

# **Single homeless people's experiences of the Work Capability Assessment**

**May 2012**

**Homelessness ends here**

The logo for Crisis, featuring the word "Crisis" in a bold, red, sans-serif font. The letters are stylized, with the 'C' and 'S' having thick, rounded shapes. The 'i's have small dots above them.

### **About Crisis**

Crisis is the national charity for single homeless people. We are dedicated to ending homelessness by delivering life-changing services and campaigning for change.

Our innovative education, employment, housing and well-being services address individual needs and help people to transform their lives.

We are determined campaigners, working to prevent people from becoming homeless and advocating solutions informed by research and our direct experience.

### **About Crisis Welfare Network**

Crisis Welfare Network brings small and specialist organisations together and empowers them to support homeless people into suitable, sustainable and progressive employment.

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## Key Findings

- The vast majority of respondents (81%) did not feel positive about their experience of the Work Capability Assessment (WCA).
- Being asked to attend a face-to-face medical assessment made nearly all people (97%) stressed, anxious, and worried that their claim would be turned down.
- Also, prior to the assessment, 85% worried that they were being forced into work.
- During the assessment, nearly 50% of people felt that the healthcare professional had a poor awareness of the impact that homelessness had on their lives.
- Nearly 50% also thought that the person conducting the assessment had a poor understanding of the complexity of their health issues and individual circumstances and needs.
- Perhaps more worryingly, 40% of respondents thought the healthcare professional did not believe them and just under 30% thought their claim was not taken seriously.
- The majority of people (58%) also reported feeling too nervous to give a good account of their condition(s).
- This is particularly significant when the length of the assessment was deemed unsatisfactory by 61% of participants because it was too short for them to give a full and true account of their condition.
- It is therefore not surprising that after the assessment 61% felt resigned to the fact that their claim would in all likelihood be turned down.
- However, people's experience of the assessment was much more positive if a support worker or friend had accompanied them. For example, 86% of those unaccompanied were dissatisfied with the length of the assessment, compared to 46% of those who had someone attend with them.
- Over half of respondents (55%) were deemed not to have 'limited capability for work' and were moved off ESA.
- However, outcomes varied greatly depending on whether clients were accompanied: 86% of those unaccompanied were deemed not to have 'limited capacity for work', whereas the figure for those accompanied was 39%.
- Over three quarter of people were unhappy with the outcome of the assessment and thought that inaccurate assessment reports were to blame.
- It is therefore not surprising to find that 76% appealed the decisions. A clear indication that there is a fundamental lack of faith in the system.

## 1. Background

The Work Capability Assessment (WCA) was introduced in October 2008 to assess entitlement to Employment and Support Allowance (ESA). ESA replaces a range of incapacity benefits with immediate effect for individuals making a new claim for financial support on the grounds of illness or incapacity. The key tool to assess an individual's capability for work is the WCA which is carried out by a healthcare professional. From October 2010, individuals who still receive the older style incapacity benefits will be reassessed and moved to ESA or other benefits deemed more appropriate to their circumstances. This exercise will run until 2014.<sup>1</sup>

Crisis has been concerned for some time about the WCA and its ability to appropriately assess the capacity for work of people with a homelessness background. The assessment fails to give adequate consideration to the intensity and variability symptoms and the weight of underlying conditions. Furthermore, people's background and circumstances are often overlooked, as are the many barriers that interfere with their ability to find and retain employment.<sup>2</sup>

A recent report for Crisis,<sup>3</sup> found that the homeless population has twice the levels of common mental health problems when compared to the general population, and psychosis is 4 to 15 times more prevalent in the homeless population, which further highlights the need for effective assessments. The average age of death for homeless people is also shockingly low at just 47 years old, and with the average age for homeless women being even lower at 43.<sup>4</sup>

Moreover, evidence suggests that homeless people often suffer discrimination and stigma. A study by the London School of Economics for Crisis found that homeless people are 13 times more likely to be victims of some violent crimes than the general public (52%, compared with only 4%). What's more, nearly 2 in 3 people had been insulted by a member of the public, and 1 in 10 had been urinated on.<sup>5</sup>

Despite this, at the very heart of the assessment process there is a glaring lack of awareness of people's increased vulnerability from the effects of current or past homelessness. Crisis is concerned that due to this, and the system's complexity and unreliability, homeless people are often being wrongly denied benefits after assessment errors. The system is therefore harming some of the weakest and most vulnerable people in society.

