

Fulfilling Potential

Building a deeper understanding of disability in the UK today



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Introduction

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1.1 Fulfilling Potential

Fulfilling Potential is an ongoing activity aimed at finding new ways to enable disabled people to realise their potential. Fulfilling Potential is about making the United Nations Convention on the Rights of Disabled People a living reality for disabled people in Britain. The UN Convention focuses on inclusion and mainstreaming, with additional support where needed, and on the involvement of disabled people in making decisions that will affect their lives.

The Government is committed to enabling disabled people to fulfil their potential and have opportunities to play a full role in society. Disabled people, as well as the people and organisations that support them are partners in developing the Government's disability strategy.

On 17 September the Government published 'Fulfilling Potential – Next Steps' which sets out the strategic narrative, priority areas for further action, specific next steps, and how we will co-produce further plans.

'Fulfilling Potential – The Discussions So Far', also published on 17 September, includes a summary of responses to 'Fulfilling Potential', the discussion document published last December, and sets out current and planned actions across Government.

As part of Fulfilling Potential a new cross-sector alliance, convened by Disability Rights UK, has been established. The Alliance is proposed as a way of bringing together disabled people and others with relevant knowledge and experience to increase influence in how local services are designed and delivered. This will involve various public, private and third sector organisations working together.

The aims of ‘Fulfilling Potential: Building Understanding’ are:

- to provide an analysis of the current evidence on disability in the UK to inform the development of the next stage of work on Fulfilling Potential – the development of actions, outcomes and indicators;
- to inform public understanding and prompt debate about disability and the issues faced by disabled people; and
- to raise awareness, drive a change in attitudes and support an increase in commitment to improving the lives of disabled people in the UK today.

The evidence base is structured in two parts. The first part provides analysis of the number of disabled people in the UK as well as looking at the way disability develops over the life course and at the fluctuating nature of disability. The second part focuses on the lives of disabled people by looking at trends in outcomes and barriers to taking part in different areas of life. The evidence is structured around the Fulfilling Potential: Next Steps themes of **early intervention; choice and control** and **inclusive communities**.

This document **summarises the analytical evidence on disability. It does not make policy recommendations** but the evidence presented here will inform the work of the Disability Action Alliance and the development of government policy on disability.

This document draws on data from a wide variety of sources. Some are based on UK data, some are based on GB data and some are based on data from England only.

1.2 Background

The 2005 Life Chances report set out a detailed evidence base on disability (*Cabinet Office Prime Minister's Strategy Unit 2005*). The report concluded that disabled people did less well than non-disabled people across a wide range of indicators and, whilst there had been improvements in a number of areas, it was still the case that outcomes for disabled people in terms of education, employment and income were significantly lower than for non-disabled people.

Since the Life Chances report further data sources have been developed. In particular: the set of disability equality indicators to monitor trends in outcomes and barriers; the development of the Life Opportunities Survey and the addition of specific disability questions on the British Social Attitudes Survey. The Life Opportunities Survey was specifically designed to meet some of the evidence gaps identified in 'Life Chances'. The Life Opportunities Survey was developed using the social model definition of disability and focuses on identification of impairment, participation in different life areas and barriers to participation.

1.3 Approach to developing the evidence base

'Fulfilling Potential: Building Understanding' provides a starting point in looking at the current evidence on disability. The development of any evidence base is an on-going process and work will continue. **This paper should be seen as a contribution to the debate on the issues facing disabled people in the UK today and how they might be addressed.**

In developing this paper we have focused more on some areas than others, for example, employment. We chose to focus on employment because, for those of working age, whether or not a person is in work has a major impact on poverty and social exclusion. However, we do recognise that other areas of life are also key. In our future work we will focus more on other areas. We are aware that there are some important gaps in this evidence base and other sources of data we could explore. We will carry out further work over the coming months to address these.

However, we believe this paper does provide **the most comprehensive overview of the evidence on disability in the UK since the Life Chances report was published in 2005** (*Cabinet Office Prime Minister's Strategy Unit 2005*).

To develop the evidence base we have:

- Synthesised published research.
- Carried out secondary analysis of surveys including the Life Opportunities Survey (LOS), Family Resources Survey (FRS) and Labour Force Survey (LFS).
- Commissioned focus groups of disabled and non-disabled people undertaken by the Office for National Statistics (ONS).
- Added questions to the ONS Opinions Survey 2012.
- Worked with academics and disabled people's organisations.
- Built on the responses made by disabled people and disabled people's organisations to the 'Fulfilling Potential' discussion document.
- Looked at international data to put the UK findings in context.

We would welcome feedback on the evidence base, particularly details of any research we have not included or any issues that you feel we have not covered. Please send views and comments to Fulfilling.potential@dwp.gsi.gov.uk.

1.4 Different data sources define disability in different ways

Disability is very different to other demographic characteristics in that it is much harder to define and measure in an objective way and there is no single agreed measure of disability. Many data sources rely on an individual's self-perception in the way survey questions are answered in order to establish if they are disabled or not.

In developing this evidence base we have used a variety of different sources which measure disability in different ways.

The Equality Act 2010 sets out the legal framework under which disabled people have rights. In the Equality Act a person has a disability if they have **a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities**. Long-term means that the effect of the impairment has lasted or is expected to last for 12 months or more. Surveys such as the **Family Resources Survey (FRS)** and the **Labour Force Survey (LFS)** use the Equality Act (and previously Disability Discrimination Act) definition of disability. The Office for National Statistics (ONS) has recently published a set of harmonised questions on disability which will gradually be introduced across a range of government surveys to ensure a more consistent approach. The harmonised questions are based on the Equality Act definition (*ONS 2011a*).

The **Life Opportunities Survey (LOS)** takes a **social model** approach and collects data on impairments and on the barriers experienced by people with impairment. Following the social model it is barriers in society which can result in an impairment becoming disabling. A person is defined as having an impairment if they have moderate, severe or complete difficulty with physical or mental functioning and activities are limited as a result.

Some surveys (for example **General Lifestyle Survey, British Household Panel Survey**) look at **limiting long-standing illness**.

Administrative data sources take yet another approach. For example DWP administrative data on benefits records the main disabling health condition and data from the Department for Education (DfE) is based on assessment of Special Educational Needs in children rather than whether or not they are disabled.

Social surveys under-represent some groups of disabled people. People with some types of impairment, for example learning disability are likely to be excluded from surveys that do not make reasonable adjustments for people with cognitive impairments. They may also be less likely to self-identify as having a disability or a long-standing illness. We have included results from qualitative research carried out with people with learning or memory impairment and from across the neuro-diversity spectrum throughout this evidence base.

Building an understanding of the number of disabled people in the UK

2

Section 1

2.1.1 The number of disabled people can be measured in different ways

Different approaches to measuring the number of disabled people in the UK include:

- The proportion of people with a long-standing illness (30 percent GLS 2010).
- The proportion of people who are covered under the disability provision of the Equality Act (19 percent FRS 2010/11).
- The proportion of people in receipt of disability-related benefits such as DLA/AA or IB/ESA (10 percent).

Estimates rely on **self-reported** responses to survey questions. These responses will be determined by the person's understanding of the question and a range of other factors such as how they were feeling on the day they answered the question.

Most social surveys do not include residential care homes in their sample. There are **380,000 people living in residential care**, many of whom are disabled (*Department of Health 2012*).

The Life Opportunities Survey (LOS) takes a different approach to the sources mentioned above and looks at whether or not a person has at least one impairment or chronic health condition. A person is defined as having an

impairment if they have moderate, severe or complete difficulty with physical or mental functioning and activities are limited as a result. LOS estimates that **29 percent of the population have at least one impairment** (LOS Wave 1 2009/11).

2.1.2 There are 15 million people in England with a long-term illness

30 percent **of the population has a long-term illness** (General Lifestyle Survey 2010, ONS 2012). In England this is 15 million people (Department of Health 2011a).

A lower proportion (**18 percent**) **have a limiting long-standing illness**. There has been an increase in the proportion of people in Great Britain with a limiting long-standing illness from 15 percent in 1975 to 18 percent in 2010 (GLS 2010, ONS 2012).

Although the age-specific prevalence of long-term conditions is expected to remain stable over the next few years **strong growth is expected in the number of people living with multiple long-term conditions**. For example, the number of people with three or more health conditions is forecast to rise by a third by 2018 (Department of Health 2011a).

2.1.3 Health conditions are associated with different impairments and many people have more than one health condition

Disabled people are often vulnerable to secondary health conditions.

Many people have more than one health condition. Nearly a third of people with long-term physical conditions have a concurrent mental health condition such as anxiety or depression (Naylor et al. 2012). People with dementia or stroke are likely to have more than one health condition. Conditions such as hypertension, speech problems, hearing loss, and diabetes are less likely to be identified as being the main disabling condition but are likely to be mentioned as one of the co-morbidity conditions for disabled people (Australian Institute of Health and Welfare 2004).

People with more than one health condition are likely to be at significant risk of being disabled by the interaction of their impairments with social and environmental factors.

83 percent of people with a long-term health condition play an active role in managing their condition. 66 percent of those with long-term health conditions have had discussions with medical professionals about better managing their health conditions (*Department of Health 2011a*). However, this varies by type of impairment. Those with mental health conditions or learning disabilities are less likely to feel confident about managing their condition themselves (*Department of Health 2012a*).

2.1.4 It is important to look at the relationship between health conditions and impairments and the interaction with environmental barriers and enablers in order to understand disability

A Health condition is a disease, disorder, injury or trauma.

Impairment is a moderate, severe or complete difficulty with physical or mental functioning which limits day-to-day activities as a result.

Disability is the dynamic interaction between impairment and attitudinal and environmental barriers that hinders a person's full and effective participation in society on an equal basis with others (*UN Convention on the Rights of Disabled People*).

Environmental barriers include all the physical and social aspects of the environment that may affect a person's experience.

Two people with the same health condition may experience different levels of disablement.

Some health conditions are more likely than others to result in impairment which is disabling. For example, in Australia at least 90 percent of people with the following conditions are considered disabled: Downs syndrome, dementia, cataract, cerebral palsy, autism, total vision disorder, multiple sclerosis, Parkinson's disease (*Australian Institute of Health and Welfare 2004*).

Some health conditions such as hypertension and asthma are less likely to result in a disability (*Australian Institute of Health and Welfare 2004*).

Associations between health conditions and impairments are complex. A health condition may be associated with a variety of impairments and an impairment may be related to a number of different health conditions.

2.1.5 Almost a fifth of the UK population have rights under the disability provisions of the Equality Act and this increases to half of adults over State Pension age

There are **11.5 million people in the UK who are covered by the disability provisions set out in the Equality Act**. This is 19 percent of the population – a similar level to the USA, Canada and Australia (*FRS 2010/11, WHO 2011*). These are people who report having a long-standing illness, disability or infirmity, the effects of which have a substantial adverse effect on their ability to carry out day-to-day activities.

Age is a factor. 6 percent (0.8 million) of children, **15 percent** (5.4 million) of adults of working age and nearly half (**45 percent** 5.3 million) of adults over State Pension age are covered by the Equality Act (*FRS 2010/11*).

28 percent of those covered by the Equality Act are women over State Pension age (*FRS 2010/11, Appendix Table 29*).

Those covered by the Equality Act are more likely to be in a **lower socio-economic group**. Of all adults in higher managerial, administrative and professional occupations, 7 percent are disabled whereas of those adults in semi-routine occupations, 12 percent are disabled (*FRS 2010/11, Appendix Table 30*).

The proportion of white people covered by the disability provisions of the Equality Act appears to be higher than any other ethnic group. However this is due to the fact that people from ethnic minority groups tend to be younger. When the data is standardised by age, around a third (35 percent) of Pakistani or Bangladeshi people are covered by the disability provisions of the Equality Act and around a quarter of white, Indian and Black or Black British people (*FRS 2010/11, Appendix Table 31*).

2.1.6 The proportion of the population covered by the Equality Act is higher in some parts of the UK than in others

The proportion of the population covered by the disability provisions in the Equality Act is **higher in Wales (24 percent) and Northern England (20-23 percent) than in London (14 percent) and the South East (16 percent)** (FRS 2010/11).

When standardised for age, part of the lower rate in London can be explained, although higher rates in Wales and Northern areas still remain.

Regional differences may reflect the changes in industry in Wales and Northern England resulting in a cohort effect as prevalence in those areas is higher amongst those aged 55 or over when compared to London and the South East (*LFS Q2 2012*). This is also supported by evidence that Incapacity Benefit claimants were concentrated in Britain's older industrial areas of the North, Wales and Scotland (*Fothergill and Beatty 2011*).

2.1.7 Within region there is variation by local authority

The 2011 Census shows a clear correlation between limiting long-term illness, prosperity and the legacy of heavy industry (*2011 Census – ONS*).

The local authorities with the highest proportion of households containing one person with a long-term illness or disability are:

- Neath Port Talbot (35%)
- Blaenau Gwent (35%)
- Merthyr Tydfil (34%)
- Blackpool UA (34%)
- Knowsley (33%)

And the lowest are:

- City of London (15%)
- Wandsworth (17%)
- Kensington and Chelsea (18%)
- Richmond upon Thames (19%)
- Wokingham (19%)

2.1.8 The number of people covered by the disability provisions of the Equality Act has increased – largely driven by an increase in the number of people over State Pension age

The number of people covered by the legal framework (Disability Discrimination Act and Equality Act) has **increased steadily from 10.7 million in 2002/3 to 11.5 million in 2010/11**. As a proportion of the UK population this is an increase from 18 percent to 19 percent (*FRS 2010/11*). This is a similar proportion to that of other countries with similar legislation (for example, the USA, Canada and Australia).

The increase in numbers is largely driven by an increase in the **number** of disabled people above State Pension age (from 4.8 million in 2002/03 to 5.3 million in 2010/11). However, **the proportion of this age group covered by the legal framework has remained fairly stable at 45 percent**. The numbers of disabled working age adults and children have remained relatively stable since 2002/03 (*FRS 2010/11*).

2.1.9 Many people identified as having rights under the disability provisions of the Equality Act do not consider themselves to be disabled

A survey carried out in 2001 which defined the disabled population as being those covered by the Disability Discrimination Act asked these people if they saw themselves as disabled.

Only 48 percent actually considered themselves to be disabled.

This **varied by type of impairment**, for example 55 percent of those with musculo-skeletal impairment considered themselves to be disabled. **Younger people were less likely than older people to see themselves as disabled**, for example 37 percent of those aged 16 to 44 compared with 55 percent of those aged 44 to State Pension age and 50 percent of those of State Pension age or older. Four factors contributed to how a person viewed themselves: type of impairment, age of onset of disability and extent of involvement in campaigning groups. Some of those who did not consider themselves to be disabled viewed themselves as ‘ill’ (particularly those with long-term illness or chronic medical condition) or ‘getting older’ (Grewal *et al.* 2002).

More recently the ONS Opinions Survey 2012 included a question asking those who came under the Equality Act definition if they thought of themselves as disabled. **Only a quarter (25 percent) did.** Those least likely to think of themselves as disabled were those who were working; those who had higher levels of qualifications; and those with medium to high income. **Those more likely to think of themselves as disabled were: economically inactive; those with no qualifications; and those with low income.** Men were more likely than women to think of themselves as disabled (ONS Opinions Survey July, Aug, Sept 2012, Appendix Table 48.1–48.4).

Those with vision or mobility impairments were more likely to think of themselves as disabled whereas those with dexterity impairment or with breathing, stamina or fatigue were less likely to. Those whose condition had existed at birth were more likely to think of themselves as disabled whereas those who described the cause of their health condition as being natural ageing were less likely to (ONS Opinions Survey July, Aug, Sept 2012, Appendix Table 48.5–48.6).

2.1.10 The Life Opportunities Survey can help us to understand the factors in society that result in impairment becoming disabling

The Life Opportunities Survey (LOS) takes a different approach to other surveys by looking at impairment and the barriers experienced by people with impairment. **LOS estimates that 29 percent of the population have at least one impairment or chronic health condition that is associated with moderate or severe difficulties** (LOS Wave 1 2009/11).

