Being disabled in Britain

A journey less equal

Equality and Human Rights Commission

About this publication

What is the aim of this publication?

'Being disabled in Britain' is a review into disability inequality in Great Britain, offering comprehensive evidence on whether our society lives up to its promise to be fair to all its citizens. It builds on the Equality and Human Rights Commission's statutory five-yearly report on equality and human rights progress in England, Scotland and Wales, 'Is Britain Fairer? The state of equality and human rights 2015.' This review also draws on new quantitative data analysis and our submission to the UN Committee on the Rights of Persons with Disabilities, published in February 2017, to present a fuller and more up-to-date examination of the key challenges facing disabled people in Britain.

Who is it for?

We want this report to be used by UK and devolved governments to make improvements to law and policies, by local government to ensure services meet the needs of disabled people, and by disability groups to strengthen their case for change.

What is inside?

The report includes chapters on six core areas of life, including education, work, health, justice and participation in politics, looking at where there has been progress and where there are still serious issues to be tackled. It also looks the experiences of those with different impairments and how these impact on people's life chances.

Why has the Commission produced this?

The Equality and Human Rights Commission promotes and enforces the laws that protect our rights to fairness, dignity and respect. As part of its duties, the Commission provides Parliament and the nation with periodic reports on equality and human rights progress in England, Scotland and Wales.

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Foreword from the Chair

What is it like to be disabled in Great Britain today? It's fair to say that we have seen significant improvements in the law to protect the rights of disabled people.

Twenty years ago the Disability Discrimination Act came into force, as the first step towards tackling the shocking inequalities of the past. In 2009, the UK ratified the United Nations Convention on the Rights of Persons with Disabilities (CRPD). In 2010 the Equality Act strengthened protection from disability discrimination, and five years ago the nation hosted the London 2012 Paralympic Games. There is no doubt that the Games challenged some of the stereotypes about disabled people and enabled us to celebrate their contribution to the nation.

At face value we have travelled far. But have these important legal protections really changed the lives of disabled people? Have we achieved equality, or is there still a long road ahead?

In 'Being disabled in Britain: A journey less equal' we seek to answer these questions. We have analysed the latest data on the experiences of disabled people in Great Britain in more detail than has ever been done before. We look at many types of impairment in all areas of life – from education, working life, standards of living, and health care, to security and participation in politics.

Our report shows that in many sectors we have failed to make real progress, and in some areas we have even gone backwards. Disabled people are being left behind in comparison with others in society; some groups of disabled people – in particular those with mental health conditions and learning disabilities – experience even greater barriers. More families that include a disabled person live in poverty; access to mental health care is inadequate; and housing and transport fail to support disabled people to live independently and fulfil their potential and aspirations.

The conclusion we must draw from the evidence is that disabled people are still being treated as second-class citizens. Progress to date is not sufficient, and the road to disability equality is littered with missed opportunities and failures.

It is a badge of shame on our society and successive governments that this has happened. The Equality Act 2010 has still not been implemented in full, the CRPD has not been incorporated into domestic law and policy, life chances for disabled people remain very poor, and public attitudes to disabled people have changed very little.

We want this report to be the start of a concerted effort to deliver the changes that are desperately needed. The evidence can no longer be ignored. This report must be used by the UK and devolved governments to make improvements to law and policies, by local government to ensure services meet the needs of disabled people, and by disability groups to strengthen their case for change.

Now is the time for a new national focus on the rights of the 13 million disabled people who live in Britain. They must not be treated any less favourably than any other citizens. Britain must be a fair and inclusive society in which everyone has equal opportunities to thrive and succeed. To achieve this we must put the rights of disabled people at the heart of our society.

We cannot, and must not, allow the next 20 years to repeat the past.

David Isaac, Chair, Equality and Human Rights Commission

I've got rights!

Executive summary

In 'Being disabled in Britain 2016: A journey less equal' we assess the state of equality and human rights for disabled people in Britain and set out the key areas requiring improvement. While progress has been made in some areas, the overall picture emerging from the data is that disabled people are facing more barriers and falling further behind.

It is a badge of shame on our society that millions of disabled people in Britain are still not being treated as equal citizens and continue to be denied the everyday rights non-disabled people take for granted, such as being able to access transport, appropriate health services and housing, or benefit from education and employment. The disability pay gap is persistent and widening, access to justice has deteriorated, and welfare reforms have significantly affected the already low living standards of disabled people. It is essential that as a society we recognise and address these structural problems urgently and comprehensively. We are calling for a new national focus on disability rights, so that disabled people are no longer treated as 'second-class citizens'.

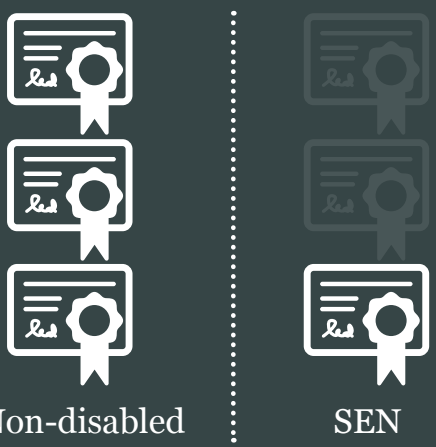
The key challenges to disability equality

In our review 'Is Britain Fairer?' (EHRC, 2015), we presented the key equality and human rights challenges for all protected characteristic groups in Britain, and concluded that greater effort was needed to identify the scale and nature of the issues affecting disabled people. This report builds on that evidence and also draws on new quantitative data analysis and our submission to the UN Committee on the Rights of Persons with Disabilities, published in February 2017, to present a fuller and more up-to-date examination of the key challenges facing disabled people in Britain.

Our purpose is to report our findings, set out the challenges for the future, and invite all concerned to address the issues by identifying and implementing the necessary solutions. This report does not speculate on the impact of proposed future legislative or policy changes, nor try to explain the causes of differences, or offer policy solutions.

Our report sets out evidence-based findings in six key areas of life: education, work, standard of living, health and care, justice and detention, and participation and identity. It highlights the key issues described on the next page which are affecting the lives of disabled people in Britain.

Educational attainment of children with Special Educational Needs



Education

Disabled pupils in England, Wales and Scotland have much lower attainment rates at school than non-disabled pupils, and are significantly more likely to be permanently or temporarily excluded. Furthermore, there is a need to address bullying experienced by disabled children and the levels of support they are offered.

In England and Wales, in 2014/15 the educational attainment of children with Special Educational Needs (SEN) was nearly three times lower than for non-disabled children. Across Britain in 2015/16, disabled young people aged 16-18 were at least twice as likely as their non-disabled peers to not be in education, employment or training (NEET).

Having a degree-level qualification can significantly improve employment outcomes. The employment gap is smaller between disabled (60% employed six months after graduating, in 2009/10) and non-disabled graduates (65% employed) compared with the gap in the general population. Although the qualification gap between disabled and non-disabled people narrowed between 2010/11 and 2015/16, the proportion of disabled people with no qualifications was nearly three times that of non-disabled people in 2015/16, and the proportion of disabled people with a degree remained lower than that of non-disabled people.

Work

Disabled people across Britain are less likely to be in employment than non-disabled people. Since 2010 there has been extensive reform to UK Government employment support programmes (Access to Work and the Work Programme), but there are specific concerns about their effectiveness for disabled people. In particular, non-disabled people (35%) are more likely than disabled people (18%) to get a job on the Work Programme.

Despite an increase in the proportion of both disabled and non-disabled adults in employment in Britain in 2015/16, less than half of disabled adults were in employment (47.6%), compared with almost 80% of the non-disabled adult population, and the gap between these groups has widened since 2010/11.

The disability pay gap in Britain continues to widen. In 2015-16 there was a gap in median hourly earnings: disabled people earned £9.85 compared with £11.41 for non-disabled people. Disabled young people (age 16-24) and disabled women had the lowest median hourly earnings.

Very low numbers of disabled people are taking up apprenticeships, and there has been little improvement in that situation in England and Wales, although Scotland has seen a slight improvement.

Standard of living

More disabled people than non-disabled are living in poverty or are materially deprived. Social security reforms have had a particularly disproportionate, cumulative impact on rights to independent living and an adequate standard of living for disabled people.

UK data from 2014/15 shows that 30% of working-age adults in families where at least one member is disabled were living in households with below 60% of contemporary median income after housing costs, compared with 18% for those living in families with no disabled members. Across Great Britain, 59% of families with children, that were in income poverty and that contained a disabled person, lived in material deprivation in 2014/15, compared with an average material deprivation rate of 20%.

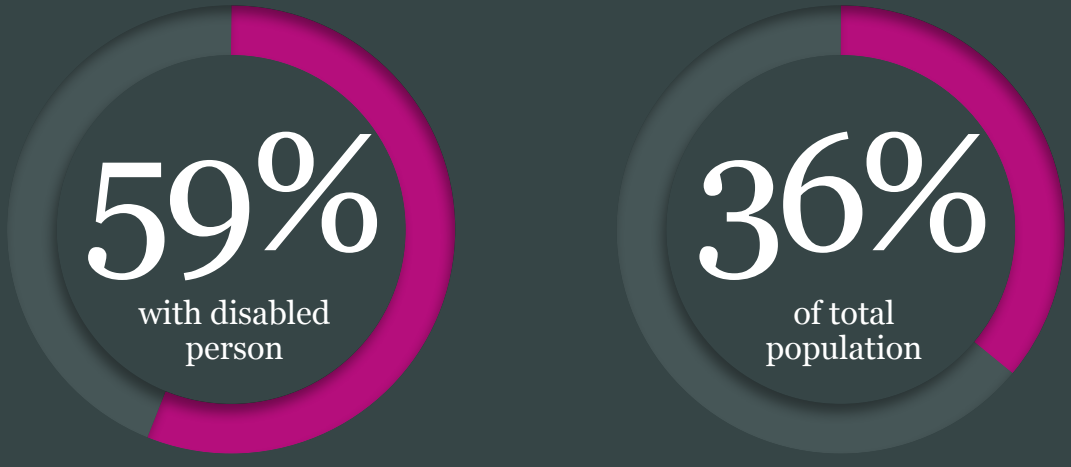
Across the UK, 18.4% of disabled people aged 16-64 were considered to be in food poverty in 2014 compared with just 7.5% of non-disabled people. Disabled people over the age of 65 were twice as likely as non-disabled people in the same age group to be in food poverty: 6.8% compared with 3.3%.