Homeless people who are unable to work due to sickness or disability can nevertheless make significant contributions to society given the right environment.<sup>6</sup> The Government must wake up to the fact that heavy-handed attempts to remove benefits from the most vulnerable in society adds to existing discrimination and stigma and can derail progress by concomitant increases in stress and anxiety.

## 2. About the study

The aim of the study was to examine homeless people's experiences of the WCA. The survey took place after year one recommendations from the Harrington Review<sup>7</sup> had been accepted. The following data collection methods were used:

1 See <http://www.dwp.gov.uk/policy/welfare-reform/employment-and-support/>

2 See Crisis (2010) Crisis' response to Professor Harrington's independent review of the Work Capability Assessment. <http://www.crisis.org.uk/data/files/publications/WCA%20Independent%20Review.pdf>

3 S. Rees (2009) Mental ill health in the adult single homeless population. London: Crisis.

4 Crisis (2011) Homelessness: A silent killer.

5 T. Newburn and P. Rock (2006), Living in fear: violence and victimisation in the lives of single homeless people. London: Crisis.

6 Many of the service users who attend Crisis' Skylight centres could be described thus. More information about our Skylight centres can be found at <http://www.crisis.org.uk/pages/what-we-do-crisis-skylight-centres-61897.html>

7 See <http://www.dwp.gov.uk/docs/wca-review-2010.pdf>

- A survey of Crisis' service users and those of the member organisations of Crisis' Welfare Network;<sup>8</sup> and
- In-depth interviews with survey participants to write up case studies that illustrate people's experiences of the assessment.

The survey ran for 3 weeks in February 2012. In total, 182 homeless or previously homeless clients took part in the survey and 151 completed it. Almost half of the respondents (49%) were aged 45-54 years old. 65% of participants reported having multiple health conditions.

## 3. Research findings

### 3.1 Being told entitlement would be looked at and ESA50 form

Being invited for a face-to-face assessment provoked strong emotional reactions. In two-thirds of respondents (66%), the invitation made them feel stressed and almost 70% felt very anxious about the prospect of having to attend. The reason for this anxiety in three quarters of them was concern that their claim would be turned down, and over half (54%) worried that they would be forced into work.

#### CASE STUDY 1: ELSA<sup>9</sup>

Elsa is 47 years old and had been homeless for over three years caused by serious mental health issues that caused her life to 'implode'. Her 18-year marriage came to an end, she left her job and left the family home and took to sofa surfing. She was put straight onto JSA as she had voluntarily chosen to leave her job. Elsa was deemed fit for work despite disclosing the scale of her mental health issues, which included suicide attempts, regular self-harming and being sectioned. She soon stopped claiming and dropped out of the system, frustrated with the way Jobcentre Plus kept insisting she look for work when all she wanted was help. Eventually she was referred to an intensive mental health treatment programme. This required her to travel and she decided to claim benefits again to cover the costs.

Elsa was placed on ESA and put into the work focus group despite the full-time medical treatment she was receiving. She received an abrupt phone call telling when to attend her work capability assessment. She only received the confirmation letter after the assessment had taken place. During the assessment Elsa was repeatedly asked to explain what was 'wrong' with her. The healthcare professional who conducted the assessment had no interest in her mental health; only what she could physically do. Their 'eyes glazed over' when she tried to explain her housing predicament. Later at her first work-focused interview the advisor expressed surprise at her being in the work-focus group. She was summoned for another assessment but she called them and explained she was in full time hospital treatment. They agreed to cancel the interview.

Subsequently Elsa's DLA claim was successful and she received a letter saying she was now in the Support Group. At no stage of the ESA process was there acknowledgement of her homeless status, which compounded her mental health issues and difficulties with finding a home. She feared being 'dragged back to work' and felt 'hounded' by a system that refused to recognise her specific issues. Attending work-focused interviews became 'another knife in the back' and despite now being in the support group she fears what the future will bring.

<sup>9</sup> All names have been anonymised.