Two people with the same impairment may have very different experiences and needs (*WHO 2011, Focus Groups*).

8 percent of adults with moderate or severe impairment do not experience any barriers to participating in life areas (*LOS Wave 1 2009/11*).

People may be disabled in some areas of life but not in others. Circumstances can disable people. Disabled people may see their conditions as being disabling but do not see themselves as ‘disabled’ (*Focus Groups*).

Those with impairment often report their health condition, impairment or disability as being a barrier to participating in life areas (*LOS Wave 1 2009/11*).

2.1.11 Disabled people are very diverse in terms of the variety of impairments they have – some are visible and some hidden

Some impairments are more likely to be visible, for example mobility impairment, whilst others, such as mental health conditions, are less visible.

Just under a fifth (18 percent) of all adults experience long-term pain, 13 percent have chronic health conditions and 8 percent have a mobility impairment. In LOS a person is defined as having an impairment if they have moderate, severe or complete difficulty with physical or mental functioning and activities are limited as a result. Those reporting only mild difficulties are not classified as having impairment (*LOS Wave 1 2009/11*).

2.1.12 There is also diversity in how often the impairment has an impact on daily living

Results from focus groups showed that when people think about ‘long-lasting health conditions and illnesses’ they consider the level of difficulty and the impact a condition has on the individual’s life (*Focus Groups*).

LOS collected data on the level of difficulty people experienced with each impairment and how often they experienced this level of difficulty. Some impairments (for example mobility or learning) are more likely than others (for example hearing, sight) to result in difficulties which are experienced often or always (*LOS Wave 1 2009/11, Appendix Table 1*).

2.1.13 The awareness of mental health conditions has increased

Whilst the prevalence of mental health conditions has not changed, the perception of mental health conditions has. There has been a change in awareness amongst people themselves, doctors, employers and society at large (*OECD 2011b*).

Common mental disorders are mental health conditions that cause marked emotional distress and interfere with daily function. They comprise different types of depression and anxiety.

Although LOS estimates that 4 percent of adults have a mental health condition other sources estimate that prevalence of Common Mental Disorders (CMDs) is much higher (18 percent) (*Adult Psychiatric Morbidity Survey 2007*).

Overall, the proportion of people aged 16-64 with at least one CMD increased from 16 percent in 1993 to 18 percent in 2000 and has remained stable since. The largest increase was for women aged 45-64, among whom the rate rose by about a fifth (*Adult Psychiatric Morbidity Survey 2007*).

Women are more likely than men to have a CMD (20 percent and 13 percent respectively), and rates are significantly higher for women across all categories of CMD (with the exception of panic disorder and obsessive compulsive disorder) (*Adult Psychiatric Morbidity Survey 2007*).

Up to the age of 65, mental health conditions account for nearly as much morbidity as all physical illnesses put together (*Naylor et al. 2012*).

Looking at serious mental health conditions: 3 percent of people have Post-traumatic stress disorder; 4 percent have had suicidal thoughts in the last year; 0.4 percent have psychosis (including bipolar disorder) and 0.3 percent have anti-social or borderline personality disorder (*Adult Psychiatric Morbidity Survey 2007*).

2.1.14 Around 6 million people are in receipt of disability or health-related state benefits

Disability Living Allowance (DLA) is a cash benefit for severely disabled children and adults to help with extra care and mobility costs they may have because of their disability. It can be paid to people in or out of work. From April 2013 DLA for working age adults will be replaced with **Personal Independence Payment** (PIP).

Attendance Allowance (AA) provides a contribution towards the extra costs faced by severely disabled people over the age of 65.

Employment and Support Allowance (ESA) is an out of work benefit for people who have limited capacity for work due to illness or disability. ESA is replacing Incapacity Benefit.

Only around half (6 million) of the 11.5 million people covered by the disability provision in the Equality Act are in receipt of disability-related benefits. In total **3.2** million people are in receipt of **Disability Living Allowance** (DLA) (2.02 million people of working age, 340,000 children and 870,000 people aged over 65). **1.6** million people receive **Attendance Allowance** (AA) and **2.3** million people are in receipt of **Incapacity Benefit/Employment and Support Allowance** (*Work and Pensions Longitudinal Study, Aug 2011*). 14 percent of those aged 16-64 in receipt of DLA are in work (*DWP 2011a*).

44 percent of families containing at least one disabled adult and one disabled child are in receipt of DLA (care component) and 35 percent in receipt of DLA (mobility component). For families containing one or more disabled adults but no disabled children 10 percent are in receipt of Attendance Allowance, 21 percent in receipt of DLA (care component) and 21 percent in receipt of DLA (mobility component). For families with one or more disabled child but no disabled adults 30 percent are in receipt of DLA (care component) and 21 percent in receipt of DLA (mobility) (*FRS 2010/11*).

Those with impairment who experience moderate or severe difficulty often or always are more likely than those with less severe impairment to be in receipt of disability benefits. For example 48 percent of those with a mobility impairment who experience moderate or severe difficulties often or always are in receipt of benefits compared to 17 percent of those who experience mild difficulty sometimes or rarely (*LOS Wave 1 2009/11 Appendix Table 2*).

Benefit receipt increases with age but across all ages not all of those covered by the Equality Act are in receipt of benefits.

How disability can impact across an individual's life

2

Section 2

The previous section showed that the number of disabled people in the population increases with age. The next section looks at onset of disability across the life course and the fluctuating nature of disability.

2.2.1 Most disabled people are not born with their impairment

At any one time the population of disabled people will include some who have been disabled since childhood and some who have developed long-term conditions in adulthood.

Only around 2-3 percent of disabled people are born with their impairment. Some will acquire impairments in childhood (or be diagnosed with an impairment in childhood). Most acquire impairments later in life (for example, 79 percent of disabled people over State Pension age reported that they acquired their impairment after the age of 50), and increasingly after State Pension age (47 percent of disabled people over State Pension age acquired their impairment after the age of 65) (*ODI 2008*).

The 2001 Census showed less than 5 percent of 0-4 year olds as having a limiting long-standing illness.

There are different life chances and opportunities for those that have a disability from birth and for those that become disabled later in life (*Burchardt 2003*).

2.2.2 The majority of us will experience disability at some point in our lives, either personally or in caring for family or friends

Although people in the UK are living for longer free of disability than ever before the number of disabled people is expected to continue to grow because **life expectancy has consistently increased over time and is projected to increase further in the future**, especially life expectancy at 65, which has increased by almost a third since 1970 (*ONS 2011c*). This means that more people are living to what used to be extreme old age. Those aged 80 to 89 are the fastest growing age cohort worldwide (*WHO 2011*). The numbers of those aged 85 years and above are set to rise by two-thirds. The prevalence of chronic degenerative diseases increases with age and these threaten independent living (*Wanless 2006*). **Over two-thirds of people over 85 are disabled** (*FRS 2010/11, Appendix Table 28*).

Forecasts predict a rise of 86 percent in the number of disabled people aged 65 years and above by 2026 translating into an additional 730,000 disabled people (*Research Council, Modelling Ageing Populations to 2030*).

In addition to this many **people are living longer as disabled people**, both those who are disabled in later life and those who are disabled from birth (where life expectancy is improving). For example, half a century ago only 25 percent of those born with congenital heart conditions survived into adulthood, whereas now 90 percent do so. About half of those born with cystic fibrosis will live beyond 41, and a baby born today with the condition is expected to live even longer (*Together for Short Lives and Marie Curie Cancer Care 2012*).

2.2.3 Different types of impairment tend to start or become disabling at different stages of life

For those aged 65 or over the most common types of health condition are osteoarthritis, dementia, coronary heart disease, stroke, Chronic Obstructive Pulmonary Disease and cancers.

For working age people there is more variation in conditions, with increasing prevalence in middle age of depression, anxiety and back pain as well as most common conditions experienced by older people.

Autism, ADHD or learning disabilities are the main disabling conditions amongst children in receipt of Disability Living Allowance (DLA). The number of children in receipt of DLA diagnosed with these conditions increased four fold between 1995 and 2012 from around 50,000 in 1995 to around 210,000 in 2012 (*DWP Adhoc statistics 2012*).

2.2.4 The population with impairments is not static and people move in and out of this group over time

In LOS a person is in the **offset** group if they reported at least one impairment at Wave 1, but did not report any impairment at Wave 2. A person is in the **onset** group if they did not report any impairment at Wave 1, but reported at least one impairment at Wave 2.

Of the 29 percent of the population with impairments **around a third (34 percent) of those adults who reported an impairment at Wave 1 of Life Opportunities Survey (LOS) no longer reported an impairment around a year later at Wave 2. Of those who had no impairment at Wave 1, 8 percent had at least one impairment by Wave 2** (*LOS Wave 2 2010/12*).

Age is a factor. Nearly half (49 percent) of adults aged 16 to 24 who reported an impairment at Wave 1 no longer reported any impairment at Wave 2. The corresponding offset rate for those aged 75 and over was 21 percent (*LOS Wave 2 2010/12*).

The rate of onset increases with age. More than one in five (23 percent) adults aged 75 and over had acquired at least one impairment by Wave 2. This compares with 9 percent of those aged 45 to 64, 4 percent of those aged 25 to 44, and 3 percent of those aged 16 to 24 (*LOS Wave 2 2010/12*).

Level of qualification is another key factor. Offset rates are much higher for those with a degree level qualification (45 percent) compared to those with no formal qualifications (28 percent). The offset rate increases with higher levels of socio-economic group. In contrast adults with no formal qualifications were almost twice as likely to have become onset-acquired at Wave 2 than adults (aged 16-64) with a degree level qualification (10 percent compared with 5 percent) (*LOS Wave 2 2010/12*).

There are differences between those who continue to report impairment over time and those who offset and onset. This is particularly the case with **employment**. The impairment at both waves group had the lowest proportion in employment (39 percent in employment at both waves) and highest proportion economically inactive (46 percent economically inactive at both waves) whilst the proportion in employment at both waves for offset and onset groups was much higher at 61 percent and 62 percent respectively, and the proportion economically inactive at both waves for these two groups was only 22 percent and 20 percent (*LOS Wave 2 2010/12*).

Those in the offset group experienced fewer barriers at Wave 2 whilst those in the onset group experienced an increase in most barriers (*LOS Wave 2 2010/12*).

Findings from the British Household Panel Survey also found evidence of the fluctuating nature of disability. Looking at working age people over a seven year period (1991-97) over half of those with a limiting long-standing illness had spells lasting less than two years. Over a seven year period as many as 1 in 4 working age adults had experienced a spell of limitation in daily activities due to a health condition (*Burchardt 2000*).

2.2.5 For some impairments, offset and onset can be a gradual process

Offset and onset may be a **gradual process reflecting the fluctuating nature of many types of impairment**. Those experiencing a mild level of difficulty with day-to-day activities are classified as having no impairment on LOS. So if a person reported an impairment which resulted in mild difficulty in Wave 1 and moderate difficulty in wave 2 they would be in the onset group. For some conditions there was evidence of gradual onset. This was particularly the case for chronic health where **more than half of those reporting onset of a chronic health condition had previously reported mild difficulties**.

Similarly if a person reported moderate difficulty at Wave 1 but mild difficulty at Wave 2 he/she would be in the offset group. There is evidence that this is the case for some types of impairment particularly sight and chronic health conditions.

Around a third of those with the four most common types of impairment (long-term pain, chronic health condition, dexterity and mobility) reported a severe level of difficulty at Wave 2.

Evidence from Wave 3 of LOS (available in 2015) will allow us to learn more about the dynamics of disability over time. LOS Wave 3 will look at whether those in the offset and onset groups change again and whether those in the group with impairments at both waves remain in that group. Evidence from Australia shows that over a five year period 38 percent of the overall population fluctuated between the disabled and non-disabled populations. As is the case with LOS, onset increases with age and offset decreases with age but even in the older age groups there is a greater than 10 percent chance of offset (*Emerson 2012*).

More recent analysis over 16 waves of the British Household Panel Survey found that looking at a three year period whilst 40 percent of adults experienced a spell of disability only 16 percent remained disabled for the three year period. **Of those who had offset between waves as many as 42 percent returned to the group of disabled people in the next wave** (*Berthoud 2012*).

2.2.6 Those who are already disadvantaged are at a greater risk of becoming disabled

There are strong associations between being poor, being out of work, having low educational qualifications and the risk of developing a long-term health condition or impairment. Those in the bottom fifth of the income distribution face a risk of becoming disabled two and a half times as high as those in the top fifth of the distribution (*Burchardt 2003*).

Experience of socio-economic disadvantage in early childhood can increase the likelihood of developing a health condition in later childhood. For children in the most socio-economically disadvantaged households in 1991, the likelihood of developing disabling chronic health conditions by 2001 was more than twice that of children in the least disadvantaged households (*Blackburn et al. 2012*).

Families of patients with Duchenne muscular dystrophy are more likely to be from a deprived background, even at the time of first diagnosis (usually by age 5) (*Bushby et al. 2001*).

Pre-existing disadvantage such as low or no qualifications; low income; being out of work; smoking; drinking and poor diet are associated with increased likelihood of onset of a health condition or impairment and onset is associated with increased likelihood of disadvantage such as unemployment or poverty. Having qualifications can provide protection against the adverse effects of onset.

2.2.7 Age, disability and caring interact

1.2 million people received care at home in 2011/12 (NHS IC 2012a). **1.8 million people are employed in the care and support workforce** (*Department of Health 2012b*). **There are 5.8 million unpaid carers in England and Wales** (*Census 2011*).

More than 8 out of 10 people aged 65 or over will need some care and support in their later years (*Department of Health 2012b*).

Mencap (2002) estimates that there are at least 29,000 people with learning disabilities living at home with family carers over the age of 70.

11 percent of all carers said there was no one who they could rely on if they wanted to take a break from their caring responsibilities. Carers who did not have someone else they could rely on were most likely to be: aged 65 or over (27 percent); caring for someone in the same home (22 percent); caring for 20 or more hours per week (23 percent) or in bad health (28 percent) (*NHS IC 2010*).

Carers find it difficult combining work and caring responsibilities. Among working age carers 26 percent felt caring had affected their ability to stay in employment (*NHS IC 2010, Arksey et al. 2005*).

A quarter of all women aged 50-64 care for an adult not living in their household in a non-professional capacity (*LOS Wave 1 2009/11, Appendix Table 3.2*).

Adults with impairments are likely to be carers themselves (15 percent of adults with impairments provide informal care compared with 8 percent adults without impairment) (*LOS Wave 1 2009/11*).

Adults with impairments are more likely to spend longer hours caring for others than adults without impairment (*LOS Wave 1 2009/11*).

Caring can have an impact on the health of the carer. Around half (52 percent) of carers said their health had been affected because of the care they provide. A wide range of effects were mentioned; a third of carers reported feeling tired (34 percent), 29 percent felt stressed, 25 percent had disturbed sleep and 22 percent reported being short tempered or irritable (*NHS IC 2010*).

42 percent of carers said their personal relationships, social life or leisure time had been affected because of the assistance they provided. Those who had been affected in this way were asked an unprompted question to establish the effects of caring. The most common effects were having less time for leisure activities (69 percent), being too tired to go out (32 percent), being unable to go on holiday (23 percent) and the effect upon their own health (20 percent) (*NHS IC 2010*).

Understanding the lives of disabled people in the UK

3

Disabled people are integral to the success of our economy and society but inequalities still exist and many face social exclusion

3.2 million disabled people are in work. 11.5 percent of all employed people are disabled and **only 9 percent of working-age disabled people have never worked.** When looking at those aged 25 or over only 5 percent of disabled people have never worked (*LFS Quarter 2 2012, Appendix Table 34, 35.1*).

15 percent of adults with an impairment provide informal care (*LOS Wave 1 2009/11*).

Over half (55 percent) of disabled people play an active role in civic society by formal volunteering, civic activism, civic participation and civic consultation (*ODI Indicator E2*).