A higher proportion of disabled people have been affected by the under-occupancy charge ('bedroom tax') than non-disabled people, as evidenced in the Department for Work and Pensions' Equality Impact Assessment. In England and Wales, at least 47% of housing benefit claimants affected by the under-occupancy charge have a disability. Families with a disabled child have also been affected by the charge.

Disabled people face problems in finding adequate housing and this is a major barrier to independent living. There is a shortage of accessible housing across Britain: of councils in England with a housing plan, fewer than 17% have set out strategies to build disabled-friendly homes. In Scotland the amount of wheelchair-adapted local authority housing for physically disabled people has decreased.

As resources become scarcer, and funding for specialist services for disabled people disappears, disabled people are finding it more and more difficult to access support.

The material deprivation rate for families with children, in income poverty and that contained a disabled member



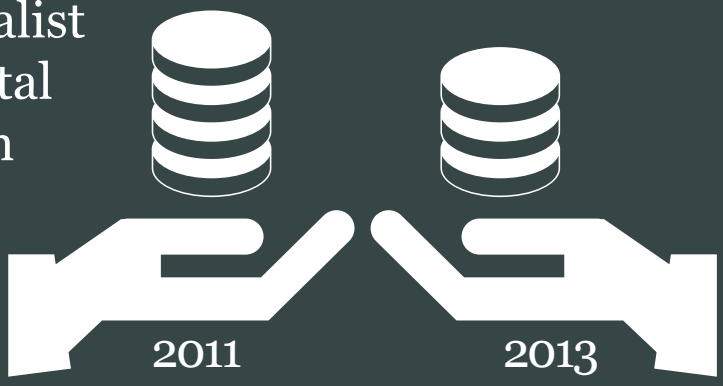
Health and care

Disabled people are more likely to experience health inequalities and major health conditions, and are likely to die younger than other people. The extent of these health inequalities is difficult to assess because of limited data on outcomes for disabled people collected by NHS providers and commissioners. Accessibility of services is problematic, and disabled people are less likely to report positive experiences in accessing healthcare services.

Despite a commitment by governments to make improvements to the provision of mental health services, considerable shortcomings remain in all three countries (England, Scotland and Wales), where disabled adults are more likely to report poor mental health and wellbeing than non-disabled adults. In England, the waiting time target for access to psychological therapies has been cut to 28 days, but some people have waited for over 90 days. The majority of Health Boards in Scotland have failed to meet the target to ensure access to psychological therapies for all patients within 18 weeks from referral to treatment. Reduced funding in specialist child and adolescent mental health service provision in England has amounted to 25% cuts between 2011 and 2013 in some areas; the NHS reports an increase in average waiting times to 15 weeks between 2011 and 2013.

- On average, men with mental health conditions die 20 years earlier than the general population, and women 13 years earlier.
- 'Do not attempt resuscitation' (DNAR) notices are being placed on patients' files without their consent or knowledge.
- Action is needed to reduce the use of physical and chemical restraint for the purposes of behaviour management in hospital and care settings.

Reduced funding in specialist child and adolescent mental health service provision in England has amounted to



25% cuts

between 2011 and 2013 in some areas

Justice and detention

There is an urgent need for prisons to monitor and report on prisoner mental health. Prisoners are more likely to have mental health conditions compared with the general population, and 70% of prisoners that died from self-inflicted means between 2012 and 2014 had an identified mental health need.

Detentions in health and social care settings under the Mental Health Act 1983 are continuing to increase in England and Wales and this is a strong concern, particularly as evidence suggests there are flaws in the way those detained are assessed and treated.

- The use of section 136 of the Mental Health Act 1983 (under which people are brought to hospital as a 'place of safety') increased by 18% to 22,965 in 2016, while the number of detentions in hospitals increased between 2009/10 and 2016 (from 46,600 in 2009/10 to 63,622 in 2016).

The UK continues to be the only country in the European Union with no time limit on immigration detention, and there is a concern that immigration detention facilities are inadequately equipped to deal with detainees who have a mental health condition.

Disabled people in Britain are more likely to have experienced crime than non-disabled people. In Scotland, disabled people were less likely to feel safe walking alone in their neighbourhood after dark compared with non-disabled people. Similarly in England and Wales, disabled people were more likely to feel unsafe walking alone in their local area during the day, and were more likely to report feeling worried about physical attack and acquisitive crime compared with non-disabled people.

Disability hate crimes recorded by the police in England and Wales increased by 44% in 2015/16 on the previous year, possibly reflecting improved reporting and recording practices. Despite this improvement, a joint inspection team from HMI Constabulary, HM Crown Prosecution Service Inspectorate and HMI Probation found that criminal justice agencies do not always understand what forms disability hate crime can take, and that more needs to be done to understand how disabled people experience hate crime. This includes the ways in which disabled people are targeted and the difficulties they face in getting public authorities to respond. In Scotland in 2014/15, crimes reported with an aggravation of prejudice relating to disability increased by 20% compared with the previous year, 86% of which proceeded to court.

Changes to legal aid in England and Wales have negatively affected disabled people's access to justice in family law, housing, employment, debt and welfare benefits cases. Across Great Britain, there has been a 54% drop in employment tribunal claims on grounds of disability discrimination between 2012/13 and 2015/16.

Participation and identity

Disabled people continue to encounter barriers to exercising their right to vote. Disabled people are also under-represented in political office and public appointments, and face continued challenges to achieving equal representation. There is an urgent need for the implementation of section 106 of the Equality Act 2010, so that political parties are required to publish diversity data about their candidates.

Poor access to transport, leisure and other services can affect the community and social life of disabled people, creating a barrier to independence and their enjoyment of day-to-day activities. Across Great Britain, there was an overall increase between 2009-11 and 2012-14 in the percentage of disabled and non-disabled adults who reported having difficulty accessing services in the areas of health, benefits, tax, culture, sport and leisure. In 2012-14 this was 45.3% for disabled people compared with 31.7% for non-disabled people.

The wide gap in internet usage between disabled and non-disabled people has persisted. The law leaves a degree of interpretation for service providers about how far they are required to go to increase digital accessibility and there is as yet no UK case law precedent on web accessibility to clarify the position. Disabled people reported difficulties accessing their bank, having a credit history and affording insurance, all of which exacerbate the financial penalty they face and can limit their family life and opportunities to learn, work and participate in society.

Negative attitudes towards disabled people remain prominent in Britain, and people with a mental health condition, learning disability or memory impairment remain particularly likely to be stigmatised. Measures of disability prejudice have focused largely on disability as a general category. There is a lack of evidence on how people's attitudes towards disability differ by disability type.

Poor access to transport, leisure and other services

"Now is the time for a new national focus on the rights of the 13 million disabled people who live in Britain"

Evidence and action on disability rights

More needs to be done to improve the evidence base on the issues facing disabled people. In particular, better evidence is needed about the experiences and outcomes of disabled people who have specific impairments or multiple disabilities, and to understand the issues for disabled people of different ethnic groups, ages or sexual orientations.

Legislation, policies, frameworks and actions plans need to be targeted at addressing the inequalities experienced by disabled people, and their impact on disabled people needs to be monitored and evaluated. For example:

- England, Wales and Scotland have action plans in place to tackle the obesity crisis, but these do not address the specific needs of disabled people, for whom weight and obesity are a particular problem but who may face barriers to forms of physical activity.
- There are inconsistent levels of protection for disabled people. In Scotland, unlike in England and Wales, there is currently no specific offence of emotional abuse under criminal law, which means that perpetrators of this form of abuse cannot be prosecuted for that particular crime.
- There are strong concerns about how the implementation of the Department for Transport's Accessibility Action Plan is being monitored, despite a House of Commons Transport Committee recommendation that the UK Government publish annual updates about implementation of the plan, including data on changes in the number and types of journeys made by disabled people.

The United Nations Committee on the Convention on the Rights of the Child, the Convention on the Elimination of all Forms of Discrimination Against Women and the International Covenant on Economic, Social and Cultural Rights have all highlighted the disparities that exist for disabled children and adults across all areas of life. This year, the UK Government will be examined on its performance under the Convention on the Rights of Persons with Disabilities (CRPD), with the expectation that it will ensure the resulting recommendations are addressed through legislation, policies, frameworks and action plans. However, there is currently no domestic mechanism requiring Ministers to have regard to the CRPD when developing new policy and law.

Recommendations

This report looks at six key areas of life and finds that disabled people in Britain are experiencing disadvantages in all of them. But our lives are not lived in neat and distinct categories, and it is critical that policy makers and influencers across all sectors recognise how the issues we have identified interact and accumulate throughout disabled people's life journeys. For example, being unable to access appropriate health services or public transport affects people's ability to access and benefit from education or work.

We are calling on the UK, Scottish and Welsh Governments to place a new national focus on disability equality, so that the rights of disabled people are fully realised, and to deliver improvements in disabled people's experience and outcomes.

We recommend that the UK and devolved governments take concerted action to:

1. Reduce educational attainment and employment gaps for disabled people.

2. Ensure that essential services, such as housing, health, transport and justice, meet the particular needs of disabled people and support their independence and wellbeing.