<sup>8</sup> For more information about Crisis' Welfare Network go to <http://www.crisis.org.uk/pages/willow-project.html>

Prior to being asked to attend a face-to-face assessment welfare recipients have to complete a Limited Capability for Work questionnaire (ESA50). This in itself generated problems for homeless people with 43% finding it 'difficult' or 'very difficult' to complete the form. Some people struggled to explain their condition on the form as it did not ask the 'right questions' and as a result the form failed to capture the complexity of their conditions and their 'actual situation'.

One homeless client explained that they found it, 'hard to translate conversation to words on paper'. Others complained that the questions on it were, 'designed to trip you up' and were 'confusing'. Consequently, over 6 in 10 needed to ask for help to complete it (in 71% of cases individuals asked a support or key worker) as many felt they 'wouldn't be able to do it' nor 'understand' the form by themselves. Of those that did not ask for help, almost a quarter of respondents (23%) did not know they could get help with the form.

### 3.2 Face-to-face assessments

The experience of attending the assessment for some was very poor. One respondent compared it to, 'arriving at A&E [with] nowhere to sit [and] we were not kept informed'. This was a similar experience to another survey respondent who said:

*'When I had my assessment there were no seats in the waiting area, my appointment was at 11am and I was not seen until 1.40pm and I had to stand and wait. I got a seat 10 minutes before being called in. It was also at this point that I was informed why I had to wait so long, which left me feeling quite incensed, not because I am on benefits and not working [but] I had other things to do. If I were on a regime for eating and taking medication at a certain time this was not taken into consideration by the reception staff or the medical practitioners, thus my condition could quite easily have deteriorated'.*

#### 3.2.1 Healthcare professionals (HCP)

In 63% of cases the assessment was carried out by a doctor, with the remainder being seen by a nurse. Just over 1 in 10 felt they were not treated with enough respect.<sup>10</sup> One respondent explained how the HCP made them feel:

*'I found it intimidating and the person asking the questions was very patronising. I have some medical problems that affect my ability to work at the moment, they do not affect my ability to think or answer questions. I was treated as if I had the mental capacity of a 3 year old'.*

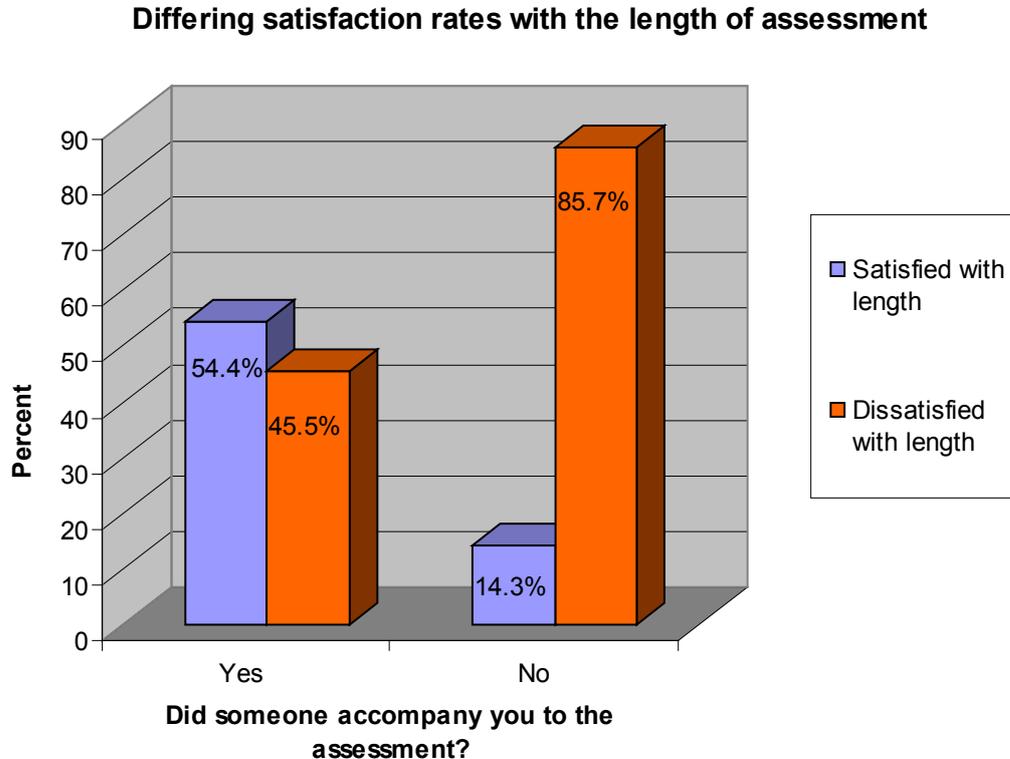
In almost 30% of cases, individuals felt their claims were not taken seriously; one respondent said that, 'the doctor assumed I was ok as I was chatting with them'. Further to this was the way in which almost half (47%) felt the HCP had a 'bad' or 'very bad' understanding of their specific health issues and needs. One reason a respondent gave for this was that staff did not care about specific health care issues 'as they fill in what they think as [the] answer'. The assessment came to feel like a 'tick box exercise' for some because the 'question[s] they asked weren't relevant to my circumstances' or ability to be able to work:

*'Just because I can prepare and cook a meal does not mean I can manage commuting to work, not having a seat on London's crowded buses and even more overcrowded train system, how much stress will I endure before arriving at my place of work – then the reverse to get home'.*

Consequently 46% of respondents felt the HCP had a 'very bad' or 'bad' awareness of

<sup>10</sup> This is also the experience of many homeless people who approach their Local Authority for help. See Crisis (2009) No one's priority: The treatment of single homeless people by local authority homelessness services. The study used mystery shopping techniques and found that homeless people were often treated like 'second class citizens' and not given any assistance. URL: <http://www.crisis.org.uk/data/files/publications/No%20one's%20priority.pdf>

Table 1: Satisfaction rates



homelessness and how it impacted upon their lives. What respondents called the 'impersonal nature' of the assessment, combined with the focus HCPs placed on sticking to a specific script of questions and not deviating from it, contributed to this. One respondent explained how 'the assessor ticked boxes on a computer but I didn't know what they were ticking as they refused to show me the screen. They didn't write much down – just clicking a mouse.' Another individual told how the assessment was all about 'physical ailments and not my mental health'.

Finally, one respondent suggested the need to have specially trained professionals that assess those with corresponding health needs. Even more fundamental was the ability to be able to communicate freely: one individual had their assessment with a 'doctor that could barely speak English, so communication was hard'.

### 3.2.2 Being accompanied

In over 6 out of 10 cases (63%), respondents had someone accompany them to the

assessment. In those cases, over half the time it was a support worker or key worker.

Having someone accompany them was a significant source of support. One person said it stopped them 'feeling alone' and 'reassured me and they prompted me if I missed anything out'. Another, similarly, claimed that having someone there ensured that they gave information they might not have realised they needed to give.

This was the general message about having someone there at the assessment; they could help those that struggled to communicate, provide further explanation and detail on their behalf and give emotional support to help ease a client's anxiety. One respondent said that they 'would not have been able to attend the assessment without the support'.

The importance of being accompanied to the overall experience and outcome of the work capability assessment is explored further later on in the briefing.

### 3.2.3 Length of face-to-face assessments

Being accompanied also dramatically affected the satisfaction rates for the length of time the actual assessment lasted. Over half of all respondents' assessments lasted for less than 30 minutes (14% lasted less than 15 minutes).

Consequently, 61% overall were left dissatisfied at the length of time they were given to provide a full account of their condition.

However, satisfaction rates with the length of the assessment changed dramatically if respondents were accompanied by a support or key worker. 86% of those not accompanied were left dissatisfied with the amount of time they had whereas for those who were accompanied, 46% felt they did not have

enough time to fully explain their condition(s). The difference in satisfaction levels amongst respondents due to being accompanied is clear.

### 3.2.4 Supporting medical evidence

33% of respondents did not take any supporting medical evidence with them. Those that did not provide any did so because they were 'forgetful' or were unsure they could provide any such material. Amongst those that did provide supporting evidence, 29% found it 'difficult' or 'very difficult' to obtain. One respondent said, 'my GP was reluctant to provide a written letter [and] I didn't know this should be sent off with the form [ESA50]'.