Disabled people along with their friends and families make up a large consumer market. The combined spending power of disabled people in the UK has been estimated to be at least £80 billion a year (*DWP 2004*).

But not all disabled people have had the opportunity to realise their aspirations. **There are still significant gaps between disabled and non-disabled people achieving outcomes.** Outcomes for many disabled people are not improving as far or as fast as they should (*EHRC 2010*).

For example:

Young disabled people are less likely to go on to Higher Education. In 2009/10 33 percent of disabled young people were in Higher Education at age 19 compared to 41 percent of non-disabled young people (*ODI Indicator A8*).

Disabled people are less likely to be in work than non-disabled people. The employment rate gap between disabled and non-disabled people is 30 percentage points. This employment rate gap represents just over 2 million people and is particularly high for those with learning disabilities or with mental health conditions. 79 percent of those with severe learning disabilities have never worked (*LFS Q2 2012, Appendix Tables 35.3 and 46.1*).

Once young people finish their full-time education and start to move into work, a much bigger gap between disabled and non-disabled people emerges. The gap widens to 27.8 percentage points at age 23 and then widens further to 36.2 percentage points at age 24 (*LFS Quarter 2 2012, Appendix Table 40.3*).

Disabled people are more likely than non-disabled people to live in poverty (*ODI Indicator C5*).

Disabled people want the same things from life as everyone else

In response to the ‘Fulfilling Potential – The Discussions So Far’ disabled people told us that they have aspirations to participate in every aspect of life (*Fulfilling Potential – The Discussions So Far 2012*).

Good health was the most important factor for quality of life for both disabled adults (39 percent) and non-disabled adults (35 percent). Other factors that were important were: **family; choice and independence; money; friends** and **leisure; housing** and **work** (*ONS Opinions Survey 2012, Appendix Table 50*).

The most important life areas mentioned by disabled people in focus groups were: **household finances and living standards and family relationships**. ‘Being able to look after myself at home’ was also seen as being important (*Focus Groups*).

An earlier consultation with disabled people carried out in 2007 showed that the issues which were most important to disabled people included: **education; employment; economic well-being; housing; social networks; health; transport; access to buildings; civic and political participation; attitudes and crime.** These issues underpinned the development of the Disability Equality Indicators (*ODI 2007*).

In response to Fulfilling Potential disabled people told us what was important to them:

Education	The education system should help disabled people to achieve what they want in life.
Employment	Disabled people should be able to work and earn.
Income	Disabled people want sufficient income to support themselves and pay for the support they need.
Health	There should be access to good quality healthcare.
Family and social life	Disabled people should have the same opportunities for family and social life as non-disabled people.
Leisure and sport	Disabled people want the same opportunities for leisure and sport as non-disabled people.
Choice and control	Disabled people should have more choice and control over the services and support they receive.
Accommodation	Disabled people should be able to access suitable accommodation.
Communities	Transport and the built environment should take into account the needs of disabled people.
Attitudes and hate crime	Disabled people should not be subject to discrimination, harassment or hate crime.

All these issues are covered in this evidence base.

Building understanding of trends in outcomes and barriers

The next section looks at trends in **outcomes** experienced by disabled people and at **barriers** to participation across a range of life areas.

As stated at the beginning of the paper it is important to bear in mind that **different data sources define disability in different ways**. For example data on disabled children is limited so in looking at educational attainment we look at children with Special Educational Needs. In looking at employment we use the LFS which looks at the working age population who are covered by the legal framework. In looking at poverty we use the HBAI data which is drawn from the FRS and based on the legal framework. In looking at barriers we use the evidence from LOS which looks at adults (both working age and State Pension age) with impairment.

The different issues faced by disabled people are inter-linked. For example low educational attainment can lead to poor employment outcomes. Not having a job can be associated with poverty and social isolation. Experiencing barriers to transport can result in not being able to get to work or education.

It is also important to remember that **experiences will be very different depending on the stage of life that a person experienced onset of their impairment or health condition**. For those who are born with a impairment or a health condition, education and other early experiences influence the whole of their life chances. For those who experience onset in adulthood, disability itself may be an outcome, not a cause, of early disadvantage; and pre-established social position (for example level of qualification) may influence response to the onset of impairment or a health condition. For those experiencing onset after State Pension age, impairment or a health condition may be seen as an outcome of old age and some of the reductions in participation may be associated with old age itself, not with impairment.

Early intervention

3

Section 1

‘encouraging early intervention and preventative approaches are often critical to disabled people continuing to realise aspirations’
(*Fulfilling Potential: Next Steps*).

3.1.1 Disabled children are more likely than other children to experience barriers

Conditions such as autism, ADHD and learning disabilities are a common cause of impairment in children.

6 percent (0.8 million) of children are disabled (*FRS 2010/11*).

Conduct disorders and autistic spectrum disorders are more common in boys than girls (*Department of Health 2011b*). 5-6 percent of children aged 5-10 have a conduct disorder (*Knapp et al. 2011*).

Looking at Special Educational Needs (SEN) provides a limited proxy for disability (there are both disabled children who do not have SEN and non-disabled children who do have SEN).

A pupil has a statement of special educational needs when a formal assessment has been made and a document setting out the child’s needs and the extra help they should receive is in place.

One in five pupils has a Special Educational Need (about 1.6 million children). Boys are two and a half times as likely as girls to have statements at primary school (2 percent compared with 0.8 percent) and three times more likely to have a statement at secondary school (2.9 percent compared with 1 percent). **Black pupils are more likely than other pupils to have SEN at primary school.** Pupils with Special Educational Needs are more likely to be eligible for free school meals. **Children in care are three and a half times more likely to have special educational needs and ten times more likely to have a statement of Special Educational Needs** (*Department for Education 2012*).

3.1.2 Disabled children are more likely to live in a lone parent family and to have poor levels of housing

Disabled children are more likely than non-disabled children to live in a **lone parent family** (32 percent compared with 22 percent) (*FRS 2010/11, Appendix Table 32*).

A quarter of disabled children **live with one or more siblings who also have a disability**. Almost half of disabled children live with a disabled parent (*Blackburn et al. 2010*).

There is an **increased risk of separation during the early stages of parenting a disabled child**. The likelihood of becoming a lone parent household is greatest when the disabled child is aged 12 months to two years (Clarke and McKay 2008). However, the risks of separation appear to be driven more by the poorer socio-economic circumstances of families of disabled children than by child disability per se (*Hatton et al. 2009*).

Families with a disabled child are **less likely to be living in a decent home** compared to families with a non-disabled child (based on analysis of 2003/2004 English House Conditions Survey data). Those with a disabled child are 50 percent more likely than other families to live in overcrowded accommodation, to rate their home as being in poor repair and to report problems with wiring, draughts and damp in a child's bedroom (*Beresford and Rhodes 2008*).

Disabled children and young people spend more time at home than non-disabled children, but there is evidence to suggest that their homes are the most restrictive environments in which they spend their time (*Beresford and Rhodes 2008*).

62 percent of families with disabled children have reported difficulties in accessing the services they need in their local area and 80 percent say that trying to access these services locally caused them anxiety and stress (80 percent). **In some cases families have to travel or live apart in order to access the services that they need** (*Brawn and Rogers 2012*).

3.1.3 Disabled children are more likely than other children to experience barriers

In England disabled children are as likely as non-disabled children to visit a library or museum. Disabled children (81 percent) were less likely than non-disabled children (90 percent) to have taken part in sport in the previous four weeks (*DCMS Taking Part Survey 2011/12*).

Disabled children are less likely to participate in sport both in and out of school. The most common barriers are lack of money, the child's health or impairment or the unsuitability of local sports facilities. Lack of transport can also be a problem. The two sports in which disabled children were more likely than non-disabled children to take part in were swimming and horse riding (*Sport England 2001*).

Half of parents of 11-15 year old children with impairment who were interviewed on LOS said that their children did not experience barriers. However, **children with impairment were more likely than those without to experience barriers**. For example around a fifth experienced barriers with transport or personal relationships (compared with 6 percent and 1 percent of children without impairment) and 28 percent experienced barriers with education or with leisure or play (compared with only 3 percent and 9 percent of those without impairment). One of the key causes of barriers for children with impairment, as reported by parents, was the **attitudes of others** (34 percent). This compared to just 8 percent of children without impairment (*LOS Wave 1 2009/11*).

3.1.4 Young disabled people have high aspirations but by the time they reach adulthood their aspirations have reduced

Disabled people told us that education is fundamental, not just in school but in higher and further education, and in lifelong learning (*Fulfilling Potential – The Discussions So Far*).

Early years in a child's life are a key time in the formation and development of aspirations. Parents play a key role along with schools. Later young people need easy access to advice and guidance and the involvement of professional or volunteers. **Young people's aspirations can decline in response to their growing understanding of the world** and what they perceive to be possible (*Gutman and Akerman 2008*).

The levels of aspirations among disabled 16 year olds are similar to those of their non-disabled peers and they expect the same level of earnings from a full-time job. However, by the age of 26 disabled people are nearly four times as likely to be unemployed compared to non-disabled people. Among those who were in employment and with the same level of qualification, earnings were 11 percent lower for disabled people compared to their non-disabled peers. **By the age of 26 disabled people are less confident** and more likely to agree that 'whatever I do has no real effect on what happens to me'. At age 16 there had been no significant differences between them and their non-disabled peers on these measures (*Burchardt 2005*).

Young people's choices may be enabled or obstructed by physical, social or attitudinal factors. Lack of positive role models can be a problem for young disabled people aspiring to meet their goals. Adults do not always prepare young disabled people for the same futures they envisage for their non-disabled children. Young people are able with the right support and guidance to make realistic decisions about their futures (*Shah 2008*).

For people with learning, memory or neuro-diversity impairment family members or support workers play an important role in shaping their aspirations and enabling their participation in different areas of life (*Office for Disability Issues 2010*).

3.1.5 Educational attainment for pupils with SEN is improving overall but the attainment gap for those with a statement is widening

Levels of educational attainment at Key Stages 2 and 4 are improving for all children. **The rate of improvement is highest for SEN pupils without a statement** (*ODI Indicators A3 and A5*).

Whilst the attainment gap at Key Stage 4 has narrowed between pupils without SEN and those who are SEN **without** a statement (from 46 percentage points in 2005/6 to 30 percentage points in 2010/11), the gap between pupils without SEN and those who are SEN **with** a statement has widened (from 58 percentage points in 2005/6 to 64 percentage points in 2010/11) (*ODI Indicator A5*). This attainment gap reduces by the age of 19 (*Department for Education 2012*).

Children with visual impairment are more likely than children with other types of impairment to achieve the expected level at Key Stages 2 and 4. In 2010/11, 54 percent of pupils with visual impairment achieved the expected level at Key Stage 2 compared to 35 percent of pupils with SEN. Equivalent figures for Key Stage 4 were 44 percent and 22 percent respectively (*Department for Education 2012*).

Whilst the use of 'labels' in education such as 'learning difficulties' can have a positive impact, **use of such labels can also have large negative impacts such as stigmatisation, bullying, reduced opportunities in life and lower expectations on what a 'labelled' child can achieve** (*Ho 2004*).

3.1.6 The proportion of disabled 19 year olds without a Level 3 qualification has fallen

The proportion of disabled 19 year olds without a Level 3 qualification has fallen in recent years, and is converging towards the average for non-disabled 19 year olds (*Aldridge et al. 2012*).

In 2010, 53 percent of disabled 19 year olds did not have a Level 3 qualification. This compares to 42 percent for non-disabled 19 year olds. There has, however, been a substantial decrease in the proportion of

disabled people without a Level 3 qualification. It has fallen from 74 percent in 2000 – a fall of 21 percentage points in ten years. This fall has been much faster than for non-disabled 19 year olds, meaning the disability gap has closed from 21 percentage points to 11 percentage points (*Aldridge et al. 2012*).

Level 3 qualifications are A level or qualifications which are equivalent to A level.

3.1.7 Disabled young people are less likely to be in Higher Education than non-disabled young people

Pupils with SEN are four times less likely than other pupils to be in Higher Education (*Department for Education 2012*).

Of those who do enter Higher Education, disabled students not in receipt of Disabled Students Allowance (DSA) are more likely than those who receive the DSA to leave Higher Education in their first year (*ODI Indicator A10*).

40,000 disabled people from the UK qualified from full-time Higher Education courses in 2010/11 (*HESA 2012*).

In 2010/11, **60 percent of disabled students who completed their first degree attained a first class or upper second class degree in comparison to 64 percent of non-disabled students** (*ODI Indicator A9*).

Having a degree level qualification can significantly improve employment outcomes. In 2012, 71 percent of disabled graduates were in employment compared to 42 percent of disabled non-graduates (*LFS Q2 2012, Appendix Table 37*).

Six months after graduating, 60 percent of disabled graduates were in employment, compared to 65 percent of non-disabled graduates (*ODI Indicator A12*).

Looking at **graduate level** employment, latest figures show that disabled graduates were just as likely as non-disabled graduates to be in graduate level employment (63 percent). Higher levels of deaf/hearing impaired graduates entered **graduate level** occupations than any other category

of graduates. Just over a half (54 percent) of graduates with mental health conditions entered graduate level occupations. Graduates who are wheelchair users or have mobility difficulties exhibited the lowest levels of full-time employment (*Agcas 2012*).

Graduate unemployment rates were higher for disabled graduates than for those without a disability (for example 26 percent of those with an autistic spectrum disorder, 15 percent of wheelchair users/those with mobility difficulties, 15 percent of those who are blind/partially sighted compared with an unemployment rate of 9 percent of those with no known disability) (*Agcas 2012*).

3.1.8 There are a number of barriers and enablers for young disabled people making the transition from education to employment

Enablers include:

- Strong aspirations;
- Experience of voluntary work;
- Self-employment;
- Experience of work placements and work experience;
- Strong family support;
- Accurate information and encouraging support from professionals.

Barriers include:

- Lack of flexibility in education leading some young disabled people to drop out;
- Accessibility and cost of transport to voluntary work;
- Attitudes of others – young disabled people believe their abilities are doubted before they are given an opportunity to demonstrate what they can do in terms of education, work and accessing services. Employers look at what a young disabled person can't do rather than what they can do;
- Lack of awareness amongst professionals of what support services are available for disabled young people.

(DWP publication forthcoming)

Disabled people have told us that there is a need for more training and retraining opportunities, including apprenticeships, volunteering, work experience and supported internships (*Fulfilling Potential – The Discussions So Far 2012*).

Although there has been an increase in overall numbers of disabled apprentices from 9,200 in 2005/6 to 35,600 in 2010/11 **the proportion of disabled apprentices has reduced from 11 percent to 8 percent** over this period. This is particularly the case amongst 19-24 year olds (*Department for Business Innovation and Skills 2012*).

The proportion of disabled apprentices completing their framework has increased from 49 percent to 70 percent but success rates for those with mental ill health, emotional/behavioural difficulties, multiple learning disabilities and moderate learning disabilities are consistently lower than for other groups (*Department for Business Innovation and Skills 2012*).

Looking at the Get Britain Working Measures **disabled young people make up 14 percent of starts on Work Experience, 18-19 percent of starts on New Enterprise Allowance and 16 percent of starts on Sector-Based Work Academies** (*DWP 2012*). There are 8 percent of disabled people in the 18-24 age group (*FRS 2010/11*).

Disabled people are just as likely as non-disabled people to engage in volunteering (*ODI Indicator E1*).

Employment

3.1.9 The employment rate for disabled people has been improving but disabled people remain significantly less likely to be in employment than non-disabled people

46.3 percent of working-age disabled people are employed (*LFS, Q2 2012*). 76.4 percent of working-age non-disabled people are employed (*LFS, Q2 2012*). **There is therefore a 30.1 percentage point gap between disabled and non-disabled people, representing over 2 million people** (*LFS Q2 2012, Appendix Table 46.1*).

The gap has reduced by 10 percentage points over the last 14 years and has remained stable over the last two years despite the economic climate (*LFS, Q2 2012, Appendix Table 46.1*).