3. Promote the inclusion and participation of disabled people in civic and political life.

4. Strengthen disabled people's choice, autonomy and control over decisions and services.

5. Improve existing legislation, policies, frameworks and action plans to better protect and promote the rights of disabled people.

6. Improve the evidence base on the experiences and outcomes of disabled people and the ability to assess how fair Britain is for all disabled people.

To support implementation of these recommendations, we will work with governments and key influencers to raise awareness of the evidence – in this report, the CRPD concluding observations and the joint Disability Rights UK, Disability Wales, and Inclusion Scotland report – and to identify the action that needs to be taken to make progress.

1. Introduction

In 'Being disabled in Britain: A journey less equal' we assess the state of equality and human rights for disabled people in Britain and set out the key areas requiring improvement. This builds upon our work in 'Is Britain Fairer?' that presented key equality and human rights challenges for all protected characteristic groups in Britain and found greater effort was needed to identify the scale and nature of the issues affecting disabled people. We therefore present the latest available evidence for England, Scotland and Wales across six major areas of life. Within each of these areas, we have used a set of indicators and measures to assess progress:

- **Education:** educational attainment, exclusions and bullying in schools, adult educational qualifications and young people not in education, employment or training (NEET)
- **Work:** employment, unemployment and pay, access to work and apprenticeships, and the impact of welfare reforms
- **Standard of living:** poverty and material deprivation, availability of support and housing
- **Health and care:** health inequalities, obesity, mental health, social care and support, healthcare for people with a learning disability
- **Justice and detention:** detention, experiences and perceptions of crime, hate crime, legal aid
- **Participation and identity:** political participation and representation, access to services, and discrimination, abuse, attitudes and stigma

There are inevitably limitations to any evidence-gathering process owing to gaps in data and difficulties involved in collecting information. While recognising these limitations, this report presents a rich range of evidence on the extent to which disabled people's rights are being realised in practice. It does not speculate on the impact of proposed future legislative or policy changes, nor try to explain the causes of differences, or offer policy solutions.

The UK Parliament has given the Equality and Human Rights Commission (EHRC), together with the Scottish Human Rights Commission, the Northern Ireland Human Rights Commission, and the Equality Commission for Northern Ireland, the role of the UK Independent Mechanism (UKIM) on the Convention on the Rights of Persons with Disabilities (CRPD). The UKIM has responsibility for promoting, protecting and monitoring implementation of CRPD in the UK. This report informs the UKIM submission to the UN Committee on the Rights of Persons with Disabilities – the expert body overseeing implementation of the treaty – published in February 2017. The key challenges set out in this report complement recommendations made to the UN Committee in our CRPD submission for action by the UK Government and devolved governments.

We believe that this report will be of value to policy makers and influencers across all sectors. Our purpose is to report our findings, set out the challenges for the future, and invite all concerned (particularly those with relevant statutory responsibilities) to address the issues by identifying and implementing the necessary solutions.

Methodology

The EHRC has a statutory requirement to regularly report to the UK Parliament on progress in society towards equality and human rights in Britain. To fulfil this duty, we have developed four measurement frameworks to monitor and evaluate progress in a systematic and consistent way across England, Scotland and Wales. These measurement frameworks cover equality for adults (Alkire *et al.*, 2009) and for children (Holder *et al.*, 2011), good relations (Wigfield and Turner, 2010), and human rights (Candler *et al.*, 2011). The latter is based on the 'Human Rights Indicators: Guide to Measurement and Implementation' by the Office of the United Nations High Commissioner for Human Rights (OHCHR, 2012).

We will present three different types of evidence:

- **Structure:** the human rights and equality standards to which the UK is committed, as evidenced by the Human Rights Act 1998, the Equality Act 2010, the European Convention on Human Rights (ECHR), CRPD and other treaties the UK has signed and ratified.
- **Process:** efforts that are being made by the State and duty holders to meet the obligations that flow from these human rights standards, including primary legislation, and regulatory and public policy frameworks.
- **Outcome:** the position and experiences of disabled people, evidenced by social survey or administration data, and concerns highlighted by regulators, inspectorates, human rights monitoring bodies, non-governmental organisations (NGOs) or academic studies.

In this report, we cover government responsibilities across England, Wales and Scotland, some of which are reserved to Westminster (for example, employment) and some of which are devolved (for example, health and housing). As a rule of thumb, where a matter is devolved, we cover the legislative, regulatory and public policy framework (Process) and the experiences of disabled people (Outcomes) separately for the three countries. Where a matter is reserved, we present Process and Outcome evidence at a Great Britain (GB) level; however, there are some exceptions.

The report draws on both qualitative and quantitative evidence that meets the EHRC's quality criteria, as explained in the 'Is Britain Fairer?' Methodology paper (EHRC, 2015). The **qualitative evidence** is based on reports by inspectorates and regulators, parliamentary committees, the UK and devolved governments, academia and NGOs. The **quantitative evidence** draws on major surveys and administrative data compiled by public bodies. In this report we have relied on different sets of quantitative data:

- Our own secondary data analysis of survey and administrative data (including national surveys on crime, health, population and life opportunities, and administrative data on education), broken down by impairments and showing change over time for GB, England, Wales and Scotland separately (where possible). The analysis was done between September and December 2016 (see Appendix A for a list of data tables and Appendix B for mappings between impairment categories used in this report and the classifications used in the main surveys analysed).

- Our own intersectional analysis of survey and administrative data, using the broader disabled and non-disabled categories, showing change over time, and taking into account the full range of protected characteristics, socio-economic status and other variables that may be associated with particular outcomes. This analysis was done in December 2016 (see Appendix C).
- Our own secondary data analysis of survey and administrative data, broken down by disabled and non-disabled people, which was published as part of the 'Is Britain Fairer?' series in October 2015 (EHRC, 2015).
- We have supplemented these with quantitative data drawn from other published analyses.

2. Human rights standards

This chapter summarises the most relevant aspects of the current equality and human rights legal framework that protect the rights of disabled people in Britain:

- international human rights treaties signed and ratified by the UK, including the Convention on the Rights of Persons with Disabilities
- the Human Rights Act 1998 (HRA)
- Wales and Scotland specific standards
- the Equality Act 2010.

International human rights instruments

The UK has signed and ratified a number of international human rights instruments:

- International Covenant on Civil and Political Rights (ICCPR)
- International Covenant on Economic, Social and Cultural Rights (ICESCR)
- Convention on the Rights of Persons with Disabilities (CRPD)
- Convention on the Rights of the Child (CRC)
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
- International Convention on the Elimination of All Forms of Racial Discrimination (CERD)
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT).[1]

While these international treaties are legally binding on the UK, they do not create free-standing individual rights that serve as a cause of action in legal proceedings because they have not been directly incorporated into domestic law. Instead, a number of rights are given at least partial effect domestically through legislation, such as the Equality Act 2010[2] and the Human Rights Act 1998,[3] and a mixture of policies and programmes. In addition, international treaties can be considered by domestic courts and the European Court of Human Rights when interpreting other relevant applicable rights, and the UK is under an obligation to comply. Under the Scotland Act 1998 and the Government of Wales Act 2006 neither the Scottish Parliament nor the Welsh Assembly can pass legislation that is incompatible with the Human Rights Act (HRA).

Convention on the Rights of Persons with Disabilities

The UK ratified the CRPD in 2009. The purpose of the CRPD is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity. The UK has also ratified the Optional Protocol to the CRPD, which enables the UN Committee overseeing the CRPD to hear complaints from individuals or groups who claim their CRPD rights have been violated.

As a State Party to the CRPD, the UK is legally bound to comply with its provisions, which cover a broad range of civil, political, social, economic and cultural rights for disabled people. Article 4 contains general obligations for all States Parties to: eliminate discrimination on the basis of disability; involve disabled people in developing and implementing legislation and policies; and adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognised in the CRPD.

The HRA is of great importance in providing disabled people with a remedy when their rights have been violated; however, a number of rights contained in the CRPD, particularly socio-economic rights, are not covered by the HRA.

There is currently no explicit statutory requirement or non-statutory commitment for Ministers to have due regard to the CRPD when developing new policy and law.

Human Rights Act 1998

Under the HRA, it is unlawful for all public bodies and other bodies carrying out public functions as defined under the Act to act in a way that is incompatible with rights set out in the European Convention on Human Rights (ECHR). This obligation is both negative (that is, not to breach the rights) and in certain circumstances positive (that is, to take steps to guarantee the rights). The HRA does not create any new rights that are not in the ECHR.

There are three types of ECHR rights:

Absolute rights – for example, the right to life and protection from torture and inhuman and degrading treatment. The State cannot breach these rights in any circumstances.

Limited rights – for example, the right to liberty and security of person, and to a fair trial. These may only be limited under the circumstances set out in the ECHR Article defining the right.

Qualified rights – for example, respect for private and family life, freedom of assembly and association, and freedom to manifest thoughts, conscience and religion. These require a balance to be made between the rights of the individual and the needs and rights of others, including wider society or the State. They can be interfered with under specific circumstances set out in each Article, which include where:

- there is a legal basis for this interference, which people can find out about and understand
- there is a legitimate aim for the interference
- the interference is necessary in a democratic society; there must be a pressing social need for the interference
- the interference is proportionate (that is, it must be no greater than is necessary to meet this social need).

Article 14 of the ECHR provides the right for people to be free from discrimination in enjoying their human rights under the Convention. However, Article 14 is not a free-standing right. Anyone wishing to rely on Article 14 must establish that the matter falls within the ambit of another Convention right, and discrimination does not breach another Convention right if it can be justified as a proportionate means of achieving a legitimate aim.

Wales and Scotland

The Government of Wales Act 2006 stipulates that:

- a provision of an Act of the Welsh Assembly is outside the Assembly's legislative competence if it is incompatible with ECHR rights
- Welsh Ministers cannot act incompatibly with these rights.