### 3.2.5 Overall experience

Having gone through the face-to-face

#### CASE STUDY 2: AGNES

Agnes had always worked and before becoming homeless she was a trainee marketing manager. She has multiple health issues which 3 years ago forced her to leave her job. Agnes was placed on ESA and received Housing Benefit for the council property she had with her husband. However, a mistake by the council calculating her Housing Benefit meant she was overpaid and not eligible for full rent payments. Her and her husband could not cover the shortfall and were evicted.

Agnes found the ESA50 questionnaire 'very restrictive' and could not convey the nature of her health conditions which vary over time. She suffers with kidney stones and is in remission from skin cancer. In addition, Agnes suffers with a bowel condition that means she has to plan her day carefully. There was also no space to explain her precarious housing situation.

Restrictive questioning also characterised the assessment and compounded further by the assessment nurse whom, Agnes felt, knew little about her medical conditions. The assessment itself consisted of 'generic and repetitive' questions that focused on mobility and physical ability. There was no documentation of, or interest in, Agnes's precarious housing status. Nor was there a proper acknowledgement of how her health could drastically deteriorate. By the end of the assessment she was convinced she would fail.

12 weeks later, and as she feared, Agnes was deemed not to have limited capacity to work and told to register for JSA. She immediately appealed. The appeals process took six months and in that time she was taken seriously ill and hospitalised. She also split from her husband and had to find a hostel to stay in. While waiting for the decision – due to a backlog of appeals – Agnes' JSA level of entitlement was contested leaving her with even less income. The Appeals Office requested further medical evidence from her GP and hospital doctors and then she received a call to inform her that the appeal had been successful and she was placed in the work-related activity group. From her experiences, Agnes felt strongly that a person's housing situation should feature more centrally in the assessment due to the impact housing status has on health and work capability.

assessment, 81% of respondents did not feel positive about the experience. The process generated stress and anxiety and made almost 60% feel too nervous to give a good account of their condition. One individual said that it was stressful because they felt, 'as though I was being judged on how unwell I was. The healthcare person, who sees you for this short period, can not truly comprehend what your daily life is really like'.

Others felt unwell at the assessment and 'only later ... realise[d] that there were things that should have been said that were not'. One respondent felt suffocated by the way they felt they 'didn't have a chance to talk' and it 'felt like they were using tick box exercise and did not deviate from this'.

Consequently a lack of confidence in the process, which was too rigid and poor understanding healthcare professionals had, characterised respondents' feelings about the WCA. One person declared that the questions asked 'weren't relevant' and applied a lot of pressure to them as their answers were interpreted by criteria that did not fit. This was expanded on by one

respondent pointing out that:

*'Just because I can wash and dress myself and walk unaided does not mean that my health issues do not impact severely on my life and prevent me from working'.*

Another believed that 'no empathy or real thought is put into the entire process'. They suggested that home visits would serve better to give a more accurate picture of people's capabilities. The lack of empathy and rigidity of the assessment left some respondents exasperated:

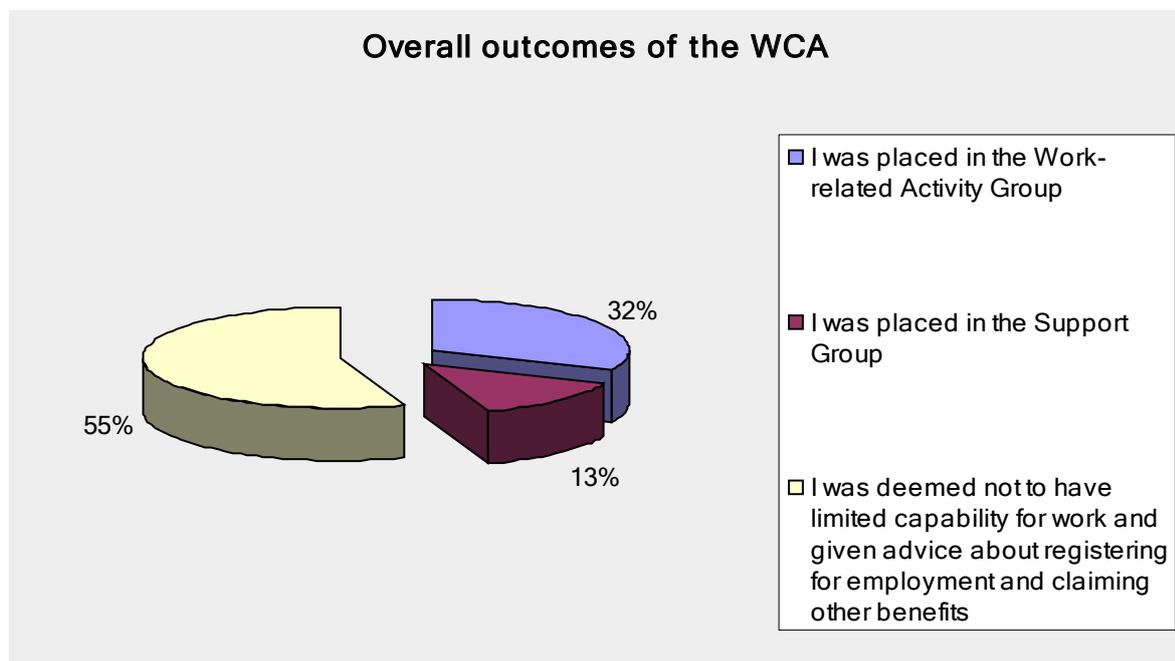
*'There was nothing more I could say. I just wanted to get out. I can't explain myself properly. I felt like he was going to trick me with the test. I didn't feel comfortable'.*