However, in 2010 the UK's employment rate for disabled people was lower than the EU average (41.9 percent compared to 45.5 percent) (*EU-SILC 2010*).

3.1.10 In particular, employment rates for DDA disabled people with a work limiting disability are very low

The questions the LFS uses to identify disabled people were written to mirror the Disability Discrimination Act (now the Equality Act). The LFS also asks respondents whether anything limits the type or amount of work they can do. We normally report the employment rate for the whole 'DDA disabled' group, but it is also useful to look separately at those with and without a 'work limiting' impairment.

The LFS estimates there are almost 7 million disabled working-age people. This is more than the official estimate from the FRS. This over-reporting might be due to question wording, or because people are being asked in the context of a survey about work and economic inactivity (*LFS Q2 2012, Appendix Table 46.3*).

Around 70 percent of the 7 million say their impairment limits the amount or type of work they can do. Looking at their employment rate reveals an even starker gap, as it is only 33 percent (though it has risen by 2 percentage points in the last ten years) (*LFS Q2 2012, Appendix Table 46.2*).

The employment rate among those (30 percent) not reporting a work limiting impairment is, not surprisingly, much higher – 75 percent, so no gap at all (*LFS Q2 2012, Appendix Table 46.2*).

People with heart, blood pressure, circulation, chest or breathing problems, asthma, bronchitis and diabetes make up almost half of this group (*LFS Q2 2012, Appendix Table 36.7*).

This may appear an obvious finding, but it confirms the importance of removing barriers and changing perceptions about work capability. Because this group has been growing (a decade ago it was only 20 percent working-age disabled people) it has already been a big driver of the closing of the gap (*LFS Q2 2012, Appendix Table 46.3*).

3.1.11 Employment rates vary significantly by age especially after individuals leave full-time education

Employment rates for older (aged 50 and over) disabled people have increased from 34.9 percent (900 thousand) in 2001 to 41.0 percent (1.4 million people employed) in 2012 and have increased slightly faster than for non-disabled people (*LFS Q2 2012, Appendix Table 40.2*).

Employment rates for older non-disabled people show an increase from 71.6 percent (5.3 million people employed) to 77.1 percent (5.9 million people employed) (*LFS Q2 2012, Appendix Table 40.2*).

Employment rates for young disabled people have dropped from 46.0 percent (198,260 people employed) in 2001 to 36.0 percent (202,980 people employed) in 2012 (*LFS Q2 2012, Appendix Table 40.2*).

However, equivalent figures for young (aged under 25) non-disabled people show a drop from 66.2 percent (3.8 million people employed) to 52.0 percent (3.4 million people employed) (*LFS Q2 2012, Appendix Table 40.2*) reflecting the wider challenge of youth unemployment at present.

Before the age of 23 the employment rate gap between disabled and non-disabled young people is not so large because of the increasing trend amongst all young people (both disabled and non-disabled) to remain in full-time education (*LFS Q2 2012, Appendix Table 40.1*).

However, **once young people finish their full-time education and start to move into work, a much bigger gap between disabled and non-disabled people emerges**. The gap widens to 27.8 percentage points at age 23 and then widens further to 36.2 percentage points at age 24 (*LFS Q2 2012, Appendix Table 40.3*).

3.1.12 The employment rate also varies by type of impairment, with some groups particularly under-represented

Employment rates for some conditions which are classed as ‘DDA only’ are close to or in some cases higher than the average non-disabled employment rate. This indicates that having a disability does not automatically mean that an individual is unable to work (*LFS Q2 2012, Appendix Table 36.1*).

The employment rates for people with some impairments remain consistently low. For example, people with learning disabilities or mental health conditions have employment rates of under 15 percent (*LFS Q2 2012, Appendix Table 36.1*).

349,000 disabled people (around 5 percent of the total disabled working age population) have a mental health condition (other than depression, bad nerves or anxiety). Their employment rate is only 14 percent and their economic inactivity rate is 79 percent (*LFS Q2 2012, Appendix Table 36.4-36.6*).

140,000 disabled people (around 2 percent of the total disabled working age population) have a learning disability. Their employment rate is only 10 percent and their economic inactivity rate is 81 percent (*LFS Q2 2012, Appendix Table 36.4-36.6*).

People with learning, memory or neuro-diversity impairment who were not in employment had mixed aspirations around work. The perceived negative attitudes of employers and the need for flexible working conditions created barriers to finding work for these groups (*ODI 2010*).

3.1.13 The reduction in the employment rate gap may be linked to the types of impairment that individuals acquire in later life

There has been an increase in the employment rate for older disabled people from 34.9 percent in 2001 to 41.0 percent in 2012. Within this age group there is a higher prevalence compared to other age groups of heart, blood pressure and circulation problems. 20 percent have heart, blood pressure or circulation problems (*LFS Q2 2012, Appendix Table 40.2*).

Employment rates for those who have heart, blood pressure or circulation problems are higher than average and have increased at a faster rate than the disabled employment rate more generally. Management of circulatory conditions has improved, so these conditions do not necessarily result in significant impairment (*LFS Q2 2012, Appendix Table 36.3*).

Trends in quarterly flows show that the number of people in employment aged over 50, who acquire an impairment and remain in employment has improved: in 2011 it was 1.7 million up by 55 percent when compared to 2001 (1.1 million) (*LFS, Q2 2012*).

Around two-thirds of this increased number of people over 50 remaining in employment after acquiring a disability said it did not limit what work they could do (*LFS Q2 2012, Appendix Table 36.8*).

By far the largest proportion (36 percent) of over 50s who stay in employment after acquiring a disability are in the public administration, education and health sectors (*LFS Q2 2012, Appendix Table 36.8*).

However, if you are an older disabled person you are still considerably less likely than an older non-disabled person to be employed than non-disabled – the employment rate gap is 36 percentage points (*LFS Q2 2012, Appendix Table 40.2*).

3.1.14 Education is key: the employment rate gap between disabled and non-disabled people decreases as the level of qualifications increases

The employment rate for disabled people with any qualifications is substantially higher (54 percent) than for those with no qualifications (17 percent) (*LFS Q2 2012, Appendix Table 37*).

54 percent (1 million) of disabled people either have no qualifications or have qualifications below GCSE grade A to C (*LFS Q2 2012*).

There is an employment rate gap of 35.4 percentage points between disabled and non-disabled people with no qualifications, compared with 15 percentage points for those with a degree (*LFS Q2 2012, Appendix Table 38.2*).

When disabled individuals graduate with a degree, the employment rate gap is around 10 percentage points, and on average remains around this mark until the age of 50 when it widens to 20 percentage points (*LFS Q2 2012, Appendix Table 38.3*).

Almost 200,000 disabled young people are NEET (not in education, employment or training). This represents 37 percent of disabled people aged 16-24 in England and 16 percent of total NEETs (*LFS Q2 2012, Appendix Table 39.1*).

Disabled young people aged 18-24 are far more likely to be NEET (42.1 percent) than non-disabled people (18.6 percent). Disabled young people aged 16-17 are also more likely to be NEET (14.6 percent) than non-disabled young people (8.0 percent) (*LFS Q2 2012, Appendix Table 39.2*).

Around 80 percent of disabled people aged 16-17 are currently in full-time education or employment. However, more than three-quarters of those who leave full-time education and are potentially in the labour market are not working (*LFS Q2 2012*).

This highlights the key issue of the transition from education to employment for young disabled people.

3.1.15 Disabled adults are less likely than non-disabled adults to have a degree

When looking at data on qualifications held by disabled adults it is important to bear in mind that many of these people will have gained their qualifications before they became disabled. Those with low levels of qualification are more likely to experience onset of impairment.

Disabled people are around half as likely as non-disabled people to hold a degree level qualification (15 percent compared with 28 percent) and nearly three times as likely not to have any qualifications (19 percent compared with 6.5 percent) (*ODI Indicator B8*).

Those with sensory impairment or long-term pain are more likely than those with other types of impairment to have a degree (*LOS Wave 1 2009/11, Appendix Table 16*).

Adults with impairment are more likely than those without an impairment to report barriers to learning opportunities (16 percent compared with 9 percent). Barriers cited are: a health condition, illness or impairment; a disability, difficulty with transport; lack of help or assistance; attitudes of other people (*LOS Wave 1 2009/11, Appendix Table 13*).

People with learning and speaking impairments or mental health conditions are most likely to experience barriers to taking part in learning opportunities (*LOS Wave 1 2009/11 Appendix Table 13*).

3.1.16 The disability employment deficit varies widely according to educational qualifications and the level of difficulty, frequency of limitation, number and type of impairments

The disability employment deficit estimates how much less likely a group of disabled people are to be in work, than a group of non-disabled people with otherwise identical characteristics (*Berthoud 2011 and LOS wave 1*).

The overall disability deficit is currently estimated at 23 percentage points (*Berthoud 2011*).

Disabled people with no educational qualifications face a larger employment deficit (33 percent) than those with a degree (11 percent).

This disability deficit is over and above the disadvantage experienced by non-disabled people without qualifications.

Job chances of severely disabled people are most adversely affected by lack of education. Severely disabled people with a good education are not much worse off than people with a mild impairment (*Berthoud, 2008*).

Employment deficits for disabled people with mental health conditions (23 percent), mobility impairment (17 percent) and behavioural impairment (14 percent) are the largest.

The extent of the disability employment deficit varies widely, depending on the level of difficulty experienced, frequency of activities being limited and number of health conditions and impairments.

If there is some function that a disabled person cannot do at all, the deficit is estimated to be 38 percentage points, compared with 9 points if the worst impairment is only “moderate”.

If there is some activity that is “always” limited, the deficit is 40 percentage points, compared with 7 percentage points if the limitations occur only “sometimes”.

The overall number of impairments is strongly associated with disadvantage. People reporting five or more impairments are 61 percentage points less likely to have a job than otherwise similar non-disabled people. For people reporting only one impairment, the deficit is only 7 percentage points.

It is important to note that the calculated deficits may also reflect unobserved aspects of an individual’s characteristics or behaviour (*Berthoud R 2012 unpublished*).

3.1.17 There are large regional differences in the employment rates for disabled people but these follow wider labour market trends

Disabled people in less prosperous (low labour demand) areas are more disadvantaged than those in more prosperous (high labour demand) areas (*Berthoud 2011*).

Following labour market trends, regions with high employment rates for non-disabled people (South West, South East and East of England) also have high employment rates for disabled people (*LFS Q2 2012, Appendix Table 41*).

Employment rates for disabled people in some parts of the country – especially in big cities and former industrial areas – are below 20 percent (*LFS, Q2 2012*).

3.1.18 Disabled people are more likely to work part-time and on average earn less per hour

Disabled people are more likely than non-disabled people to work part-time and less likely to work full-time. 13 percent of disabled people compared with 11 percent of non-disabled people are under-employed and would like to work more hours (*LFS, Q2 2012 and ODI Indicator B6*).

The number of disabled full-time workers needs to almost double in size by 1.8 million (83 percent) and the number of part-time workers needs to increase by 300,000 (29 percent) to reduce the employment gap between disabled and non-disabled people to zero (*LFS Q2 2012, Appendix Table 42.2*).

7 percent of working age disabled people are self-employed, compared to 10 percent of working age non-disabled people. However, if we focus on those that are in employment a greater proportion of disabled people are self employed (15 percent) than non-disabled people (13 percent) (*LFS Q2 2012, Appendix Table 42.3*).

In 2012, the mean hourly wage rate of disabled people was £12.15, while that of non-disabled people was greater at £13.25 (*ODI Indicator B7*).

3.1.19 Disabled people are more likely to work in the private sector but less likely to work in senior management or professional jobs

Most disabled people in work are employed in the private sector. Around 800,000 (26 percent) work in the public sector, about the same proportion as non-disabled people (23 percent) (*LFS Q2 2012, Appendix Table 43.1*).

Disabled people make up 12.9 percent of the Public sector workforce and 11 percent of the Private sector workforce (*LFS Q2 2012, Appendix Table 43.1*).

Similarly, there is little difference by employer size – with disabled people being marginally more likely to work in smaller workplaces than non-disabled people (*LFS, Q2 2012*).

However, there has been a greater increase of 30 percent (188,000) in the number of disabled people working in the public sector compared to 24 percent in the private sector (445,000) since 2002 (*LFS Q2 2012, Appendix Table 43.2*).

People with difficulty in hearing (64 percent), depression, bad nerves or anxiety (66 percent), mental health conditions such as phobia, panics, nervous disorders (65 percent) are less likely (than the overall average) to work in the private sector (*LFS Q2 2012, Appendix Table 43.3*).

The employment rate gap is especially marked in senior management, the professions (including medicine), construction trades, engineering and IT, the arts and media, food, and hospitality (*LFS Q2 2012, Appendix Table 47*).

It is less wide in clerical jobs (especially in the public sector), nursing and caring, shop and sales work, and cleaning (*LFS Q2 2012, Appendix Table 47*).

3.1.20 Economic inactivity rates are high for disabled people

Working age disabled people are nearly three times more likely than non-disabled people to be economically inactive (45 percent compared with 16 percent) (*ODI Indicators B3*).

There are currently 3.7 million disabled people who are not in employment. 3.3 million are economically inactive (1.9 million of whom describe themselves as long-term sick or disabled) and 420 thousand are unemployed (*LFS Q2 2012, Appendix Table 35.4*).

Around half of workless households contain a disabled working-age adult (*LFS, Q2 2012*).

Conditions such as diabetes, stomach/liver/kidney/heart/chest problems, skin conditions stand out as having higher employment and lower economic inactivity rates (*LFS Q2 2012, Appendix Table 36.5*).

Conversely, **conditions such as mental health conditions and learning disabilities stand out as having low employment rates and high economic inactivity rates** (*LFS Q2 2012, Appendix Table 36.5*).

A disproportionate number of disabled people (79 percent) with severe or specific learning disabilities have never worked (*LFS Q2 2012, Appendix Table 35.3*).

43 percent of those flowing onto ESA in the last 12 months have a mental health condition or a behavioural impairment (*ESA on flows data, March 2011 to February 2012 DWP tabulation tool*).

3.1.21 There is little movement out of economic inactivity towards labour market participation

4.2 million people are disabled in both quarters of the LFS. In the first quarter, 1.2 million (28 percent) were employed, 0.2 million (5 percent) were unemployed and 2.8 million (67 percent) were economically inactive.

There is very little movement between employment states for those who are disabled in both quarters.

The risk of moving out of employment and into economic inactivity (5 percent) is higher than the risk of moving into unemployment (2 percent).

There is hardly any movement out of economic inactivity (3 percent in total).

Movements out of unemployment are significant and more likely to be into economic inactivity (21 percent) than into employment (10 percent).

Therefore, the main route out of unemployment is economic inactivity, not employment.

3.1.22 The right work is generally good for physical and mental health and well-being

Work is generally good for physical and mental health and well-being. Work can be therapeutic and can reverse the adverse health effects of unemployment. That is true for many disabled people. However it is important to take account of the nature and quality of work and its social context; jobs should be safe and accommodating (*Waddell and Burton 2006*).

80 percent of people agree that work is good for physical and mental health. There are some differences by employment status with those not in employment being less likely to agree that work is good for mental health and those in employment more likely to say that they would go into work under hypothetical scenarios of being ill. 91 percent people said that they would go to work with a short-term condition while around 60 percent said that they would go to work with longer-term physical and mental health conditions (*Collingwood 2011*).

There is general support for the idea of employers taking steps to help employees with long-term health conditions so that they can carry on working. Over 80 percent of those in employment said that they would be willing to ask their current employer to take steps so that they could carry on working (*Collingwood 2011*).

Two-thirds of JSA claimants agreed that working would lead to better health. People who entered employment were more likely to experience an improvement in their mental health (*McManus et al. 2012*).

3.1.23 We need to develop our understanding of economically inactive disabled people and their motivations to work

37 percent of disabled people who are not in work (unemployed and economically inactive) compared with 45 percent of non-disabled people reported that they would like to work (*ODI Indicator B9*).