The Rights of Children and Young Persons (Wales) Measure (2011) provides a statutory duty for Welsh Ministers to have due regard to part 1 of the Convention on the Rights of the Child (CRC).

The Scotland Act 1998 stipulates that:

- a provision of an Act of the Scottish Parliament is not law so far as it is incompatible with ECHR rights
- a Member of the Scottish Parliament has no power to make any subordinate legislation or to carry out any other act, so far as the legislation or act is incompatible with ECHR rights.

The Children and Young People (Scotland) Act 2014 also places a duty on Scottish Ministers to keep under consideration the requirements of the CRC.

Equality Act 2010

The Equality Act 2010 prohibits unlawful discrimination, harassment and victimisation on the basis of what are called 'protected characteristics' in a wide variety of fields, including employment, education, the exercise of public functions, and the provision of services and associations.

The nine 'protected characteristics' are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

Prohibited conduct takes a number of forms, although not all are relevant to all protected characteristics. Prohibited conduct includes the following:

- **Direct disability discrimination** – less favourable treatment of a disabled person because of their disability compared with others who are not disabled.
- **Indirect disability discrimination** – where a policy, practice or criterion is applied to everyone (or would be), but in fact puts (or would put) disabled people at a particular disadvantage when compared with others who are not disabled. Indirect disability discrimination can be lawful if objectively justified as a proportionate means of achieving a legitimate aim.
- **Discrimination arising from disability** – less favourable treatment of a disabled person, because of something arising in consequence of the disabled person's disability, where the less favourable treatment cannot be shown to be a proportionate means of achieving a legitimate aim. Discrimination arising from disability does not occur if the person does not know, and could not reasonably be expected to know, that the disabled person has the disability.

- **Duty to make reasonable adjustments** – discrimination against a disabled person occurs where there is a failure to comply with a duty to make reasonable adjustments. The duty comprises three requirements:
  - Where a provision, criterion or practice puts disabled people at a substantial disadvantage compared with those who are not disabled, take reasonable steps to avoid that disadvantage.
  - Take reasonable steps to remove or alter a physical feature or provide a reasonable means of avoiding such a feature where it puts a disabled person at a substantial disadvantage compared with those who are not disabled.
  - Take reasonable steps to provide an auxiliary aid where a disabled person would, but for the provision of that auxiliary aid, be put at a substantial disadvantage compared with those who are not disabled.
- **Harassment related to disability** – unwanted conduct related to a person's disability that has the purpose or effect of violating the person's dignity, or creating an intimidating, hostile, degrading, humiliating or offensive environment for that person.
- **Victimisation** – subjecting someone to a detriment because they have, in good faith, carried out a protected act, such as:
  - making an allegation of discrimination
  - bringing proceedings under the Equality Act 2010
  - giving evidence or information in relation to such proceedings
  - doing anything else in connection with the Equality Act 2010.

The Equality Act 2010 permits proportionate positive action measures that aim to overcome disadvantage connected to a particular protected characteristic. The Equality Act 2010 goes further in relation to the protected characteristic of disability than it does for other protected characteristics: it is not discrimination to treat a disabled person more favourably than a non-disabled person.

"A survey of almost 9,000 young people aged 12-20 in the UK revealed that 10% of respondents had been bullied because of attitudes towards their disability"

3. Education

This chapter reviews evidence relating to disabled people's access to and experiences of education, from primary school level through to tertiary education and lifelong learning. Education is a fundamental human right that enables people to access other rights, including an adequate standard of living and the highest attainable standard of health.

Five specific indicators were chosen to assess how well disabled people's rights relating to education are protected in Britain. These are:

1. Educational attainment for children and young people
2. Exclusions from schools
3. Bullying in schools
4. Young people not in education, employment or training (NEET)
5. Educational qualifications for adults.

Due to the devolved arrangements, England, Wales and Scotland have different legislative, regulatory and public policy frameworks in place, all of which make provisions for protecting disabled people's rights to education. There remain some similarities across countries, particularly between England and Wales.

3.1. Educational attainment for children and young people

Legal and policy framework

England and Wales

Much of the legislative and policy framework remains unchanged since the Children and Families Act 2014. However, there have been some important developments.

The UK Government is overhauling the system for identifying children and young people in England with Special Educational Needs (SEN), assessing their needs and making provision for them. The key reform is the introduction of a single Education, Health and Care plan covering birth to 25 years of age.[4] The reformed system was introduced in September 2014 and the full transition is intended to be complete by April 2018 (Long, 2016).

In its impact assessment of the 'Educational Excellence Everywhere' White Paper, the Department for Education (DfE) acknowledged that schools specialising in provision for children with Special Educational Needs and Disability (SEND) may struggle to find commercial sponsors, and said it was exploring ways to overcome this. It also noted that disproportionate numbers of children with SEND may be required to re-sit Year 7 Key Stage 2 tests. This is to be mitigated by an exemption for those with the most severe needs (DfE, 2016b).

In January 2016 the UK Government allocated £80 million to charities and local councils to better meet the needs of children with SEND (DfE, 2016c). However, in a DfE strategy document the department acknowledged that more needs to be done to improve educational outcomes for children with SEND, which are typically poor. Those with SEND but without an Education, Health and Care plan are far more numerous and may number as many as three or four out of an average class (DfE, 2016d). In May 2016 Ofsted and the Care Quality Commission began inspecting local area implementation of the Education, Health and Care plans, focusing on how well the needs of children with SEND are identified and met by local agencies, including schools (Ofsted, 2015).

In 2016, 2.8% of pupils had a statement of SEN or Education, Health and Care plan and 991,980 pupils received SEN support – this is equal to 11.6% of the total pupil population (DfE, 2016f). The number of pupils with SEN has reduced from 1,301,445 in 2015 to 1,228,785 in 2016. The reduction in numbers is explained by declining numbers of children qualifying for lower level SEN support. This is partly as a result of reclassifying pupils who would previously have qualified for SEN support as having no need at all. It is important to note that as statements of SEN and Education, Health and Care plans are only given to those with more serious need, there may be an issue about unmet need at lower levels of SEN. An early DfE evaluation of the new system of Education, Health and Care plans found some modest improvements in making services more efficient, but said there was still much work to do to ensure adequate provision for all (DfE, 2016g).

In May 2016 Ofqual launched a consultation on proposed restrictions to the reasonable adjustments that awarding bodies in England can make for disabled students when undertaking assessments. This was to ensure that qualifications are an accurate reflection of the student's ability and maintain public confidence in them.

Proposals include restricting the use of electronic readers, speech recognition aids and supporting materials (Ofqual, 2016).

The Welsh Government has announced plans for new legislation to support children and young people with additional learning needs. The proposals are similar to those being implemented in England. They focus on providing more integrated services and greater transparency (Welsh Government, 2016).

In 2014/15 the SEN categories for school pupils in England changed, making comparison of attainment data with previous years impossible. However, the UK Government clearly states that the attainment gap between pupils with SEN compared with pupils with no identified SEN remains the largest gap of all characteristics groups: pupils with SEN perform significantly worse than pupils with no identified SEN across all headline measures of attainment (DfE, 2016e).

Scotland

The Education (Additional Support for Learning) (Scotland) Act 2004 as amended was introduced to provide greater assistance to children in need of support. It established the concept of Additional Support Needs (ASN), placed new duties on local authorities and other agencies, and established the Additional Support Needs Tribunals for Scotland. The Education (Scotland) Act 2016 further extended the rights of children with ASN (see chapter 6 for discussion on mental health for children). Section 96(7) of the Equality Act 2010 gives the Scottish Qualifications Authority, as the appropriate regulator of general qualifications in Scotland, a power to specify and publish where 'reasonable adjustments' to National Qualifications should not be made.

The Scottish Attainment Challenge invested £750 million to provide targeted support to schools and local authorities with the highest concentrations of primary school children living in multiple deprivation to close the attainment gap. The Scottish Government reports that a range of continued actions, including expanding the reach, scope and investment of the Scottish Attainment Challenge is required to make the desired progress in closing the attainment gap. Subsequently, the Scottish Government launched a delivery plan for its nationwide education strategy. The education of children with ASN[5] does not feature prominently in the delivery plan but it does state: 'We are intent on delivering equity for all children and we will consider the impact of issues such as looked after status, ASN and English as an additional language' (Scottish Government, 2016, p.6). It should be noted that the Scottish Attainment Challenge was designed specifically for children attending schools in deprived areas and no Equality Impact Assessment was done at the time of its launch, although it is now being retrospectively completed.

Outcomes

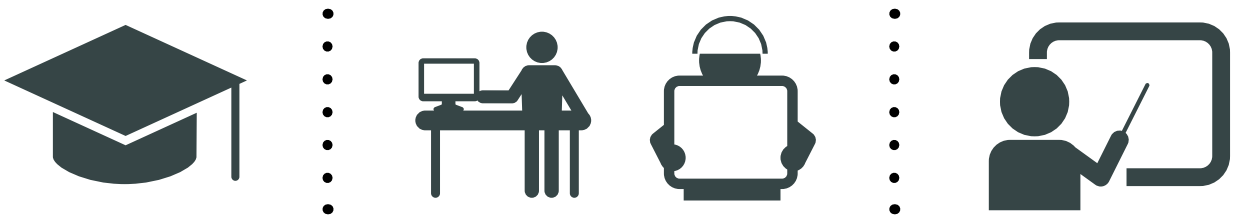
Unless otherwise stated, the figures reported here, on the educational attainment of school-age children and young people, are from analysis specifically for this report using pupil attainment data from the Department for Education, Welsh Government and Scottish Government. See online data table CE1.5.