61% left the assessment believing that their claim, in all likelihood, would be turned down.

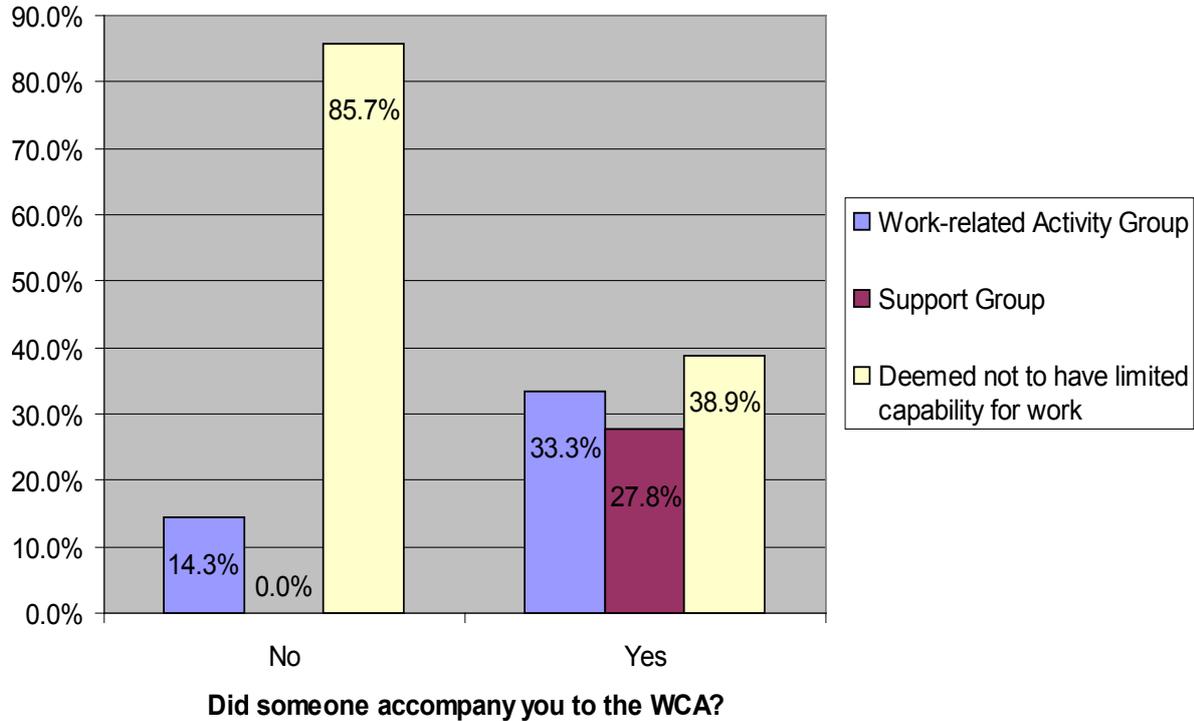
### 3.3 Outcomes

In almost a quarter of cases, people had to wait between six and nine weeks or more to receive the outcome of their assessment. In terms of overall outcomes, 55% were

Table 2: WCA outcomes



**WCA outcomes according to accompaniment**



deemed fit-for-work and given advice about how to find work and receive other benefits, 32% of individuals were placed in the work-related activity group and the remaining 13% in the support group.