Figures from the LFS (Q2 2012, Appendix Table 45) let us draw this out further:

- **There are 3.3 million economically inactive disabled people.**
- **2.3 million (71 percent of all economically inactive disabled people) are economically inactive and not currently seeking work, and would not like work.**
- **0.9 million (28 percent of all economically inactive disabled people) are economically inactive and not currently seeking work, but would like to work.**
- Around 60 percent of economically inactive disabled people cite their long term sickness or disability itself as the reason why they are not looking for work. However, 40 percent are not looking for work due to other reasons including looking after their family/home and retirement.

3.1.24 Health condition, illness or impairment is cited as the main barrier to work by over a quarter of unemployed adults with impairment

Employed adults

- **The most common barrier to work reported by employed adults with an impairment is their health condition, an illness or an impairment (12 percent).** Family responsibilities are also cited as a barrier by 10 percent of adults with an impairment and 8 percent of adults without an impairment. Other barriers to employment are lack of job opportunities (5 percent) and lack of qualifications/experience/skills (5 percent) (*LOS Wave 1 2009/2011, Appendix Table 20.1*).

- Employed adults with mobility (58 percent), dexterity (50 percent) and mental health (50 percent) impairments more likely, than adults with other types of impairments, to experience at least one barrier to employment opportunities. Those with long-term pain (33 percent) and sight or hearing impairments are the least (35 percent) likely to experience barriers (*LOS Wave 1 2009/2011, Appendix Table 5.1*).

Unemployed adults

- **The most frequently reported barriers amongst unemployed adults with an impairment are their health condition (26 percent) and the lack of job opportunities (25 percent).** Family responsibilities are a barrier for those with and without an impairment. Other barriers reported by adults with an impairment are difficulty with transport (17 percent), lack of qualifications/experience/skills (16 percent), attitudes of employers (11 percent) and anxiety/lack of confidence (9 percent) (*LOS Wave 1 2009/2011, Appendix Table 20.2*).

Economically inactive adults

- 70 percent of adults of economically inactive adults with an impairment reported their health condition as being the main barrier to employment. For adults without an impairment the majority (67 percent) reported family responsibilities as the main barrier to employment. Disability-related reasons (41 percent), family responsibilities (22 percent), difficulty with transport (11 percent) and anxiety/lack of confidence (19 percent) are also reported as barriers by adults with an impairment (*LOS Wave 1 2009/2011, Appendix Table 20.3*).
- Those experiencing moderate or severe difficulty often or always with mobility, dexterity, long-term pain or chronic health experience anxiety/lack of confidence as a barrier to employment with around 1 in 5 citing this as a barrier (*LOS Wave 1 2009/2011, Appendix Table 6.17–22*).

3.1.25 Enablers like modified hours can play an important part in helping disabled people enter or stay in work

Approaching half of employed disabled people say that modified hours or other enablers have helped them to stay in work (*LOS Wave 1 2009/11*).

Some enablers are more important and reported and useful for people with particular impairments – for example building modifications for people with mobility or dexterity impairments, or a job coach or personal assistant for people with a mental health condition (*LOS Wave 1 2009/11*).

Around 60 percent of disabled people not currently in work say that such enablers would help. Again, modified hours are most commonly cited, though this is also the case for non-disabled people seeking work. Modified duties appear to be more of an issue specifically for disabled people (*LOS Wave 1 2009/11*).

Up to 1.3 million economically inactive disabled people have a health condition which would necessitate workplace adaptations or assistance to allow them to work (*EU LFS module, 2011*).

However, this overstates demand, at least in the short term, because large numbers say they do not wish to work as they consider themselves retired or long-term sick or disabled.

Job control is important. People with more control over their work can change the way they work or the timing of their work, but people without this level of autonomy can't. People in the third of occupations with the lowest control were about one-third more likely to claim incapacity benefits in the following year than those in the highest-control occupations (*Baumberg 2011*).

3.1.26 Flexible working is a key enabler

The most commonly mentioned enabler in LOS was modified hours or days or reduced work hours. Employed adults with mobility or dexterity impairments were more likely to require building modifications than adults with any type of impairment. Employed adults with a mental health condition were more likely to require a job coach or personal assistant than employed adults with any type of impairment (*Appendix Table 27*).

Job control is important. People with more control over their work can change the way they work or their timing of their work but people without this level of autonomy cannot. People in the third of occupations with the lowest control were about one-third more likely to claim incapacity benefits in the following year than those in the highest-control occupations (*Baumberg 2011*).

3.1.27 Work-focused healthcare and flexible employment are key enablers for retention in jobs

Every year 300,000 people leave work, of whom nearly half do so without having a period of sick leave first, meaning they have no support to get back into work and no attachment to an employer (*Black and Frost 2011*).

A third of employers had taken at least one action in the last 12 months to keep employees with health problems in work or facilitate their return to work while 67 percent had not. Employers who were most likely to take action to retain employees included large organisations, public sector and trade unionised employers (*Young and Bhaumik 2011*).

The most commonly cited measures used by employers in the last 12 months included reduced or different hours (29 percent), meetings to discuss extra help (28 percent) and reducing employee workload (25 percent) and different duties (25 percent) (*Young and Bhaumik 2011*).

Effective support to help a disabled person to stay at, return to and remain in work depends on effectively co-ordinated work-focused healthcare and accommodating workplaces. Employers play a key role in this process (*Waddell et al. 2009*).

There is a need for flexibility in employment to enable people to remain in work for example part-time working during the early stages of a degenerative disease but with the flexibility to move back to full-time if the condition improves (*EHRC 2010*).

3.1.28 Evidence points towards a focus on personalisation along with work-based learning or experience

A voluntary approach to pre-employment support includes a combination of work-focused interviews, ongoing support from an experienced adviser and access to a range of employment-related support (*Evaluations of New Deal for Disabled People and Pathways to Work*).

International evidence suggests that the key to achieving job outcomes is a focus on work capacity rather than disability and active engagement with the labour market. Work should pay and provide clear financial incentives to take up jobs (*OECD 2010*).

Whilst it is appropriate to look at barriers within the social context it may not be appropriate to use the term ‘barriers’ at an individual level for example talking to a person in terms of barriers to work can contribute to lowering self-efficacy and therefore hinder a return to work. Enabling discussions should focus on capability and solutions (*Williams and Birkin 2011*).

Individual Placement and Support (IPS) consists of individual support, rapid job search followed by placement in paid employment and time-unlimited in-work support for employees with mental health conditions and employers. A key principle of the programme is that employment specialists and clinical teams work and are co-located together on one site. Evidence suggests that IPS participants are twice as likely to gain employment compared with traditional vocational alternatives (*Burns et al. 2007*). **The Perkins Review stated that this approach should be adopted as the model for future support for people with mental health conditions** (*Perkins et al. 2009*).

Work-based learning opportunities, for example longer-work placements, work experience for students as well as part-time or weekend jobs are important for preparing disabled people for work and raising their aspirations (*Beyer and Robinson 2009*). These opportunities at Year 10 (age 15) are critical on the ‘pathway’ to employment for young disabled people (*Beyer and Kaehne 2011*).

3.1.29 Having a disabled child can impact on the employment of parents, particularly lone parents and mothers

For parents who have a disabled child both lone parents and mothers with a partner are less likely to participate in paid employment. Having a disabled child has the strongest effects on full-time work and it also slightly reduces part-time work. However, most fathers work full-time hours and having a disabled child does not have much impact (*McKay and Atkinson 2007*).

Couples with a disabled child are less likely to both have a job, compared to those with no disabled child. Almost twice as many couples with a disabled child are workless, compared to those without and the likelihood of work falls as caring responsibilities increase. For parents of disabled children who wished to work, securing suitable childcare was the greatest barrier to employment (*Hall et al. 2011*).

10 percent of all families with children have a disabled child who needs extra help and support owing to his or her impairment (*McKay and Atkinson 2007*).

Where parents did need to spend more time caring, the majority (59 percent) said that the extra work of looking after their child would restrict their ability to work (*Coleman and Lanceley 2011*).

Choice and Control

3

Section 2

‘enabling disabled people to have increased and informed choice and control over their lives’ (*Fulfilling Potential: Next Steps*).

3.2.1 Independent living and social care

To achieve independent living, disabled people should have the same choice and control in their lives as everyone else. Three quarters (74 percent) of disabled people feel they have choice and control over their lives compared with 81 percent of non-disabled people (*ODI Indicator I1*).

Those disabled people who are more likely to say that they have no choice and control tend to be below State Pension age; single/divorced/separated; not in paid employment; have no qualifications; on a low income (*ONS Opinions Survey 2012, Appendix 51.1-5*).

Having choice is key to improved health, maintaining independence and relationships within families and retaining lifestyles. The choices people make are influenced by their age, the nature and severity of their condition, previous experiences of services, future expectations, availability of information, individual preferences and family responsibilities (*Rabiee and Glendinning 2010*).

Barriers and enablers to choice include: access to appropriate transport; financial constraints; removing barriers to education, training and employment; support and assistance from family members; caring responsibilities; access to equipment and adaptations; confidence; lack of awareness of support available; disability awareness of employers and staff in organisations providing goods and services to remove attitudinal barriers (*Ipsos Mori 2010*).

There is a difference in the approach to choice and control between people with fluctuating conditions who have long-term experience of managing their condition **and those who have recently experienced onset of impairment** who tend to rely more on professionals for information and advice. Sensitivity to people's concerns about making and changing choices and to the role of family members is important (*Glendinning et al. 2011*).

Community living brings more choices but living in a private household does not necessarily bring choice and control. Supplied equipment is often of poor quality resulting in low user satisfaction (*Priestley et al. 2009*).

Aspirations and expectations regarding choice and control differ by age and life stage with older people having lower aspirations than younger people (*Ipsos Mori 2010*).

Older people want the opportunity to 'live a normal life' including being able to handle and use money on day-to-day expenditure. Access to information to enable informed choices is important along with support to understand the wealth of information available. Quality of communication is also important and the need for support workers and care staff to take time to listen to what is being communicated both verbally and non-verbally (*Granville et al. 2011*).

3.2.2 Personal budgets can help people achieve a better quality of life but some users can experience difficulties managing a personal budget

A **personal budget** is the amount of money that will fund a person's care and support costs. It is calculated by assessing a person's needs and is spent in line with a support plan that has been agreed by both the person and the local authority. The person may also choose to pay for additional support on top of the budget. A personal budget can be taken by an individual as a **direct (cash) payment**; as an account held and managed by the local authority in line with the individual's wishes; or as an account placed with a third party (provider) and called off by the individual; or as a mixture of these approaches.

Direct payments are cash payments given to service users in lieu of community care services they have been assessed as needing, and are intended to give users greater choice in their care. The payment must be sufficient to enable the service user to purchase services to meet their eligible needs, and must be spent on services that meet eligible needs.

A **personal health budget** enables patients to work alongside health service professionals to develop and execute a healthcare plan to meet their needs.

Personal budgets offer a greater degree of choice and control for the individual. They can also offer better value for money (*Audit Commission 2011*).

47 percent of people who had accepted a personal budget reported that their view of what could be achieved in their lives had changed a lot compared with a third who reported that their view had not changed at all. **People in receipt of a personal budget were more likely than those in a comparison group to report that they felt in control of their daily lives (48 percent compared with 41 percent)** (*Glendinning et al. 2008*).

Some users experience difficulties with personal budgets. The main difficulties are in accessing information and advice, having personal needs assessed, understanding what the budget could be spent on, being in control of what the budget was spent on and planning and managing care and support (*Hatton and Waters 2011*).

63 percent of people with dementia had not been offered a personal budget (*Alzheimer's Society 2011*).

Disabled people have told us that rules around the use of personal budgets may act as a barrier to disabled people achieving positive outcomes (*Fulfilling Potential – The Discussions So Far 2012*).

Personal health budgets can result in improvements in quality of life and psychological well-being. Awareness of the budget amount, a degree of flexibility in the services that could be purchased and a choice in how the budget could be managed have a positive effect on outcomes (*Forder et al. 2012*).

3.2.3 The proportion of people in receipt of direct payments is increasing

The proportion of social care service users and carers receiving a direct payment has increased from 12 percent in 2010/11 to 14 percent in 2011/12. 25 percent of those aged 18-64 with a learning disability receive a direct payment and 35 percent of carers receive a direct payment (*NHS IC 2012b*).

Those using direct payments benefit from on-going help and support in managing direct payments as their circumstances and capabilities change over time (*Glendinning et al. 2011*).

Looking more broadly at self-directed support, the proportion of social care users and carers who received self directed support was 43 percent in 2011/12 compared to 29 percent in 2010/11. It was highest for those service users aged 18-64 with a learning disability (59 percent) and lowest for those aged 18-64 with a mental health problem (14 percent) (*NHS IC 2012b*).

The **Right to Control** trailblazers are running in seven local authority areas in England. Right to Control is a new **legal** right for disabled people which is being tested in the seven areas. It gives disabled people in those areas more choice and control over the support they need to go about their daily lives. Disabled adults living in the test areas are able to combine the support they receive from six different sources and decide how best to spend the funding to meet their needs. Disabled people are able to choose to: continue receiving the same support; ask a public body to arrange new support; receive a direct payment and buy their own support or have a mix of these arrangements.

Early evaluation of the seven Right to Control trailblazers found that awareness and understanding of the Right to Control was low amongst disabled people with many thinking it was the same as direct payments. Where individuals were aware of the Right to Control and had followed the intended customer journey they were happy with the process and felt that they were able to exercise choice and control over the funding they received which often resulted in more flexible and tailored support (*Tu et al. 2012*).

3.2.4 Where people need assistance with everyday activities they are most likely to get help from a family member or friend

Adults with impairments who require assistance completing everyday activities **were most likely to receive assistance from a family member or relative (81 percent)**. 25 percent received assistance from a friend or neighbour. 12 percent received paid help inside the home. **80 percent of adults with impairment often or always received assistance when it was required. 82 percent said that they either always or often had a say over the assistance that they received** (*LOS Wave 1 2009/11*).

Each year nearly one and a half million people in England approach their local authority for help due to their age or disability. **There are over 17,000 organisations providing adult social care employing 1.6 million workers, across the private, voluntary and public sector** (*Hatton and Waters 2011*).

It is estimated that around 170,000 (45 percent) of the registered care home places in England are occupied by self-funders and 170,000 older people pay for care in their own home. This increases to 270,000 if activities such as housework and shopping are included (*Institute of Public Care 2011*).

79 percent of people with a long-term condition reported that they had sufficient support from local services or organisations to help manage their long-term health condition(s) (ODI Indicator I2). 63 percent of people are extremely or very satisfied with the support they receive through Adult Social Care (NHS IC 2012b).

Latest data from the NHS Information Centre shows that 74 percent of disabled people and carers find it easy to find information about Adult Social Care services (NHSIC 2012b). However, there is a need for better information about social care available particularly at points of crisis or transition (Winchcombe 2012).

Information and advice needs to be tailored to meet the needs of the individual. People struggle to navigate the system, often finding it difficult to distinguish between health, housing and care services (TASC 2010). People in lower socio-economic groups may have less skills and resources to seek information but they are also the group that are likely to require social care services (Baxter et al. 2008).

3.2.5 There is local variation in social care

The budget for publicly funded social care is managed at Local Authority level and is means tested. Local authorities have discretion over the level of need that they support. Local authorities set needs thresholds, for eligibility for means-tested social care support. In 2005/06, around 60 percent of local authorities set thresholds at 'substantial' or 'critical'; this has risen to 82 percent of local authorities in 2010/11 (Department of Health 2011c).

There is a large variation by local authority in the proportion of state funded users of adult social care in receipt of self-directed support and in the proportion in receipt of a direct payment. For example, ignoring outliers and looking at 90 percent of councils the proportion of service users in receipt of self-directed support ranged from 23 percent to 68 percent and the proportion of service users in receipt of direct payments ranged from 6 percent to 30 percent (NHS IC 2012b).

