwealthfund.org/topics/international-health-policy/countries/united-kingdom

Transportation Research and Innovation Portal. (n.d.). *08/2002-03/2003: Attitudes of disabled people to public transportation*. Retrieved from http://www.transport-research.info/web/projects/project_details.cfm?id=7441&page=contact

Vocational Rehabilitation Association-UK. (2007). *Vocational rehabilitation standards of practice*. Author. Retrieved from http://voca-vr.co.uk/pdf?VRA_standards_of_practice.pdf

Waddell, G., & Aylward, M. (2005). *The scientific and conceptual basis of incapacity benefits*. London: The Stationery Office.

Waddell, G., & Burton, A. K. (2004). *Concepts of rehabilitation for the management of common health problems*. London: The Stationery Office.

Waddell, G., Burton, A. K., & Kendall, N. A. S. (2013, July 8). *Vocational rehabilitation: What works, for whom, and when?* Vocational Rehabilitation Task Group. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209474/hwwb-vocational-rehabilitation.pdf

Wilson, M. C., & Scior, K. (2015). Implicit attitudes towards people with intellectual disabilities: Their relationship with explicit attitudes, social distance, emotion and contact. *PloS One,* 10(9): e0137902. Doi:10.1371/journal.pone.0137902. Retrieved from https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0137902

Wood, J. (2004, January). *Rural health and healthcare: A North West perspective*. Institute for Health Research, Lancaster University. Retrieved from http://www.nwph.net/publications/ruralhealth.pdf

Young, A., Prouse, P., & Williams, P. (2009). The effect of rheumatoid arthritis on job loss and work productivity: Results from an inception cohort with 10-year follow-up. *Rheumatology (Oxford), 48*, (1), i111(271).