England

In 2014/15 the overall proportion of children with SEN in England who achieved at least five A*-C GCSEs, including English and mathematics, was 20%, whereas this was 64.2% for non-disabled children. This

Disabled 16-18-year-olds

2x as likely to not be in education, employment or training



large gap has only got 1.8 percentage points smaller since 2009/10, mainly because the proportion of non-disabled children achieving at least five A*-C GCSEs came down by 2.3 percentage points; the proportion has remained roughly the same for disabled children. Note, however, that major reforms have affected both the calculation of Key Stage 4 (KS4) achievements and the identification of SEN, which affect the comparability of the data over time. Overall the number of children with SEN has fallen by over a third between the two years, with a reduction of those with more minor needs.

Based on their primary need, all groups of children with SEN have significantly lower proportions achieving at least five A*-C GCSEs, including English and mathematics, than non-disabled children in both 2009/10 and 2014/15. Note, however, that only children with Statements of SEN or in School Action Plus had a primary need identified in 2009/10, while children previously under School Action are now having their primary need identified, so the two years are not comparable.

Allowing for the combined effects of age, SEN, ethnic group, gender, whether eligible for Free School Meals, whether English is their first language, and school type, disability continues to reduce the percentage achieving at least five A*-C GCSEs, including English and mathematics, in 2014/15, and the percentage was also lower for children in special schools than in other secondary schools. Children aged 13-14 when starting their last year in Key Stage 4 were more likely to achieve these qualifications than those aged 15, and the percentage was lowest for those aged 16-18.

A higher percentage of girls than boys achieved at least five A*-C GCSEs, including English and mathematics, but the effect of SEN was greater, so the gender gap was slightly smaller for children with SEN. White children were least likely to gain these qualifications compared with Asian, Black or Chinese children or those of Mixed or Other ethnic group. However, the impact of SEN was higher for Asian children, negating the advantage for Asian children without SEN.

Children eligible for Free School Meals were less likely to have achieved at least five A*-C GCSEs, including English and mathematics, and the effect of SEN was slightly less for this group. Not being a native English speaker also reduced the percentage for those without SEN.

A UK report by the Joseph Rowntree Foundation recommends that policy-makers focus on SEND as a priority, that better training for school staff is provided and that targeted funding is available for children at risk of exclusion. Evidence suggests children with SEND are more likely than those without to experience poverty, have an unfulfilling education and go on to be poor as adults (JRF, 2016). Similarly in England, a survey of 585 members of the Association of Teachers and Lecturers found that education staff believe that children and young people with SEND are not getting the support they need: 83% of respondents did not believe the current system in England enables all children with SEND to be supported appropriately and 71% did not agree that the system enables all such children to be identified in a timely fashion (ATL, 2016).

Wales

In 2014/15 the overall proportion of children with SEN in Wales who achieved at least five A*-C GCSEs, including English or Welsh First Language and mathematics, was 23.3%, whereas this was 69.5% for children without SEN. This large gap has remained roughly the same since 2009/10 as the attainment levels of both have risen by 10 percentage points. It means that nearly double the percentage of children with SEN in Wales achieved at least five A*-C GCSEs in 2014/15 compared with 2009/10.

Based on their primary need, all groups of children with SEN have significantly lower proportions achieving at least five A*-C GCSEs, including English or Welsh First Language and mathematics, than children without SEN in both 2014/15 and 2009/10, apart from children with 'Hearing impairments' in 2014/15. Among those with SEN, children with 'Hearing impairments' (63.1%), 'Physical and medical difficulties' (51.7%), 'Autistic spectrum disorders' (41.7%) or 'Specific learning difficulties' (36.6%) had high attainment rates in 2014/15. Achievement rates increased for each of these groups, as well as for children with 'Behavioural, emotional and social difficulties' and those with 'Moderate learning difficulties'. Note that the latter may be influenced by the introduction of a 'General learning difficulties' category. The improvements were larger for children with 'Hearing impairments' or 'Specific learning difficulties' than for children without SEN.

Scotland

In 2014/15 the overall proportion of children with ASN in Scotland who achieved at least one award at SCQF level 5 or better was 60.7%, whereas this was 90.3% for those without ASN. However, this large gap was reduced by 5.7 percentage points since 2011/12.

Among children with ASN, those with 'Dyslexia' (73.9%), 'Another Specific Learning Difficulty' (63.6%) or a 'Hearing Impairment' (63.2%) had high attainment rates in 2014/15, while the attainment rates increased by more than the improvement seen for children without ASN for those with 'Dyslexia' or 'Social, emotional or behavioural difficulties' and also increased for children with 'Learning Disabilities', 'Autistic Spectrum Disorders' or 'Mental Health Conditions'.

3.2. Exclusions from schools

Legal and policy framework

England

The Joint Committee on Human Rights has expressed concerns about the UK developing an inclusive education system. Section 33 of the Education Act allows schools to say that to educate a child with disabilities or SEN would undermine the effective education of other children, and that this poses a barrier to a really inclusive educational system. Noting the high proportion of children excluded from schools who have SEN, the Committee recommended that the UK Government must monitor the impact of Section 33 of the Education Act on the fair and equitable provision of education in schools and take steps to remedy any harmful impact of this (JCHR, 2015).

In *X v Governors of a School [2015]* the Upper Tribunal decided that it was not discriminatory for a school to exclude a six-year-old child because of her tendency to physically abuse others. It concluded that such a tendency is excluded from the definition of disability under the Equality Act 2010 even if it arises as a result of a disability such as autism. That exclusion applies regardless of whether the person concerned is an adult or a child. The EHRC is concerned about this interpretation and that it may have a negative impact on disabled children if reflected in the DfE's 'Mental health and behaviour in schools' guidance due in March 2017, which is expected to clarify the issue.

From September 2012, the appeal process for permanent exclusions changed, with new Independent Review Panels replacing the previous Independent Appeals Panels. Where requested by a parent, an SEN expert can be appointed to advise the Independent Review Panel on the contribution of SEN to the exclusion, even if the school does not recognise the child as having SEN. The alternative route for appeals, the First-tier Tribunal (Special Educational Needs and Disability), is specifically for cases where parents feel that the exclusion was based on discrimination because of the child's disability. The Tribunal's remit has been extended from fixed-period exclusions to cover all exclusions.

The DfE's statutory guidance relevant to school exclusions states that: 'Head teachers should, as far as possible, avoid excluding permanently any pupil with a statement of SEN or a looked after child' (DfE, 2012).

Wales

The Welsh Government published guidance on exclusion from schools and pupil referral units in September 2012, which directly references that: 'The best interest of the child, in line with the UN Convention on the Rights of the Child, needs to be at the core of any decision to exclude and any subsequent exclusions procedures' (Welsh Government, 2015, p.24).

Scotland

A national working group was established in 2014 to update the Scottish Government's guidance on managing school exclusions (Scottish Government, 2011). The scope of the group includes exploring the management of exclusion and employment of readmission strategies, identifying issues relating to the recording of exclusion and readmission plans, and collating and sharing examples of best practice within

local authorities. In Scotland, as elsewhere, a local authority must still take steps to ensure that appropriate provision can be made to meet the learner's ASN during the period of exclusion.

Outcomes

Unless otherwise stated, the figures reported here, on children who have been excluded from school (either for a fixed period or permanently), are from analysis specifically for this report using pupil exclusion data from the Department for Education, Welsh Government and Scottish Government. See online data table CE2.10.

England

The exclusion rate[6] in England decreased for children with SEN between 2010/11 (135.2 per 1,000) and 2014/15 (130.8 per 1,000), reflecting an overall decrease across all children. The exclusion rate for children with no identified SEN increased during this time (from 19.4 per 1,000 to 22.9 per 1,000). This led to a narrowing of the gap between children with SEN and those with no identified SEN, which may be in part related to reforms resulting in a reduction in children classified as having SEN. Despite this, the exclusion rate in 2014/15 for children with SEN remained more than five times higher compared with children with no identified SEN.

Allowing for the combined effects of age, SEN, gender, ethnic group, Free School Meals, whether a native English speaker, and type of school (primary, secondary or special school), having SEN continued to have a substantial impact on the probability of being excluded[7] during the academic year and children in special schools had the highest probability of exclusion compared with primary and secondary school children. This was highest for 11-15-year-olds and lowest for the under-fives, and although the effect reduced slightly with age, having SEN increased the probability of exclusion for all age groups.

Boys and young men were more likely to be excluded than girls and young women and the effect of having SEN was also slightly larger for the former. Black children and those of Mixed ethnic group were more likely than White children to have been excluded, while Asian, Chinese and Other children were less likely to have been excluded. For both Asian and Black groups, having SEN slightly reduced the probability of being excluded, but this did not affect the overall ordering of the ethnic groups.

Being eligible for Free School Meals increased the probability of exclusion, while having SEN and being eligible for Free School Meals slightly decreased the effect of SEN. Exclusion was slightly more likely for native English-speaking children, although the gap was larger for children with SEN.

In 2014/15 pupils with identified SEN accounted for just over half of all permanent exclusions and fixed-period exclusions. Pupils with SEN support had the highest permanent exclusion rate and were over seven times more likely to receive a permanent exclusion than pupils with no SEN. Pupils with an Education, Health and Care plan or with a statement of SEN had the highest fixed-period exclusion rate and were almost seven times more likely to receive a fixed-period exclusion than pupils with no SEN (DfE, 2016h).

In 2013/14 boys with SEN had higher rates of exclusions than girls. Of those with a statement of SEN, 7.8% of boys received at least one fixed-period exclusion compared with 2.7% of girls. Boys with 'behaviour, emotional and social difficulty' had the

highest rate of exclusions – 19.2% of pupils with this type of need received at least one fixed-period exclusion compared with 1.9% of all pupils. Pupils with SEN were more likely than those without to be excluded due to physical assault against an adult (DfE, 2016i).