Levels of satisfaction with the support received through Adult Social Care also varies. For example, looking at 90 percent of councils the proportion of users who were extremely or very satisfied with the support they received through Adult Social Care ranges from 52 percent to 70 percent (NHS IC 2012b).

Poverty and material deprivation

3.2.6 Disabled people are more likely than non-disabled people to experience poverty

Relative income poverty is defined as 60 percent of contemporary median income **before housing costs**.

22 percent of children living in families with a disabled member live in income poverty compared with 16 percent of children in families with no disabled member (*ODI Indicator C1*). **20 percent of individuals** (adults and children) living in families with a disabled member live in income poverty compared with 15 percent of people living in families with no disabled member (*ODI Indicator C3*).

Excluding Disability Living Allowance and Attendance Allowance from income has the effect of increasing the percentage of families with disabled members living in poverty. For example, the proportion of individuals living in families with a disabled member who live in income poverty excluding DLA and AA is 23 percent instead of 20 percent, and the proportion of children living in families with a disabled member who live in income poverty excluding DLA and AA is 23 percent rather than 22 percent (*ODI Indicators C1 and C3*).

Looking at adults **there is a difference in the poverty rates between disabled working age adults and disabled pensioners. 29 percent of working age adults** in families where someone is disabled were in poverty in 2010/11 compared with **14 percent of pensioners** living in a family where someone is disabled. **Looking at pensioners the poverty rate is the same for families with and without disabled people** (*Aldridge et al. 2012*).

3.2.7 There has been a decrease in relative income poverty

There has been a fall in the proportion of children living in families with a disabled member who live in income poverty since 2004/05 (from 29 percent to 22 percent) (*ODI Indicator C1*). There has also been a fall in the proportion of individuals living in families with a disabled member who live in

income poverty since 2004/05 (from 23 percent to 20 percent) (*ODI Indicator C3*). This reduction could be because families with disabled members are more likely to receive a greater proportion of their income in benefits. **So the reduction in poverty may have been driven by increases in benefit income, as a result of the uprating of benefits by more than earnings growth.**

Households with a disabled person who do not receive a disability-related benefit are twice as likely to be in poverty as households with a disabled person who do receive disability-related benefits (*Aldridge et al. 2012*).

12 percent of disabled adults live in persistent poverty compared to 6 percent of non-disabled adults (*ODI Indicator C5*). Persistent poverty is defined as spending three or more years, out of any four-year period, in a household with an income below 60 percent of median income.

People move in and out of poverty. Looking at the population as a whole, those in persistent poverty make up less than half of all those who spend time in poverty (*Aldridge et al. 2012*).

3.2.8 Disabled people are more likely than non-disabled people to experience material deprivation

Children in families containing one or more disabled people are more likely to live in households in low income and material deprivation than children in families with no disabled person (*ODI Indicator C2*).

Overall (including those in paid work) **disabled people are more than twice as likely to experience material hardship** as those who are not disabled. Disabled people are more likely to report that they cannot afford most goods on the deprivation scale. For example, around 50 percent of those who are not in work and are disabled, could not afford to save for a rainy day, compared to around 35 percent of those who are not disabled and not working (*McKay and Atkinson 2007*).

Although disabled people who are working are better off than those who are not working, they are in a similar position to non-disabled people who are not working when it comes to being able to afford/access particular items.

For example, almost 40 percent of disabled people who are not working say they cannot afford fruit and vegetables, compared to around a quarter of working disabled people. However, the proportion of **working** disabled people who say they cannot afford fruit and vegetables (27 percent) is comparable to the rate for **non-working** non-disabled people (26 percent) and much higher than the rate for working non-disabled people (19 percent) (*McKay and Atkinson 2007*).

Those aged 65 or over living in households in which someone is disabled are more than twice as likely to be materially deprived as those in households which do not contain a disabled person (11 percent compared to 5 percent) (*HBAI 2010/11*).

20 percent of households including a disabled person live in fuel poverty, compared to 15 percent of households with no disabled person (*ODI Indicator C4*).

Material deprivation is where people are unable to afford a high number of items which are considered to be necessary.

3.2.9 Disabled children are likely to experience socio-economic disadvantage

The association between poverty and child disability indicates that disabled children are significantly more likely to live under conditions that have been shown to impede development, educational attainment and adjustment, and increase the risk of poor health, additional impairment and social exclusion. However when compared to other families with similar levels of personal and social resources, families supporting a disabled child are no more likely to escape from or descend into poverty than other families (*Shahtahmasebi et al. 2011*).

The presence of a disabled child in a family does not increase the risk of poverty but the presence of a disabled adult does. In terms of the percentage of children living in households with relative low income, there is no difference between families with a disabled child and no disabled adults, and families where no-one is disabled (16 percent). However, for families with no disabled children and one or more disabled adults, the risk of poverty is greater, with 26 percent of this group being found in relative low income (*HBAI 2010/11*).

However, **families supporting a disabled child are significantly more disadvantaged across a wide range of indicators of socio-economic position**. The hardship experienced by these families can only partly be accounted for by between group differences in income, debt and savings. It is likely that the additional costs associated with caring for a disabled child account for a significant portion of the unexplained risk for increased hardship. The association between supporting a child at risk of disability and socio-economic disadvantage holds true for both lone parent and couple families (*Emerson and Hatton 2007*).

Families supporting a disabled child are more than twice as likely as other families to be tenants of local authorities or housing associations, not to be home owners, to live in a house that could not be kept warm enough in winter, to be unable to keep a child's bedroom warm enough in winter and to be unable to keep the house warm enough in winter due to the cost of heating (*Emerson and Hatton 2007*).

3.2.10 Families including a disabled person find it harder to manage their finances

27 percent of households where at least one person had an impairment reported that they found making loan repayments a heavy burden

(compared with 14 percent of households where no-one had an impairment). 44 percent of households including at least one person with impairment were able to pay usual expenses fairly easily compared with 49 percent of households where no-one had impairment (*LOS Wave 1 2009/11*).

One in four individuals with a mental health condition also has debt problems which can seriously affect their wellbeing (*ONS 2002*).

Improving ability and understanding of money matters can make a difference and moving from low to average financial capability improves psychological wellbeing by 6 percent and reduces risk of anxiety/depression by 15 percent (*Taylor et al. 2009*).

The effect of disability on total family income does not vary much for lone parents (likely to be the effect of income-related benefits and tax credits). However, among couples with children, disability appears to have significant

effects on the distribution of incomes. Where family members are disabled (either adults or children) average (median) incomes are reduced and in particular the chances of having a high income are much reduced. Among couples, the effect of being a carer appears to lower incomes more than disability (*McKay and Atkinson 2007*).

3.2.11 'Extra costs' benefits provide support for a range of different things

Whilst it is recognised that there are additional costs associated with disability, research shows that these vary greatly in level and nature, and **there is no general agreement on how to objectively measure these costs** (*Stapleton et al. 2009*).

Disability Living Allowance and Attendance Allowance **have a major positive impact on recipients' lives**. These allowances help them to: maintain independence and control; meet some of the extra costs of disability; improve quality of life; access other help and services; enhance physical and mental health; maintain warmer, cleaner, more comfortable homes (*Corden et al. 2010*).

Having a family

3.2.12 Disabled people are less likely to be married/cohabiting and less likely to have children

Disabled people are more likely to remain single (never marry) or to be divorced or separated. Among those aged 30-44, 36 percent of disabled people remain single compared with 26 percent of non-disabled people. Similarly, for this age group, 19 percent of disabled people are divorced compared with 14 percent of non-disabled people. Households that are most likely to stay together are those where no adult has any impairment or the experience of impairment is stable. **Where impairment is fluctuating there is a greater risk of breakdown** (*Clarke and McKay 2008*).

Among disabled adults of working age 27 percent have dependent children, compared with 38 percent of non-disabled people. Although younger disabled people (those aged 20-29) were more likely to have dependent children than their non-disabled peers (*Clarke and McKay 2008*).

5 percent of couples with dependent children contain partners who are both disabled, and there is an association between parent and child disability. There could be a number of explanations for this, including the hereditary nature of some impairments, shared environmental factors and consistent bias in reporting (*McKay and Atkinson 2007*).

Disabled people have different experiences of having children. This includes lack of preparation among disabled people for parenthood and negative attitudes towards some disabled people becoming parents. Additionally financial restrictions and lack of space also inhibit family life. In very rare cases disabled children and young people have their fertility restricted through medical interventions by either restricting the growth and physical maturation of the child or sterilising them (*Parnell and Bush 2009*).

Inequalities in health

3.2.13 Disabled adults are more likely than non-disabled adults to experience difficulties accessing health services

A higher proportion of adults with impairments compared with adults without impairments experience difficulty with access when using hospitals (34 percent compared with 25 percent). Those with impairments are also more likely than those without impairments to have difficulties with access to a GP surgery (19 percent compared with 11 percent) (*LOS Wave 1 2009/11*).

All impairment groups with the exception of those with a learning or intellectual impairment are more likely to use health services but even after controlling for age, gender and ethnicity the **likelihood of experiencing difficulties with accessing health services is much higher for those with**

an impairment. For example those with memory/speaking impairment are 5.3 times more likely to experience difficulties than those without impairment (*Allerton and Emerson 2012*).

Difficulty getting an appointment in order to access health services is cited as a barrier by both the impaired and non-impaired groups but slightly more so by the impaired group (17 percent compared with 13 percent) (*LOS Wave 1 2009/11, Appendix Table 18.1*).

Those experiencing moderate or severe difficulty often or always with mobility, dexterity, long-term pain or chronic health are more likely than those with less severe impairment to cite anxiety/lack of confidence, not providing a home visit, lack of help with communication, transport, difficulty getting in and out of the building and difficulty using facilities as barriers (*LOS Wave 1 2009/11, Appendix Table 8.1–4*).

Health and social care users often find systems to be fragmented. People often have to explain their needs to multiple people or organisations. This can lead to care packages that do not reflect the needs of the individual. For example, preventable hospital admissions, unnecessarily long stays in acute health settings and avoidable admissions to residential care (*National Voices 2011*).

For disabled people from Black and Minority Ethnic groups difficulties with communication can be a particular issue. Even those who speak good English struggle with technical or medical terms. There is also evidence of mis-diagnosis if patients who do not speak English cannot communicate with their doctor. Patients can fail to understand their impairment accurately as a result of communication difficulties (*Scope 2012*).

People with sudden onset are likely to require acute health services and then rehabilitation. People with intermittent conditions require speedy acute health support at time of change and then rehabilitation through a period of adjustment. Those whose condition is progressive or stable may need regular health checks and be supported to manage their condition as it changes. Support workers and carers need to feel confident in having the appropriate knowledge. People need to be better supported in getting a diagnosis and adjusting to and managing their condition. People need support to enable them to continue in everyday life and to contribute to society on equal terms (*Winchcombe 2012*).

3.2.14 Disabled people are also more likely to experience inequalities in health outcomes

A number of factors contribute to the health inequalities experienced by disabled people. These include:

- Some health conditions or impairments involve **increased risk of secondary health conditions or impairment** for example people with Down's syndrome are more likely to experience congenital heart disease, impaired hearing and early onset dementia. People using wheelchairs are at increased risk of pressure sores and urinary tract infection.
- Increased risk of **exposure to common determinants of poor health** (for example childhood poverty). Evidence suggests that this could account for 20-50 percent of the risk of poorer mental and physical health among children with general intellectual impairment.
- **Barriers to accessing health care.** (*Emerson et al. – forthcoming*).

People with learning disabilities have poorer health than their non-disabled peers. Mortality rates among people with moderate to severe learning disabilities are three times higher than in the general population, with mortality being particularly high for young adults, women and people with Down's syndrome. Barriers to accessing health services include: scarcity of appropriate services; physical barriers to access; eligibility criteria for accessing social care services; failure to make 'reasonable adjustments' in light of the literacy and communication difficulties experienced by many people with learning disabilities; variability in the availability of interpreters for people from minority ethnic communities; lack of expertise and discriminatory attitudes among healthcare staff; 'diagnostic overshadowing' (for example symptoms of physical ill health being mistakenly attributed to either a mental health/behavioural problem or as being inherent in the person's learning disabilities) (*Emerson and Baines 2011*).

People with serious mental health conditions or mental health conditions that are covered by the Equality Act framework are also more likely to experience major illnesses, to develop them younger and to die of them sooner than other people. People with mental health conditions are more likely to experience obesity, smoking, heart disease, high blood pressure, respiratory disease, diabetes and stroke. Both groups are likely to die younger than other people. People with serious mental health conditions are also more likely to get conditions such as strokes and coronary heart disease before the age of 55. Once they develop these conditions they are less likely to survive for more than five years. People with learning disabilities or long-term mental health conditions on average die 5-10 years younger than other people, often from preventable illnesses (*Disability Rights Commission 2006*).

Inclusive communities

3

Section 3

‘promoting communities which include disabled people, including actions which will change attitudes and behaviours’ (*Fulfilling Potential: Next Steps*).

3.3.1 Disabled people are less likely to participate in leisure activities

Disabled people have told us that access to information about and availability of information about leisure activities is important (*Fulfilling Potential – The Discussions So Far 2012*).

Disabled adults are less likely than non-disabled adults to participate in cultural, leisure or sporting activities (for example using a public library service, visiting a museum, gallery or archive, engaging with the arts, visiting a historic environment site, participation in sports and going to the cinema) (*ODI Indicator E3*).

Adults with impairments are more likely than those without impairments to experience barriers to taking part in leisure activities. For example a much higher proportion of adults with impairments experience barriers to playing sport than adults without impairments (72 percent compared with 54 percent). 68 percent of adults with impairments experience barriers to going to a museum or place of historical interest compared with 58 percent of adults without impairments (*LOS Wave 1 2009/11*).

Only 7 percent of disabled adults participate in at least 30 minutes of moderate intensity sport three times per week compared with 35 percent of all adults (*Sport England 2011*). As shown earlier, disabled children also participate less in sports than non-disabled children (*DCMS Taking Part Survey 2010/11*).

Adults with impairments are less likely to feel that they have choice over the use of their free time – 22 percent reported having little choice compared with 13 percent of those without impairment (*LOS Wave 1 2009/11*).

Some of those with learning, memory or neuro-diversity impairment attend day centres or social clubs run by voluntary disability organisations, which allow them to take part in activities that might not otherwise have been available to them. Some are keen to become more independent and be less reliant on family members when deciding what to do in their leisure time. Older people tend to have fewer aspirations, often feeling that they could not do everything they used to as a result of their age and that nothing could be done to change this (*Office for Disability Issues 2010*).

3.3.2 Cost is more likely to be a barrier to leisure activities for those with impairment

Cost is more likely to be a barrier for those with an impairment whereas lack of time is more likely to be a barrier for those without impairment. There is a difference by age with cost being less of a barrier for people of State Pension age or older (*LOS Wave 1 2009/11, Appendix Table 19.1–8*).

Those with an impairment who experience severe or moderate difficulties always or often with mobility, dexterity, long-term pain or chronic health conditions were more likely than those with less severe impairment to experience lack of help or assistance, difficulties with transport with using facilities as being barriers (*LOS Wave 1 2009/11, Appendix Table 11.1–8*).

3.3.3 Disabled people are less likely than non-disabled people to have access to the internet

The proportion of disabled people living in households with internet access has increased from 40 percent in 2005 to 61 percent in 2011 **but disabled people are significantly less likely than non-disabled people to live in households with internet access (61 percent compared with 86 percent)** (ODI indicator F3).

Access to the internet varies by age group. People of working age are more likely than those of State Pension age to have access to the internet. For example **86 percent of disabled women of working age have access to the internet** compared with only 40 percent of disabled women aged 65 or over (BSAS 2011).

Access to the internet to shop online is an enabler to accessing goods and services (Ipsos Mori 2010).

Disabled people are concerned that moving more services online will mean only those with access to the internet will be able to participate fully in society (Fulfilling Potential – The Discussions So Far 2012).

An impact assessment of the proposed use of digital services by DWP concluded that whilst some disabled people would benefit from self-service, overall disabled customers are more likely to use traditional methods and less likely to be aware or have used the Jobcentre Plus website. Access varies by type of disability; 45 percent of visually impaired people do not use the internet (DWP 2011b).