However, the distribution of these outcomes changes considerably if someone (key or support worker) accompanied respondents to the assessment. 86% of those that went unaccompanied were deemed fit-for-work. This figure dropped to 39% for those who were accompanied.

These figures highlight the importance of having someone at the assessment that can lend moral support and encouragement, provide further information or clarification, for the final outcome.

Having someone accompany them clearly helped in ensuring the HCP got a clearer and more accurate picture of respondents' condition(s) during the assessment.

However, 29% of those surveyed did not know they could have asked someone to the assessment with them.

**3.3.1 Multiple health conditions**

Individuals taking the survey were asked whether they considered themselves to have multiple health conditions and how these affected their daily activities. The majority (65%) reported having multiple health conditions. Conditions ranged from multiple physical ailments through to recovering from addiction and mental health issues – ‘acute anxiety and depression: I don't like going out by myself because I worry.’ One respondent explained their multiple health conditions as such:

‘Back and leg problems - I can't walk a long distance. Depression - I am still feeling quite depressed I see and hear things that others don't I still have constant suicidal thoughts, especially when I am stressed. My use of substances has increased recently to cope

**CASE STUDY 3: JOHN**

John lives in a hostel and is a recovering heroin addict who is on a methadone replacement treatment plan. He suffers with osteoporosis and has osteoarthritis in his right hip. He has gone through two assessments and won two appeals. The contrast between the initial outcome of both work capability assessments and the subsequent appeals could not be more different.

When he went to his first work capability assessment he was also undergoing outpatient treatment for hepatitis C and took along a prescription list not only for this but also for his methadone treatment and osteoporosis. The HCP looked at it quickly but was not interested in it. John was asked to put his arms out and touch his toes and was not allowed to elaborate on the full nature of his conditions. The assessment lasted twenty minutes and he accrued no points meaning he was deemed fit-for-work. John appealed the decision and the tribunal awarded him 42 points.

Five months later he was asked back for another assessment. This time he went with his support worker whom was only asked what their relationship was to John. Three weeks later he learnt that he had been stripped of his 42 points. With the help of the support worker he appealed again and once more the tribunal found in his favour but this time awarding him 81 points (after a thirteen month wait because of the backlog of appeals). The doctor at the tribunal and John's GP both expressed surprise not only at the discrepancy of the two outcomes but also the short period of time between the assessments.

John was 'livid' with the way he has been treated and the illogical nature of his assessments which he firmly believes are all 'target driven things'. He did, however, praise the support network he had and claims that without it he would have given up a long time ago and just tried to sign on to JSA.

with a stressful situation where I live. When I am anxious I rock backwards and forward The combination of my issues mean there is no way I am ready for work at the moment'. Another said this:

*'I suffer from kidney stones, skin cancer, womb prolapse and bowel problems. I need to plan my day carefully with access to toilets. I have had multiple hospital treatments and am often admitted to hospital for treatment'.*

Mental health conditions were a common feature amongst the respondents often in conjunction with physical health issues yet it was mental health issues that individuals said HCPs had poor awareness of and failed to fully explore in the assessment.

Despite almost two-thirds of respondents stating they had multiple health conditions there

were instances when they were deemed fit-for-work, while others who declared they did not were not passed immediately fit for work and placed in the work-related activity group.

**3.4 Appeals**

Upon hearing the outcome of their WCA, 76% appealed the decision. Those that decided not to do so because they felt there was no point and 20% felt that the process was too complicated. This meant a sense of pessimism pervaded:

*'All the people I know who have appealed against the decision have failed and end up in debt as a result of having to live on reduced benefits while waiting for the appeal to be processed'.*

Others could not make the appeal hearing as they had no one to accompany them. In one case, the official appeals process appears to

have been bypassed by a phone call:

*'They turned my claim down initially by telling me over the phone I'd failed. I asked them to call my support worker who spoke on my behalf explaining my medical condition, operations I have had etc then they overturned their decision'.*

At the time of the survey 56% were waiting for the result. For those that had got a result, a quarter had been successful.