Wales

In Wales, comparing equivalent figures for maintained primary, middle, secondary and special schools, the overall exclusion rate[8] decreased from 32.3 exclusions per 1,000 pupils in 2011/12 to 29.9 per 1,000 in 2014/15. However, adding in pupil referral units to the 2014/15 data, this overall decrease vanished, while the rates for both children with SEN and those with no identified SEN both decreased between 2011/12 and 2014/15. Children with SEN saw a greater decrease (from 90.9 per 1,000 to 83.8 per 1,000), which led to a narrowing of the gap between children with SEN and those with no identified SEN.[9] Despite this, the exclusion rate in 2014/15 for children with SEN was around seven times that of children with no identified SEN (12 per 1,000).

Scotland

The exclusion rate per 1,000 pupils[10] in Scotland decreased between 2009/10 and 2014/15. This decrease was reflected for both children with any ASN and for those with no ASN. Children with any ASN saw a greater decrease (from 174.3 per 1,000 to 69.0 per 1,000), which led to a narrowing of the gap between children with any ASN and those with no ASN. Despite this, the exclusion rate in 2014/15 for children with any ASN remained more than four times higher compared with that of children with no ASN (16.1 per 1,000).

Boys and children living in areas of multiple deprivation are also more likely to experience exclusion from schools (Scottish Government, 2016).

3.3. Bullying in schools

Legal and policy framework

The UK Government provided more than £4 million to four anti-bullying organisations (BeatBullying, The Diana Award, Kidscape and the National Children's Bureau) to help schools develop strategies to tackle bullying. This includes £1.5 million for the National Children's Bureau to focus on children and young people with SEN (DfE and Edward Timpson MP, 2014).

England

Under the Education and Inspections Act 2006, schools in England have a statutory duty to prevent all forms of bullying among pupils, and head teachers can impose disciplinary sanctions to deal with unacceptable behaviour. There is a general duty on local authorities to cooperate with different bodies to ensure that the physical and mental health and emotional wellbeing of children is protected, under Section 10 of the Children Act 2004. This is a framework in which the child's welfare is central and schools must proactively deal with potential problems with bullying (DfE, 2014a).

The UK Government's updated guidance states that schools should take into account a pupil's Special Educational Needs and/or Disability (SEND) when administering punishment (in cases where a child with SEND is the perpetrator). Schools are also advised to invest in specialist skills for dealing with the needs of their pupils, including those with SEND (DfE, 2014).

Wales

The Education and Inspections Act 2006 also applies to Wales, but policy and operational matters are devolved. In 2011, the Welsh Government published 'Respecting others' (Welsh Government, 2011), a series of anti-bullying guidance that included bullying around Special Educational Needs and Disabilities.

The Welsh Government also established the All Wales Anti-Bullying Leadership Group to provide a strategic approach to tackling bullying and hate crime in schools and the wider community (National Assembly for Wales, 2014). As part of the Welsh Government's (2016g) 'Tackling hate crimes and incidents: framework for action', the group will support local authorities and schools on the implementation of recommendations by Estyn, the office of Her Majesty's Inspectorate for Education and Training in Wales, to schools and local authorities (Estyn, 2014).

A successful anti-bullying programme, KiVA, has been implemented in over 40 primary schools in Wales. Some of the material has been delivered through the personal, social, health and economic education (PSHE) curriculum, which is compulsory in Wales but not in England. The results of the pilot study (rolled out in 17 schools – 14 from Wales and three from Cheshire) across Years 5 and 6 showed a significant reduction in both victimisation and bullying (Hutchings and Clarkson, 2015).

Compared with England there is no general duty on the local authority to cooperate with different bodies to ensure the protection of physical and mental health and emotional wellbeing.

Scotland

There is no specific statutory duty in Scotland to prevent, monitor, or proactively deal with bullying, although it can form part of the duty to offer additional support for learning (Scottish Government, 2010) and education authorities are subject to the Public Sector Equality Duty.

There is a requirement on local authorities in Scotland, under Section 2A of the Schools (Health Promotion and Nutrition) (Scotland) Act 2007, to endeavour to ensure that schools are 'health promoting', which involves providing activities and an environment and facilities 'which promote the physical, social, mental and emotional health and wellbeing of pupils' (Scottish Government, 2010, p.6).

The Children and Young People (Scotland) Act 2014 has a provision to ensure that all children and young people have access to a 'named person', whose role is to work with them and their parents to promote, support and safeguard their wellbeing . Within the school setting, the named person, supported by other staff, will help to identify changes of mood or behaviour that could reflect a wellbeing issue that needs help or support for children as well as their families.

The Scottish Government continues to fund and support respect*me*, Scotland's anti-bullying service. The Scottish Advisory Group on Relationships and Behaviour in Schools provides advice at a local and national level on behaviour and relationships in schools. Education Scotland provides support and resources to develop anti-bullying strategies. This includes help to promote understanding of equality and inclusion, and tackle prejudice, through the curriculum.

A research report produced for the EHRC by LGBT Youth Scotland and respect*me* (Lough Dennell and Logan, 2015) made a number of recommendations in several areas of anti-bullying policy in Scotland, including:

- Review of local authorities' anti-bullying policies to check for alignment with the Equality Act 2010
- Implementation of effective systems to report bullying (and considering steps to enable this anonymously, discreetly or confidentially) and the involvement of young people in making decisions about appropriate action
- Monitoring and evaluation through surveys of pupils to capture experiences of bullying, and sharing of good practice
- Review of Scotland's national approach to anti-bullying.

Regarding the latter, the Scottish Government is in the process of updating its 2010 guidance to ensure that it remains current and reflects policy developments in line with the legal framework outlined in the Equality Act 2010, and captures findings from recent research, including the respect*me* study 'Bullying in Scotland' (respect*me*, 2014) and 'Behaviour in Scottish schools' research (Scottish Government, 2012b). After appearing in front of the Equalities and Human Rights Committee of the Scottish Parliament, the Education Secretary has agreed to review again the extent to which the recording of bullying and identity-based harassment could become a statutory requirement on all education authorities.

Urgent action is required for education authorities in Scotland to monitor school bullying based on disability, race, religion, gender and sexuality.

In a letter to the Education Secretary, the EHRC outlined evidence that suggests that bullying and harassment can lead to poorer attainment and attendance for pupils affected, and urged schools to monitor and record incidents to determine whether actions being taken are successful and to share information with local partners to gain a more complete picture of prevalence across the country. The Scottish Government acknowledged the inconsistency in the recording of incidents of bullying and the circumstances around them and committed to publishing an updated anti-bullying strategy (*The Scotsman*, 2016).

Outcomes

The evidence on bullying is relatively sparse, with the available evidence limited largely to surveys carried out by a variety of organisations. No government department collects regular data. The complexity of bullying also presents difficulties in identifying the cause of bullying and whether it relates to the protected characteristics.

England

Academic research published in 2016 found an association between SEND and being a victim of bullying in schools, suggesting that wider social inequalities are reproduced in schools (Chatzitheochari *et al.*, 2016).

On the basis of surveys carried out by the anti-bullying charity Ditch the Label (2015) the likelihood of being bullied can vary greatly by disability: 40% of children and young people with no disability reported being bullied. This compares with: 58% with a physical disability; 62% with a learning disability; 67% with autism/Asperger syndrome. Further survey research with almost 9,000 young people aged 12-20 across the UK shows 10% of respondents

had been bullied because of attitudes towards their disability (Ditch the Label, 2016).

Findings from the Longitudinal Study of Young People in England, involving a cohort of young people (those born in 1989/90 and at school in England), showed that in the period 2005-14 the proportion of Year 10 children who said they had been bullied declined from 41% to 36% (DfE, 2015). Young people from the cohort with SEN reported bullying more than young people without SEN (DfE, 2015a).

Wales

Estyn's review (2014) cites a range of estimates of the extent of bullying in Welsh schools: between 20% and 50% of pupils have experienced bullying at some point during their school years, with pupils with SEND at particular risk of being bullied. The review also drew attention to wide variations in pupils' experiences of bullying and schools' actions to deal with bullying, both between and within schools. Examples include: varying levels of understanding of what would count as a 'reportable incident' owing to no agreed definition of bullying that is understood by the school community as a whole; a lack of common understanding of the importance and legal implications of the protected characteristics under the Equality Act 2010; and a lack of specific understanding and action on bullying related to protected characteristics.

There were also a number of issues raised about strategic equality plans: they did not pay enough attention to the full range of protected characteristics and there was confusion over the difference between a disability equality plan and a strategic equality plan. There was also a lack of adequate training provided to school governors to enable them to fulfil their statutory responsibilities for monitoring the strategic equality plans. Local authorities provided schools with support when drawing up their strategic equality plans, but the level of ongoing support from local authorities, and from regional consortia for monitoring and progress tracking, was less comprehensive (Estyn, 2014) .

Scotland

Data on bullying is also not collected centrally in Scotland. The national approach to anti-bullying is that recording and monitoring of bullying incidents is essential, but best carried out locally where it can be understood and acted upon. However, research conducted for the EHRC in 2015 by LGBT Youth Scotland and respect*me* found that while 26 (out of Scotland's 32) local authorities' policies said that they recorded each incident, only 14 local authorities could provide evidence of how such reports were being monitored. The same research found that pupils who had been bullied were 20% less likely to report feeling safe at school, or that they felt supported, respected, included or simply happy (Lough Dennell and Logan, 2015).

3.4. Young people not in education, employment or training (NEET)

Unless otherwise stated, the figures reported here, on 16-18-year-olds who are not in education, employment or training (NEET), are from analysis specifically for this report using data from the Annual Population Survey. See online data table CE1.7.

Outcomes

GB

Between 2010/11 and 2015/16, the proportion of non-disabled 16-18-year-olds who were NEET decreased from

8.7% to 5.8%. The proportion of disabled 16-18-year-olds who were NEET (13.2%) was higher than for non-disabled 16-18-year-olds who were NEET (5.8%) in 2015/16. In 2015/16, those with mental health conditions were more likely to be NEET (20.3%) compared with non-disabled people (5.8%).