3.3.4 There have been some improvements in public attitudes towards disabled people

Since 2005 a **higher proportion of people are likely to think of disabled people as the same as everyone else** (80 percent in 2011 compared to 77 percent in 2005) (Staniland 2011).

There has been an increase in the proportion of people who have friends or acquaintances who are disabled – this has increased from 66 percent in 2007 to 73 percent in 2009. Compared with other EU countries, the UK and Ireland has the highest proportion of people with friends and acquaintances who are disabled (ANED 2010).

81 percent of people thought that the Paralympics had a positive impact on the way disabled people are viewed by the British public (*Ipsos Mori 2012*).

However, in 2011 almost **one in ten (9 percent) said that they thought of disabled people as getting in the way** (most of the time or some of the time), similar to when this was asked in 2005 (9 percent) and in 2009 (7 percent) (*Staniland 2011*).

The **proportion of non-disabled people feeling there is a lot or a little prejudice towards disabled people increased from 73 percent in 2005 to 79 percent in 2009**. However, among disabled people there was no significant change (76 percent and 77 percent respectively). This may reflect increased public awareness of prejudice rather than an actual increase in prejudice (*Staniland 2011*).

Views towards disabled people are influenced by: personal relationships; the media; role models (*Focus Groups*).

Disabled people have told us that there is a need for greater disability awareness amongst the general public, for example in understanding more about the barriers faced by disabled people and to develop better understanding of particular types of impairment (*Fulfilling Potential – The Discussions So Far 2012*).

3.3.5 However negative attitudes still remain

In 2011 **86 percent of people thought that disabled people need caring for some or all of the time**, up from 72 percent in 2009 (*Staniland 2011*).

Around four in ten people (41 percent) in 2011 felt that disabled people cannot be as productive as non-disabled people (compared with 36 percent in 2009) (*BSAS 2011*).

Awareness of disability rights has decreased in recent years. In 2011 67 percent of the general population were aware of the Disability Discrimination Act (DDA) and/or the Equality Act (EA) compared with 73 percent in 2005 (*ODI Indicators D2*).

Whilst the majority of the public have a strong belief that the Government should be mainly responsible for providing welfare for the long-term sick and disabled (84 percent in 2010) **support for more spending on disabled people has declined in recent years**. In 1998, almost three-quarters (74 percent) wanted to see more spending on benefits for disabled people, compared to 63 percent in 2008 and 53 percent by 2011. Support for more government spending on those caring for sick and disabled people has also declined from 85 percent in 2008 to 75 percent in 2011 (*BSAS 2011*).

Whilst understanding and tolerance of mental health conditions remained high in 2011, the proportion of adults voicing these tolerant attitudes has decreased since 1994. For example agreement that 'We need to adopt a more tolerant attitude towards people with a mental health condition' fell from 92 percent in 1994 to 86 percent in 2011 (*NHS IC 2011*).

Discrimination due to a health condition, illness or impairment was reported by 8 percent of adults with impairment and discrimination due to a disability by 5 percent of adults with impairment in 2009/11 (*LOS Wave 1 2009/11*).

Across Europe 2 percent of people had been discriminated against on the grounds of disability in the previous 12 months. 7 percent of people had witnessed discrimination due to disability happening to someone else. Of all the EU countries, Austria (11 percent), Sweden (11 percent) and the UK (10 percent) had the highest proportions of respondents that had witnessed disability discrimination. This could be due to higher awareness of discrimination (*European Commission 2008*).

Disabled people are concerned about the portrayal of disabled people in the media and the way that media messages can reinforce or promote negative perceptions of disabled people (*Fulfilling Potential – The Discussions So Far 2012*).

There has been a significant increase in the reporting of disability in the print media in 2009/10 as compared with 2004/5. During this period there has been a reduction in the proportion of articles which describe disabled people in sympathetic and deserving terms. This was coupled with **an increase in the number of articles documenting the claimed 'burden' that disabled people are alleged to place on the economy** (*Briant et al. 2011*).

3.3.6 Discrimination and prejudice vary by type of impairment

People are more likely to express being comfortable interacting with people with physical or sensory impairments than with people with learning disabilities or mental health conditions (*Staniland 2011*).

Most people are inclined to help out where they could or when asked to in a range of hypothetical situations presented to them which involved disabled people. However, situations involving a person with a mental health condition produced more mixed reactions than those involving physical or sensory impairments (*Grewal et al. 2002*).

Over four-fifths of adults (85 percent) think that people with mental health conditions experience stigma and discrimination (*NHS IC 2011*).

Evaluation of the Time to Change campaign shows that there is a clear link between awareness of the campaign and improved knowledge, attitudes and behaviour around mental health (*Henderson and Thornicroft 2009*).

3.3.7 Discrimination and prejudice can occur in a variety of settings

Attitudes towards disabled people also vary depending upon the context. People are least likely to express being comfortable where the disabled person was in a position of authority, such as being a Member of Parliament or a boss at work (*Staniland 2011*).

Education

Young disabled people are more likely than other young people to have reported all types of bullying (*Green et al. 2010*).

More than four-fifths of 16-year-olds with a statement of special educational needs or disability that affected their schooling reported being bullied in the previous three years. This contrasts with around two-thirds of non-disabled young people who reported being bullied in the same period (*Department for Children Schools and Families 2008*).

Employment

Amongst unemployed adults, 20 percent of adults with an impairment thought attitudes of employers were an employment barrier compared to 6 percent of adults without impairments (*LOS Wave 1 2009/11*).

Care homes

A serious case review of Winterbourne Hospital showed that disabled people in care of the hospital experienced poor care and abuse (*South Gloucestershire Safeguarding Adults Board 2012*).

3.3.8 Disabled people are significantly more likely to experience unfair treatment at work than non-disabled people (19 percent compared to 13 percent) (*Fevre et al. 2009*)

The most frequently reported type of workplace discrimination is **being given fewer responsibilities than wanted** (17 percent of all adults reporting health or disability related discrimination) (*LOS Wave 1 2009/11*).

In 2009 20 percent of employers were able to spontaneously name the Disability Discrimination Act; and another 49 percent were aware of some legislation related to employment but were unable to name it. Just under one-third (30 percent) did not know of any such legislation. Awareness of the Act was greatest in large establishments, establishments that were part of a larger organisation, and establishments that have employed a disabled person in the last ten years. Employers said it would be easiest for them to employ someone with a condition falling within the DDA if they did not actually consider them to be disabled, for example, people with severe facial scarring, dyslexia, or epilepsy. Small establishments said that they had less scope for employing disabled people due to a limited number of job roles, and the need for each person to perform several tasks, requiring a range of capabilities. Additionally employers thought that employment practices towards disabled people had improved over time, and that it had become easier to employ people with a range of conditions. The DDA, and changes to building design and other legislation were cited by some as a factor in this (*Dewson et al. 2010*).

Awareness of rights to request reasonable adjustment is not universal and, even where people are aware of their rights, they do not always exercise them. **Some people felt that requesting reasonable adjustment could be a risk and in some cases ‘hid’ their impairment from their employer** (Adams and Oldfield 2012).

3.3.9 Discrimination can come from a range of sources

For those who experience discrimination it can come from a range of sources. The three most common are: health staff, strangers in the street and employers (LOS Wave 1 2009/11).

3.3.10 Disabled people have many concerns in relation to hate crime, bullying and harassment

A **disability hate crime** is:

- Any criminal offence, which is perceived, by the victim or any other person, to be motivated by hostility or prejudice based on a person’s disability or perceived disability (any disability including physical disability, learning disability and mental health).

A **disability hate incident** is:

- Any non-crime incident which is perceived, by the victim or any other person, to be motivated by a hostility or prejudice based on a person’s disability or perceived disability.

Disability-related harassment was defined by the Equality and Human Rights Commission, in their recent inquiry as:

- Unwanted, exploitative or abusive conduct against disabled people which has the purpose or effect of either:
 - violating the dignity, safety, security or autonomy of the person experiencing it, or
 - creating an intimidating, hostile, degrading or offensive environment.

The **reported prevalence of disability hate crimes is low**. There are a number of hate crime data sources, each providing slightly different estimates:

- In 2011/12 of the 43,748 hate crimes recorded by the police in England and Wales only 1,744 were recorded as disability hate crimes (*Home Office 2012*).
- The Crime Survey for England and Wales (CSEW) shows that 0.1 percent of adults were a victim of disability hate crime in the year to interview. This equates to an **estimated 65,000 incidents of disability hate crime on average per year** (2009/10 and 2010/11). These included an estimated 29,000 incidents of personal hate crimes and an estimated 35,000 incidents against the household. The CSEW crime estimates are higher than the number of crimes recorded by the Police as the survey captures offences that are not reported to or recorded by the Police (*Smith et al. 2012*).
- **Motivations for hate crimes experienced by disabled people are not always due to their disability**. In 2009/11 2 percent of all adults interviewed on LOS had been a victim of any hate crime in the past 12 months. Victims were asked what they thought the motivations were for the hate crime they had experienced. For adults with impairment:
 - Ethnicity was the most commonly reported motivation for hate crime (as for all respondents); with 27 percent of adults with impairment giving this as the reason.
 - 15 percent gave health condition, illness or impairment and 18 percent gave disability as the reasons why they were victims of hate crime.
 - Other motivations were age (9 percent), religion (9 percent), sexual orientation (8 percent) and sex (6 percent).

(LOS Wave 1 2009/11)

3.3.11 Harassment and hate crime towards disabled people is often under-reported

The main reasons cited for under-reporting are:

- The relationship between the perpetrator and disabled victim.
- The victim's lack of awareness of their human rights.
- Interpretation of what constitutes a hate crime, and that disabled people's interpretations of what constitutes a hate crime can lead them to down play the everyday experiences of targeted violence and hostility.
- Previous experiences with and confidence in the criminal justice system.
- Accessibility issues.
- Embarrassment (particularly among those with learning disabilities and mental health conditions).
- Fear of losing control or independence.
- Previous advice from others telling the disabled person to ignore the incidents.
- Difficulty verbalising experiences.

(*Sin et al. 2009*)

Disabled people are more likely to have experienced violent crime and hate crime than non-disabled people in the previous 12 months. **Adults with mental health conditions and cognitive impairment were most likely to experience hate crime.** However, these increased risks only occurred when people also experienced higher levels of poverty (*Emerson and Roulstone 2012*).

3.3.12 There has been an overall increase in disability hate crime prosecutions in the last 5 years

The Crown Prosecution Service (CPS) reports that **over 2,500 defendants were prosecuted for disability hate crime** in England and Wales in the five years from April 2007 to March 2012.

However in 2011/12 the numbers fell:

- The volume of cases referred to the CPS by the police for a charging decision fell in 2011/12 to 643 from 690 in 2010/11.
- The number of completed prosecutions fell in the last year, from 726 in 2010/11 to 621 in 2011/12.
- The number of convictions fell over the year from 579 to 480 as did the proportion of successful outcomes from 80 percent to 77 percent.

It is too early to indicate if this is a long term trend (*Crown Prosecution Service 2012*).

Offences against the person and public order offences were the most common offences in 2011/12, representing 53.8 percent of all disability hate crime prosecutions (41.7 percent and 12.1 percent respectively) (*Crown Prosecution Service 2012*).

3.3.13 Disabled people experience loss of confidence and fear as a result of crime

The extent to which disabled people were adversely affected by incidents of crime differed from the experiences of non-disabled people. The impact was also greater if the crime was considered to be related to them being disabled.

Disabled people were more likely to be **affected 'very much' or 'quite a lot'** by 81 percent of incidents that were thought to be motivated by their impairment, compared with 62 percent of other incidents that they had experienced. In the case of non-disabled people, 49 percent of incidents of crime had such an emotional effect.

Most of the emotional reactions experienced by disabled people were stronger after crimes they thought were motivated by their impairment than after other crimes. Of crimes motivated by their impairment, 54 percent caused them to **lose confidence or feel vulnerable**, compared with 21 percent of other incidents of crime; and 40 percent of incidents motivated by their impairment caused them to feel afraid, compared with 19 percent of other incidents. Of the incidents of crime experienced by non-disabled people, 15 percent caused them to lose confidence or feel vulnerable, and 15 percent caused them to feel afraid (*Nocon et al. 2011*).

3.3.14 Disabled people are more likely than non-disabled people to be a victim of any crime

This gap is largest amongst 16-34 year olds (11 percentage points), and is statistically significant amongst all age groups except for those aged over 65 (*ODI Indicator H1*).

Disabled women and men were more likely than non-disabled women and men to report being either ‘very’ or ‘fairly’ worried about being a victim of crime. Among disabled women, 46 percent felt very or fairly worried, compared to 39 percent of non-disabled women. For men, the figures were 37 percent for disabled men and 30 percent for non-disabled men (*EHRC 2011*).

Disabled people are less likely to be confident in the Criminal Justice System (CJS) than non-disabled people, and this gap broadly decreases with age. Young disabled people are less likely than their non-disabled peers to think the Criminal Justice System (CJS) is effective, with the gap being largest amongst 16-34 year olds (10 percentage points). The gap between disabled and non-disabled people who think the CJS is effective is statistically significant for both the 16-34 and 35-54 age groups. **Disabled people are also less likely than non-disabled people to think the CJS is fair.** The gap in perceived fairness is highest amongst 16-34 year olds (12 percentage points) (*ODI Indicator H2*).

3.3.15 Disabled people are more likely to have a lower level of social contact

38 percent of adults with an impairment compared with 33 percent of adults without an impairment do not spend as much time as they would like with family. Cost is more likely to be mentioned as a barrier by those with an impairment (10 percent of adults with an impairment compared with 6 percent of adults without an impairment). **Difficulty with transport** is also more likely to be reported as a barrier by adults with an impairment than those without an impairment (4 percent and 1 percent) (*LOS Wave 1 2009/11, Appendix Table 19.3*).

Adults with an impairment have a lower level of social contact (i.e. contact with close friends and relatives) than those without an impairment. For example, adults with an impairment are more likely to have no or just one or two close contacts compared with adults without an impairment (14 percent and 8 percent respectively). Adults with speaking (28 percent), learning (23 percent), behavioural, intellectual or memory impairment (26 percent) or a mental health condition (26 percent) are more likely than adults with any type of impairment to have none or only one or two friends they can rely on (*LOS Wave 1 2009/11, Appendix Table 15.1*).

Looking at the number of close contacts people had actually met or spoken to in the past week, adults with an impairment were less likely than those without an impairment to have had close contact with at least six people in the week prior to interview. Adults with speaking (36 percent), learning (33 percent), behavioural, intellectual or memory impairment (37 percent) or a mental health condition (36 percent) are more likely than adults with any type of impairment to have met or seen no or just one or two close contacts (*LOS Wave 1 2009/11, Appendix Table 15.2*).

The reason reported most often by all adults for not meeting or speaking with close contacts was being too busy or not having enough time. This was more likely to be reported by adults without an impairment (76 percent compared with 51 percent of adults with an impairment). A higher proportion of adults with an impairment than those without an impairment reported other people being too busy as a barrier (49 percent and 45 percent respectively). Financial reasons were reported by a higher proportion of adults with an impairment than those without an impairment (14 percent and 10 percent respectively). Difficulty with transport was also reported by a higher proportion of adults with an impairment than adults without an impairment (10 percent and 5 percent respectively) (*LOS Wave 1 2009/11, Appendix Table 26.2*).

People with learning, memory or neuro-diversity impairment tend to have small social networks consisting of close family and a handful of friends, and are reliant on these people to initiate or enable wider social contacts (*Office for Disability Issues 2010*).

Earlier in the paper we showed that disabled people were less likely to be in employment. In modern industrial societies work provides important social benefits, including a sense of personal worth, connection with wider social objectives, and a time structure to their days and weeks. Consequently being out of work can lead to a lack of shared experience, status and identity (*Jahoda et al. 1972*).