## 4. Conclusions and recommendations

For homeless people a positive experience of the WCA is linked to receiving support with the original ESA50 questionnaire and being accompanied to the assessment itself. Satisfaction rates with length of the assessment confirm this.

Final outcomes also show that if a homeless person has someone with them during the assessment then they are more likely to be placed in the appropriate group.

There is a lack of confidence in the ability of the healthcare professionals to accurately and fairly assess the complex health issues and needs of homeless people.

Because the assessment is currently 'blind' to the specific needs of homeless people the reports produced are often inaccurate and result in some of the most vulnerable in society being denied benefit. In particular, mental health issues are repeatedly given as one such gap in training and understanding.

Counter-intuitively those with multiple health conditions were sometimes deemed fit-for-work; there is an obvious need for greater interrogation of a client's physical and mental capabilities in the assessment.

## Recommended actions

### ESA50 form completion

- Over 40% of survey participants found the ESA50 questionnaire difficult to complete. The form should be reviewed with a view to making it more 'user friendly' and also to ensure that it is fit for purpose.
- People with a homelessness background should be encouraged to get help to complete the form and be actively signposted to access and navigate existing support.
- The DWP hope to identify the majority of people who qualify for the Support Component on paper evidence, i.e., avoiding the need for a face-to-face assessment. Yet many of the homeless people who took part in the study were unaware that they could provide supporting medical evidence at an early stage of their assessment process. The DWP should raise awareness that it might be possible to end the process early by gathering evidence in advance and sending it to the DWP without delay.

### Preparing for the face-to-face assessments

- Homeless and vulnerably housed people are often not aware that they can be accompanied to the assessment so more should be done to raise awareness and people should be encouraged to attend with someone (support or key worker, friend or family member).
- A third of respondents did not take any supporting medical evidence with them. Prior to the assessment, everyone should be encouraged to gather and take supporting materials with them. Homeless people need to be told how such evidence might help bring the nature of their condition(s) to light, especially when provided by professionals they have a longstanding relationship with.

### The face-to-face assessments

- Homelessness is a significant yet 'invisible' issue within the assessment. The DWP should encourage awareness of people's increased vulnerability from the effects of current or past homelessness and related conditions (e.g. drug and alcohol misuse and mental ill health).
- The Limited Capacity for Work Test should be reviewed to ensure it gives a meaningful picture of claimants' lives and the specific challenges faced by those who are vulnerably housed or homeless. However, a computer-based assessment alone will never give a complete picture of the nature and complexity of needs of people with a homelessness background. The DWP should therefore consider introducing to the system 'observation and assessment' visits to people's homes and communities.
- Homeless people taking part in the survey often felt that their claims were not being taken seriously and that they were being set up to fail. To avoid adding to existing discrimination and stigma it is vital that healthcare professionals respond appropriately to the homeless people they assess, who may well be experiencing a multitude of other problems besides.
- Good communication skills on the part of the healthcare professional are crucial if homeless people are to be accurately and fairly assessed. Awareness of how poor interviewing skills impact on vulnerable people's ability to put their case across should be encouraged and adequate training made available.
- The transparency of the face-to face assessment should be improved and independent 'quality checks' undertaken to ensure vulnerable people don't fall through the net because they are unable to put their case across sufficiently clearly.
- The occupational health service provider conducting the assessments should provide a caring, safe and welcoming environment in which waiting times are kept to a minimum and within which some of the most vulnerable people in society feel empowered to talk in-depth about their health and background.

### The decisions

- Over a quarter of respondents had to wait between 6 and 9 weeks for their WCA decisions. The decision can have a momentous impact on people's lives and choices and having to wait for prolonged periods to receive it will in all likelihood have a negative impact on their health. Waiting times should be reduced and people should be told what to expect while they are waiting. Should delays be inevitable, individuals should be informed at the earliest opportunity.
- 76% of survey respondents appealed their decision. This indicates there is a lack of faith in the system. The WCA should be fundamentally rethought; otherwise the current system will continue to harm some of the most vulnerable in society whilst providing little benefit to employers.



## **Get in touch**

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