Allowing for the combined effects of age, disability, ethnic group, gender, religion, socio-economic group, whether in a couple, and region, being NEET was more common for 18-year-olds, young men, those with no religious affiliation and those in a couple.

England

Between 2010/11 and 2015/16, the proportion of non-disabled 16-18-year-olds who were NEET in England decreased from 8.4% to 5.7%. The proportion of disabled 16-18-year-olds who were NEET remained higher (12.6%) compared with non-disabled people (5.7%) in 2015/16. In 2015/16, a high percentage of those with mental health conditions were NEET (18.9%) compared with non-disabled people.

Wales

Between 2010/11 and 2015/16, there was no change in the proportion of 16-18-year-olds who were NEET in Wales, for disabled or non-disabled people. In 2015/16, a greater proportion of disabled 16-18-year-olds were NEET (17.9%[11]) compared with non-disabled (6.7%), with a high percentage of those with mental health conditions being NEET (27.7%) compared with non-disabled people.

Scotland

Between 2010/11 and 2015/16, the proportion of non-disabled 16-18-year-olds who were NEET in Scotland decreased from 11.5% to 6.9%. The proportion of disabled 16-18-year-olds who were NEET (17.2%[12]) was higher than for non-disabled people (6.9%) in 2015/16. In 2015/16, a high percentage of those with mental health conditions were NEET (28.8%) compared with non-disabled people.

3.5. Educational qualifications for adults

Legal and policy framework

England and Wales

In December 2015 the Department for Business, Innovation and Skills (BIS) announced significant cuts to the higher education Disabled Students' Allowance. The fund enables those with access requirements to attend university by providing financial support to help meet extra costs, for example specialist equipment or non-medical helper allowances. It is expected that education providers will now take responsibility for financing the necessary adjustments (Parliament, 2015).

In its equality analysis of the cuts to the Disabled Students' Allowance, BIS acknowledged that if individual institutions do not take responsibility for meeting the needs of disabled students then these students will be put at a disadvantage (BIS, 2015). Responding to the planned changes, the EHRC expressed concern that the proposed changes to the Disabled Students' Allowance system could have a significant negative impact on how disabled people access, participate and succeed in higher education, so affecting their employment opportunities and economic productivity (EHRC, 2015a).

In March 2016, Ofsted stated that local authorities and further education providers were failing to effectively implement the Children and Families Act 2014 and that the support received by 'high needs' learners

aged 16 and over varied considerably. According to the report, nearly half of the providers visited by Ofsted did not have adequate strategies, experience or expertise to support disabled learners. In addition, careers guidance was inadequate, too many learners were on programmes with unsatisfactory outcomes (leading neither to employment nor further learning opportunities) and progress was slow in English and maths (Ofsted, 2016).

Scotland

The Scottish Government has promised that: 'Every adult in Scotland will have the right to access learning to meet their educational needs and their aspirations. Barriers to participation, learning and achievement will be removed and inclusion and equality promoted' (Scottish Government, 2014, p.1). However, an earlier report on improving the lives of people with learning disabilities noted the cuts to college places that had taken place, and urged colleges to become more accessible for those with profound and multiple learning disabilities (Scottish Government, 2013).

Scotland's youth employment strategy acknowledges that young disabled people are much more likely to experience difficult transitions through education and to be unemployed after they leave education. The strategy puts forward several recommendations to improve disabled people's prospects for employment, including to support and encourage employers who hire young disabled people (Scottish Government, 2014a). The Scottish Government will continue to provide Disabled Students' Allowance.

Outcomes

Unless otherwise stated, the figures reported here, on people aged 25-64 with no qualifications and with degree-level qualifications, are from analysis specifically for this report using data from the Annual Population Survey. See online data tables EE2.1 and EE2.2.

GB

Between 2010/11 and 2015/16, the proportion of both disabled and non-disabled 25-64-year-olds with no qualifications decreased. The proportion of disabled people with no qualifications was higher (18.0%) than that of non-disabled people (6.4%) in 2015/16, although the gap between these groups had narrowed since 2010/11. In 2015/16 (as well as in 2010/11), those with 'learning difficulties or disabilities' (49.2%) were most likely to have no qualifications.

Allowing for the combined effects of age, disability, ethnic group, gender, religion, socio-economic group, whether in a couple, and region, the proportion with no qualifications increased with age and was higher for disabled than for non-disabled people in all age groups. By gender, non-disabled women were more likely than men not to have qualifications, but the effect of disability was greater for men and the gender difference was reversed for disabled people. By ethnic group, Pakistani and Bangladeshi people and those in the 'Other' group were more likely not to have qualifications, while the effect of disability was greater for the Indian, Pakistani and Bangladeshi ethnic groups. Having no qualifications was least common in the Christian group and most common for people with a religious minority affiliation, however the effect of disability was less for this latter group.

Between 2010/11 and 2015/16, the proportion of both disabled and non-disabled people aged 25-64 with degree-

level qualifications increased, but the proportion of disabled people remained lower (18.7%) than that of non-disabled (35.3%) in 2015/16 and the gap increased over that period. In 2015/16, those with 'learning difficulties or disabilities' had the lowest percentage (7.4%) and were the only group not to see an increase since 2010/11.

Allowing for the combined effects of age, disability, ethnic group, gender, religion, socio-economic group, whether in a couple, and region, degree qualifications decrease with age, however the gap between disabled and non-disabled people is slightly greater for the 25-34 and 35-44 age groups than for the older age groups. White non-disabled people were least likely to have a degree-level qualification, but for disabled people it was the Pakistani and Bangladeshi groups that had the fewest degree qualifications, followed by White disabled people. By religion, both disabled and non-disabled people with a Christian affiliation were least likely to have a degree-level qualification, while among disabled people those with a religious minority affiliation were most likely to have a degree-level qualification.

England

Between 2010/11 and 2015/16, the proportion of both disabled and non-disabled 25-64-year-olds in England with no qualifications decreased. The proportion of disabled people with no qualifications was higher (17.4%) compared with that of non-disabled people (6.3%) in 2015/16, although the gap between these groups had narrowed since 2010/11. In 2015/16 (as well as in 2010/11), those with 'learning difficulties or disabilities' (48.6%) were most likely to have no qualifications.

Between 2010/11 and 2015/16, although the proportion of both disabled and non-disabled people aged 25-64 in England with degree-level qualifications increased, the proportion of disabled people remained lower (18.9%) compared with that of non-disabled (35.6%) in 2015/16 and the gap had increased since 2010/11. In 2015/16, those with 'learning difficulties or disabilities' (7.1%) were least likely to have a degree-level qualification and those with a 'progressive health conditions' were most likely (23.4%).

Proportion of people **with no qualifications** in 2015/16

Wales

Between 2010/11 and 2015/16, the proportion of both disabled and non-disabled 25-64-year-olds in Wales with no qualifications decreased, and the proportion of disabled people with no qualifications was higher in 2015/16 (21.3%) compared with that of non-disabled people (7.6%). In 2015/16, those with 'learning difficulties or disabilities' (48.5%) were most likely to have no qualifications.

Between 2010/11 and 2015/16, although the proportion of both disabled and non-disabled people aged 25-64 in Wales with degree-level qualifications increased, the proportion of disabled people with no qualifications remained lower (15.5%) compared with that of non-disabled (30.9%) in 2015/16. Only those with a 'mental health condition' or 'physical disabilities' have seen a similar increase to non-disabled people, although to much lower percentages (13.0% and 13.4% respectively).

Scotland

Between 2010/11 and 2015/16, the proportion of both disabled and non-disabled 25-64-year-olds in Scotland with no qualifications decreased. The proportion of disabled people with no qualifications remained higher (22.5%) compared with that of non-disabled people (6.8%) in 2015/16. In 2015/16, those with 'learning difficulties or disabilities' (56.4%) were most likely to have no qualifications.

Between 2010/11 and 2015/16, although the proportion of both disabled and non-disabled people aged 25-64 in Scotland with degree-level qualifications increased, the proportion of disabled people remained lower (18.3%) compared with that of non-disabled (34.6%) in 2015/16 and this gap had increased since 2010/11.

Data gaps

More information is needed about the extent and nature of bullying regarding children with SEN, ASN and disabilities, particularly the different issues faced by those with specific impairments. There is also less evidence on what causes the high exclusion rate of children with SEND and ASN and how this can be tackled.

In England and Wales, the effectiveness of the new Education, Health and Care plans is not fully clear. There are also concerns that many children without a formal plan, but with some sort of need, are not being properly supported.

Research is needed to identify the causal links between disability and NEET status among young people.

In Scotland, the National Improvement Framework for Education focuses on improving data collection, including assessing children's performance throughout their school career. However, there is no commitment to collect data and evidence about the educational performance of disabled children and young people.

"47.6% of disabled adults are in employment compared with 79.2% of non-disabled people in 2015/16 in Britain"

4. Work

This chapter is concerned with the opportunity for individuals to undertake paid work and how disabled people engage with the labour market, including levels of employment and unemployment, as well as pay. Some disabled people will not be able to work, but are nevertheless entitled to an adequate standard of living and social protection. Thus this chapter looks at how disabled people interact with the welfare state and, in particular, the impact of welfare reforms.

Four specific indicators were chosen to assess how well disabled people's rights relating to work, income and the economy are protected in Britain. These are:

1. Access to work, employment and unemployment
2. Access to apprenticeships
3. Earnings
4. Welfare reforms

This chapter covers government responsibilities that are reserved (for example, employment law) and others that are devolved (for example, modern apprenticeships) in England, Wales and Scotland. Where a matter is devolved, we cover the legal and policy framework separately for England, Wales and Scotland. Where a matter is reserved, we present the legal and policy framework for Britain as a whole.