3.3.16 Disabled people are just as likely as non-disabled people to play a role in civic life

55 percent of disabled people compared with 57 percent of non-disabled people undertook at least one activity of civic involvement (for example formal volunteering, civic activism, civic participation and civic consultation in the last 12 months) (*ODI Indicator E2*).

36 percent of disabled people compared with 33 percent of non-disabled people were involved in civic participation (for example contacting a local councillor, MP, local council official, government official, attending a public meeting or rally, taking part in a public demonstration or protest, signing a petition) (*ODI Indicator E2*).

17 percent of both disabled and non-disabled people were involved in civic consultation (for example taking part in consultation, attending a public meeting or being involved in a group to discuss local services) (*ODI Indicator E2*).

10 percent of disabled people compared with 9 percent of non-disabled people were involved in civic activism being a local councillor, school governor, a volunteer Special Constable or a Magistrate; being a member of a decision making group about local services for example, local health services) (*ODI Indicator E2*).

There have been some improvements in access to the voting process for disabled people but more needs to be done to ensure that existing barriers can be removed. In the 2010 Election, 67 percent of polling stations had one or more significant access barriers to disabled voters. The kinds of barriers that were reported included lack of a ramp to access the building; lack of a tactile voting system to help visually impaired voters to vote independently and not having a large print version of the ballot paper (*Scope 2010*).

3.3.17 Disabled adults are no more likely to live in non-decent accommodation but their homes are more likely to be in disrepair and disabled children are less likely to be living in suitable accommodation

Households with a disabled person are no more likely than other households to live in non-decent accommodation (ODI Indicator G2) and 80 percent of disabled people said that their current accommodation is suitable (ODI Indicator G1). However, **disabled people are more likely to live in homes with substantial disrepair** (with basic standardised repair costs over £35 per square metre) (*English Housing Survey 2010/11, DCLG 2012*). Families with disabled children are less likely to be living in adequate accommodation.

8 percent of adults with an impairment experienced difficulty getting into any room within their home. The room that adults with an impairment most often had difficulty accessing was the bedroom (5 percent) or the toilet/bathroom (5 percent). The most common barrier to accessing rooms was ‘stairs, lack of ramps/stair lift’ reported by 4 percent of those with impairment (*LOS Wave 1 2009/11, Appendix Table 23, 24*).

The most common barrier that those with an impairment experienced getting in or out of their home was **difficulty due to stairs or lack of ramps/stair lift** (4 percent) (*LOS Wave 1 2009/11, Appendix Table 25*).

Provision of housing adaptations and equipment for disabled people can produce savings to health and social care budgets by reducing the need for residential care and therefore providing a more cost effective form of support and by resulting in potential prevention of accidents (*Heywood and Turner 2007*).

Disabled people have told us that there can be delays in getting properties adapted and new developments are not always designed with disabled people in mind (*Fulfilling Potential – The Discussions So Far 2012*).

Households including a disabled person are more likely than other households to live in a home with key accessibility features such as having a bathroom or WC at entrance level (44 percent and 65 percent respectively) or having a room at entrance level that could be used as a bedroom (60 percent) (*English Housing Survey 2010/11, DCLG 2012*).

Only 26 percent of homes occupied by households with a disabled person have a burglar alarm compared with 32 percent of other households (*English Housing Survey 2010/11, DCLG 2012*).

Compared with other groups of disabled people, **disabled children who require specially adapted homes are the least likely to be living in suitable accommodation**. Less than half of disabled children (47 percent) who require specially adapted homes are living in suitable accommodation; compared with over 80 percent of people aged 65 or more, more than 70 percent of those aged 45-64, and around 60 percent of those aged 16-44 (*Beresford and Rhodes 2008*).

3.3.18 Disabled people are more likely than non-disabled people to experience barriers to accessing public services

A higher proportion of adults with impairment than those without impairment experience difficulty accessing public services (36 percent compared with 24 percent). The public services where the highest proportion of adults with impairment experienced at least some difficulty with access was **benefits and pensions** services followed by **tax services** (34 percent and 30 percent respectively). For those adults experiencing difficulty with the benefits and pensions services, those with speaking (55 percent) and learning impairments (49 percent) were most likely to have difficulty (*LOS Wave 1 2009/11*).

A review of customers' experiences of contact with the Pension, Disability and Carers Service concluded that the service could be improved by improving communication, reducing customer administrative burden, information sharing between relevant agencies and for more vulnerable customers providing a single point of contact such as a complex case worker (*Whitfield et al. 2011*).

3.3.19 Difficulty contacting by phone is the most commonly reported barrier

Difficulty contacting by phone is the most commonly reported barrier

particularly for pensions and benefits services and tax services. This barrier is slightly more likely to be experienced by those with impairment (*LOS Wave 1 2009/11*).

Inexperienced or unhelpful staff were cited as a barrier to accessing the pensions and benefits service. This was reported by adults with and without impairment but slightly more so for those with impairment (11 percent compared with 16 percent). This was also cited as a barrier in accessing tax and justice services although by a smaller proportion of people (*LOS Wave 1 2009/11, Appendix Table 18.3,5*).

Disability and Carers Service (DWP) customers who found that the first person they spoke to during telephone contact was able to answer their query reported higher levels of overall satisfaction than customers who found that the first person they spoke to was unable to answer their query (91 percent compared with 68 percent) (*Howat et al. 2011*).

3.3.20 The proportion of disabled people experiencing difficulties with accessing goods and services has decreased but disabled people are still more likely than non-disabled people to experience barriers

32 percent of disabled people experience difficulties, related to their impairment or disability, in accessing goods or services

(goods and services include going to the cinema/theatre/concert, library/art galleries/museums, shopping, pubs/restaurants, sporting events, using public telephones, websites, a bank or building society, arranging insurance, accommodation in a hotel/guest house, accessing health services/Local Authority services, Central Government services, law enforcement services, or any other leisure, commercial or public good or service). This figure has decreased from 42 percent in 1995 (*ODI Indicator F4*).

For shops and supermarkets the main barriers are: lack of transport; difficulties with carrying shopping; using a wheelchair in a crowded place; reading price labels and lack of disability awareness among staff. Enablers include discussing things in person, dealing with the same member of staff and being given clear information. Paying for goods and services is an issue for those with dexterity and/or visual impairment as they experience problems with paying using CHIP and PIN technology, writing cheques and handling cash (*Ipsos Mori 2010*).

3.3.21 The most commonly reported barrier to accessing public buildings is difficulty moving around the building

The most commonly reported barrier among adults with an impairment is difficulty moving around the building, **because of stairs, doors or narrow corridors** (13 percent of adults with impairment). Other issues are inadequate lifts or escalators, the lack of ramps/handrails, the inappropriate location, layout and size of the bathroom facilities (*LOS Wave 1 2009/11, Appendix Table 21*).

Less widely reported barriers (reported by less than 5 percent of adults with an impairment) are: inadequate ventilation; difficulty finding the building; inadequate desk height, seating, or too much noise in the reception areas; having difficulties in seeing or understanding written information. These issues may be more common amongst people with particular types of impairment (*LOS Wave 1 2009/11, Appendix Table 21*).

Those with an impairment experiencing severe or moderate difficulties always or often with mobility, dexterity, chronic health or long-term pain were more likely than those with a less severe impairment to experience barriers with transport, parking, footpath design and surfaces, approach area (lack of ramps/handrails), inadequate lifts or escalators, moving around the building, lack of help or assistance (*LOS Wave 1 2009/11, Appendix 10.1–4*).

3.3.22 Transport is an important factor in supporting participation but remains a barrier for one in five disabled people

Transport is an important factor in supporting participation in employment, education, social and cultural activities and accessing a range of services.

The proportion of disabled people who report having difficulties accessing transport has reduced since 2005 from 27 percent to 22 percent in 2011 (*ODI Indicator F2*).

Disabled people in the UK are nearly a third less likely to experience difficulties in accessing transport compared to the EU average (*ANED 2011*).

There has been a large increase in the proportion of full-sized buses accessible to disabled people or equipped with low-floor wheel chair access in Great Britain. This has increased from 52 percent in 2004/05 to 88 percent in 2011/12 (*ODI Indicator F1*).

For each mode of transport (motor vehicles: car, van, motorcycle or moped, local buses, long distance buses, underground, local trains, long distance trains, taxis/minicabs) adults with impairment compared to those without impairment were more likely to have used that type of transport less than they would have liked (*LOS Wave 1 2009/11*).

The mode of transport that adults with impairment were most likely to experience a participation restriction with was using long distance buses (38 percent), and the least likely was travelling by taxi (24 percent) (*LOS Wave 1 2009/11*).

3.3.23 Cost of transport is the most common barrier for people of working age

No single barrier was reported by as many as 20 percent of people with an impairment. **Cost is the most commonly reported issue for those with impairment** (with the exception of local buses). With the exception of taxis, **cost is less of an issue for those of State Pension age or older** – probably because of concessionary travel. Completing bus journeys can be a problem as can getting to the bus stop or station; getting from the stop to the final destination or getting on or off the bus. Difficulty getting to or

from a stop or station or getting in and out of transport is more of a barrier for those on State Pension age or older. Less widely reported issues include: overcrowding; delays and disruption; anxiety; fear of crime; lack of help or assistance; attitude of passengers; attitude of staff; seeing signs or hearing announcements; lack of information (*LOS Wave 1 2009/11*).

Those experiencing moderate or severe difficulty with mobility, dexterity, long-term pain or a chronic condition always or often were more likely than those with less severe impairment to mention difficulty in getting in and out of transport, getting to or from the stop or station or anxiety/lack of confidence as a barrier (*LOS Wave 1 2009/11 Appendix Table 12.1–8*).

People with learning, memory or neuro-diversity impairment use public transport, but rarely on their own. Many need to be accompanied when they go out. Many people have access to door-to-door services, for example to transport them from their home to a day centre (*Office for Disability Issues 2010*).

Transport barriers need to be viewed within the wider context of the whole journey. Disabled people are up to three times more likely than non-disabled people to cite poor connections as a barrier. They are less likely to be aware of travel information services and less likely to use travel information websites. Disabled people find it difficult to travel to basic services such as their GP or Post Office and are more likely to rely on help from others (*Jolly et al. 2006*).

Conclusions and Next Steps

4

Applying the Government's definition of disability, as set out in 2010 Equality Act, almost a fifth of the population are disabled. Older people are more likely than younger people to be disabled – almost half of those of State Pension Age or older are covered by the Equality Act. Around half of the 11.5 million people covered by the Equality Act are in receipt of disability-related benefits. The population with impairment is not static. People move in and out of the population over time.

There is a great diversity in the range of impairments people have and in the extent to which they have an impact on daily life. **Most people are not born with an impairment.** Most people acquire impairment in their adult life, mostly from the age of 50. The experiences of young people who are born with impairment or acquire an impairment in childhood are very different to those of someone who acquires an impairment later in life and who has lived through a large part of their life as a non-disabled person.

A wide range of outcome measures show improvement from the baseline (usually 2005). There have been significant improvements in educational attainment, in the employment rate and a reduction in the employment rate gap. There have also been improvements in other factors contributing to quality of life, for example in access to transport and access to goods and services. Attitudes towards disabled people have also been improving in some cases.

Even so, disabled people can still face significant barriers to fulfilling their potential and playing a full part in society. Analysis of new information from the Life Opportunities Survey and other data sources is providing an improved basis for understanding the barriers faced by disabled people and suggesting options for action.

Fulfilling Potential – Discussions So Far sets out a wide-ranging programme of action that Government is undertaking to ensure disabled people can realise their aspirations, addressing the issues highlighted by disabled people themselves.

Fulfilling Potential – Next Steps built on this by outlining further public service reforms and plans for a new disability action alliance to identify and implement national and local action to remove and overcome barriers.

Later in 2013 a further action plan and outcome framework will be published, drawing on the analysis in this document, including actions from the alliance and steps to ensure a strong legacy for disabled people from the Olympics and Paralympics.

The evidence base will also be further developed, including:

- further analysis of barriers and choice and control;
- using future waves of the Life Opportunities Survey to further analyse the fluctuating nature of the disabled population including onset and offset of impairment;
- looking in depth at attitudes and perceptions; and
- exploring lessons from international comparisons.

This will be used to inform future strategy, policy and delivery action.

We would welcome feedback on the evidence base, particularly details of any research we have not included or any issues you feel we have not covered. Please send views and comments to fulfilling.potential@dwp.gsi.gov.uk

Annex 1: Data sources

Family Resources Survey (FRS) is the primary source for data on the number of people covered by the disability provisions in the 2010 Equality Act in the UK. It uses the Equality Act definition of disability.

Life Opportunities Survey (LOS) is a longitudinal survey of disability in Great Britain. It is the first major social survey to explore disability in terms of the social barriers to participation that people experience.

Results are published:

- **Wave 1** 2009/11:
- **Wave 2** 2010/12:

LOS uses the social model definition of disability.

Labour Force Survey (LFS) is a source of disability employment statistics.

Working age refers to the new definition of males and females aged 16 to 64. This may have a small effect on figures quoted pre-2010.

Unless specified otherwise, wherever we refer to disabled people, this means DDA disabled people. LFS respondents who report a current disability consistent with the Equality Act (EA) 2010 are defined as disabled. The non-disabled population refers to all those not classified as EA disabled. From 1 October 2010, provisions in the EA replaced the majority of provisions in the Disability Discrimination Act (DDA). This means there is a discontinuity in reporting behaviour from this date onwards. Any figures prior to this date may be slightly distorted by this reporting discontinuity.

DDA disabled is the sum of the two LFS categories DDA only disabled and DDA disabled with a work-limiting condition. People who are DDA only disabled have a condition which effects their day-to-day activities. Whereas people who are DDA disabled with a work-limiting condition have a condition which effects both their day-to-day activities and limits the type of work they can do.

There may be other slight discontinuities in the LFS time series from 2008 onwards due to the way some of the questions have changed and the increase in age coverage around this time.

The LFS definition of **Economically Inactive** people is those who are not in work and do not meet the internationally agreed definition of unemployment. They are people without a job who have not actively sought work in the last four weeks and/or are not available to start work in the next two weeks.

The LFS definition of **Unemployed** people is those who are jobless, have been actively seeking work in the past four weeks and are available to start work in the next two weeks; or they are out of work, have found a job, and are waiting to start it in the next two weeks.

British Social Attitudes Survey (BSAS) provides evidence on attitudes towards disabled people. Disability modules funded by DWP have been included on the survey in 2005 and 2009. It uses the Equality Act definition of disability.

ONS Opinions Survey 2012 is a monthly survey which includes a module on disability. It uses the Equality Act definition of disability.

DWP administrative data is held by the Department for Work and Pensions on receipt of benefits, for example receipt of Disability Living Allowance (DLA), Attendance Allowance (AA), Employment and Support Allowance (ESA) or Incapacity Benefit (IB). AA and DLA are assessed on a person's care and/or mobility needs. While the vast majority of those in receipt of AA/DLA have rights under the EA only a minority of those with rights under the EA are in receipt of AA/DLA. Administration data is available on the DWP tabtool.

The Work and Pensions Longitudinal Study (WPLS) links benefit and programme information held by DWP on its customers, with employment records from Her Majesty's Revenue and Customs (HMRC).

DWP adhoc statistics

Analysis of new claims for Disability Living Allowance and Attendance Allowance by main disabling condition 2011/12.

Households Below Average Income (HBAI) research and data to give an insight into the standard of living of the household population in the UK, focusing on the lower part of the income distribution. It uses the Equality Act definition of disability.

ODI Disability Equality Indicators are published on the ODI website and measure progress towards disability equality in the areas disabled people said were most important to them. They use the Equality Act definition of disability.

Focus Groups were carried out by ONS to explore perceptions of disability held by disabled and non-disabled people. Disabled people were defined according to the Equality Act definition.

Responses to **'Fulfilling Potential – discussion document'**. The Fulfilling Potential discussion exercise ran from December 2011 to March 2012. Over 5,000 disabled people were involved either through individual responses or via participation in events and engagement activities.

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