4.1. Access to work, employment and unemployment

Legal and policy framework

GB

In 2013, the UK Government introduced a disability and health employment strategy (DWP, 2013) with proposals to reform employment support for disabled people and those with health conditions. The UK Government also convened a cross-government Health, Work and Wellbeing initiative to improve the health and wellbeing of the working population and support those with health conditions in and into work. There are a number of policies and reformed benefits including:

- Work Choice – introduced in October 2010, a specialist employment programme for disabled people offering three levels of help: work entry; in-work support for up to two years; and longer-term in-work support.
- Access to Work – introduced in June 1994, a publicly-funded employment support programme that provides practical and financial support for people who have a disability or long-term physical or mental health condition.

The evaluation of Work Choice in July 2013 showed those involved reported a positive impact on the participants' ability to secure and maintain employment. However, there were concerns about reduced access to the programme for those with the highest support needs. For example, although Work Choice had been set up to support disabled people with the highest support needs into employment, most of those recruited to the scheme were disabled people claiming mainstream Jobseeker's Allowance rather than the specialist schemes designed for disabled people claiming Employment and Support Allowance. According to reports: 'Only the most severely ill or impaired get onto Employment and Support Allowance in the first place, from which they face conditionality and sanctions and next to no chance of getting the "specialist" help that's apparently available through Work Choice' (Disability News Service, 2015; Hale, 2014). The Department for Work and Pensions (DWP) altered its guidance to address this but the evaluation suggests this has had limited impact on practice (DWP, 2013).

In the 2015 Spending Review, the UK Government announced its intention to combine the Work Programme[13] and Work Choice into a single Work and Health Programme from 2017. The House of Commons Work and Pensions Committee recommended that the UK Government retain a separate, voluntary, expanded employment programme and that specialist organisations should continue to deliver it (HoC Work and Pensions Committee, 2015).

In November 2016, the UK Government published a Green Paper, 'Work, health and disability: Improving lives', which sets out proposed reforms to: improve support for disabled people and people with health conditions; explore the roles of employers; reduce the disability employment gap; and promote integration across health and employment. The paper acknowledges systemic issues with the original design of Employment and Support Allowance and that some are treated in a 'one-size-fits-all' way and get little practical support from Jobcentre Plus to help them into work. It sets out an extensive package of proposals for consultation, focusing on areas needing change to make systems work better, including:

- introducing a new Personal Support Package offering tailored employment support through Jobcentre Plus work coaches to help disabled people or people with health conditions.
- exploring whether breaking the link between cash entitlement and Jobcentre Plus support would lead to a more personalised offer of support, rather than this being decided by the category an individual is placed in following their Work Capability Assessment (DWP and DH, 2016).

From 2013 to 2014, Access to Work spent £108 million to help 35,540 disabled people enter or remain in work, over 4,000 more than in 2012 to 2013. Reviews have found the scheme to be cost effective, with positive benefits including increased productivity and staff retention and reduced sickness absence. However, reviews also found low awareness of Access to Work among employers and concerns from some customers[14] that the scheme focused support on those with physical impairments rather than more complex or invisible conditions such as mental health (Sayce, 2011; Dewson *et al.*, 2009).

In 2012, the UK Government accepted the Sayce (2011) review recommendations that Access to Work should be made available more widely, and that funding should be increased as resources were released from the reform of less effective programmes. However, in March 2015, the Minister for Disabled People announced that grants would be limited to one and a half times the average salary (£40,800 at current rates) but would provide users with more freedom over how they use this. The DWP estimated that capping individual awards would save £3 million per year by 2018, which could be used to expand the scheme and fund 1,000 average Access to Work users or 3,000 places on the Workplace Mental Health Support Service. The Access to Work cap will mean some of the cost of support may fall back on employers with 'a risk that this may discourage employers from employing disabled people, increasing the likelihood of unlawful discrimination and reducing equality of opportunity' and would largely affect those with a hearing impairment (DWP, 2015b, p.12). The DWP has committed to 'take steps to monitor the impact and will consider if further flexibilities are required should an adverse impact be found' (DWP, 2015b, p.12).

Further concerns about disabled people's access to work revolve around what employers are doing to improve access:

- The Business Disability Forum report on retaining and developing employees with disabilities outlines aids and barriers to retaining and developing disabled employees, for example, a lack of skilled and confident line managers, and notes a lack of targeted development opportunities and not enough awareness of disability in the workplace (Selvanera and Whippy, 2015).
- The Disability Confident scheme was launched by the UK Government in 2013 to support employers to open up work opportunities for disabled people.
- The UK Government has published guidance to help employers become more confident when attracting, recruiting and retaining disabled people and people with mental health conditions (DWP, 2014).
- A new 'small employer offer' with tailored employment support and a new Disability Confident self-assessment accreditation scheme for employers to replace the 'two ticks positive about disability' symbol[15] were being piloted in 2016. The DWP

has recognised the need to make the new scheme more dynamic and effective than its predecessor (*Recruiter,* 2014).

- There are also indications that spending on employment support for those with a mental health condition and/or a learning disability by local authorities and the NHS has levelled off. This may even be declining after a period of growth in recent years (NDTi, 2014; British Association for Supported Employment, 2014).[16]
- Advisory, Concilation and Arbitration Service (Acas, 2015) launched a guide to help employers identify, tackle and prevent disability discrimination in the workplace. There is evidence that the reasonable adjustments duty and other disability employment protections are often breached (Adams and Oldfield, 2012) and a number of reports suggest that employment protection reform is having the effect of encouraging some employers to take their legal obligations less seriously in relation to disabled workers (Harwood, 2015).

In its 2015 manifesto, the UK Government set out its aim, as part of its objective to achieve full employment, to halve the disability employment gap and transform policy, practice and public attitudes (Conservative Party, 2015). The UK Government has a commitment to bring approximately 1.2 million disabled people into work by 2020. However, despite research showing that the employment gap was narrowing between disabled and non-disabled people, Scope (2015) and the TUC (2016) state that the UK Government is years behind this target and claim it would not be reached until 2030. A Resolution Foundation report claimed that 1.5 million disabled people (aged 16-64) would need to find employment to meet the 2020 target. The report also stated the focus of support and existing programmes has been on those individuals out of work, rather than supporting those already in work to remain employed (Gardiner and Gaffney, 2016).

Despite requests from the House of Lords, the DWP declined to release an annual report on the progress the UK Government has made in addressing its target of halving the disability employment gap by 2020 (Disability Wales, 2016). However, an inquiry into the UK Government's commitment was launched by the House of Commons Work and Pensions Committee in March 2016, and its report was published on 23 January 2017 (HoC Work and Pensions Committee, 2016). The report welcomed the UK Government's new focus on work, where appropriate, for disabled people, but emphasised the need for employers to open opportunities to disabled people and the need to enhance in-work support, with some disabled people still being left behind in the labour market. The report also called for the UK Government to produce a disability employment strategy that would bring together and develop initiatives from across departments, and highlighted the risk of plans to lower benefits to some claimants in the ESA Work-Related Activity Group, negatively affecting disabled people's quality of life and likelihood of moving into work.

In Wales, the 2013 Framework for Action on Independent Living set out the targets around increasing employment for disabled people. Objectives include: continuing the Welsh Government Placement Scheme for disabled people; exploring opportunities to further align programmes, and raising awareness of specialist provision to maximise positive outcomes for disabled people and employers (through the Welsh Government and Department for Work and Pensions Joint Employment Delivery

Board); continue to raise awareness of autism with employers and provide information on the support that is available for disabled people with autism and their employers in the workplace (through the Autistic Spectrum Disorder Employment Ambassador) (Welsh Government, 2013).

The 'Tackling Poverty Action Plan' also includes a range of actions that will impact on disabled people in Wales, including investing in support for disabled children, tackling barriers to employment and mitigating the impact of poverty on communities, families and individuals (Welsh Government, 2015a).

Employment support programmes for disabled people were devolved to Scotland as part of the most recent devolution settlement and will be delivered by the Scottish Government from 1 April 2017. The Convention of Scottish Local Authorities Supported Employment Framework in Scotland aims to improve access to work outcomes for disabled people with a more person-centred approach, and focuses on how to support disabled people into sustainable work in mainstream employment, at both a national and a local level. The Framework also recognises that Scotland has to work within existing UK employment programmes run by the DWP to avoid duplication (COSLA, no date).

In October 2015, the Scottish Government invested £163,400 to remove the barriers that young disabled people face. Scotland's Youth Employment Strategy included a recommendation to develop a better understanding of the issues employers face in taking on young disabled people. The Scottish Chambers of Commerce pledged to work with employers to identify the barriers and then work with other stakeholders to help break them down (Scottish Government, 2016a).

Outcomes

Access to work

Between June 2011 and March 2016, around 37,000 Employment and Support Allowance claimants were referred to the UK Government's main welfare to work scheme, the Work Programme, where non-disabled people (35%) were more likely than disabled people (18%) to receive a job outcome. Between October 2010 and March 2016, there were 126,000 referrals to Work Choice, while between April 2007 and December 2015, 132,740 people

Number of people who get a job through the Work Programme

were assisted through Access to Work. The number of individuals assisted by the scheme increased slightly between 2013/14 and 2014/15 (Clarke, 2016).

The EHRC's 2012 study (Adams and Oldfield, 2012) reported that employers were making assumptions about disability or underestimating the capabilities and contribution of disabled people. Further barriers mentioned include inflexibility about work patterns and restrictions on leave or breaks, and a lack of awareness about how some of these challenges can be addressed.

In 2014, Mind reported that since 2011 only 5% of the Employment and Support Allowance Work-Related Activity Group[17] has moved into work via the Work Programme. The target during this time was 16.5% after two years. Demoralisation and increased distance from the labour market were just two of the effects of this highlighted by the individuals in this group (Hale, 2014).

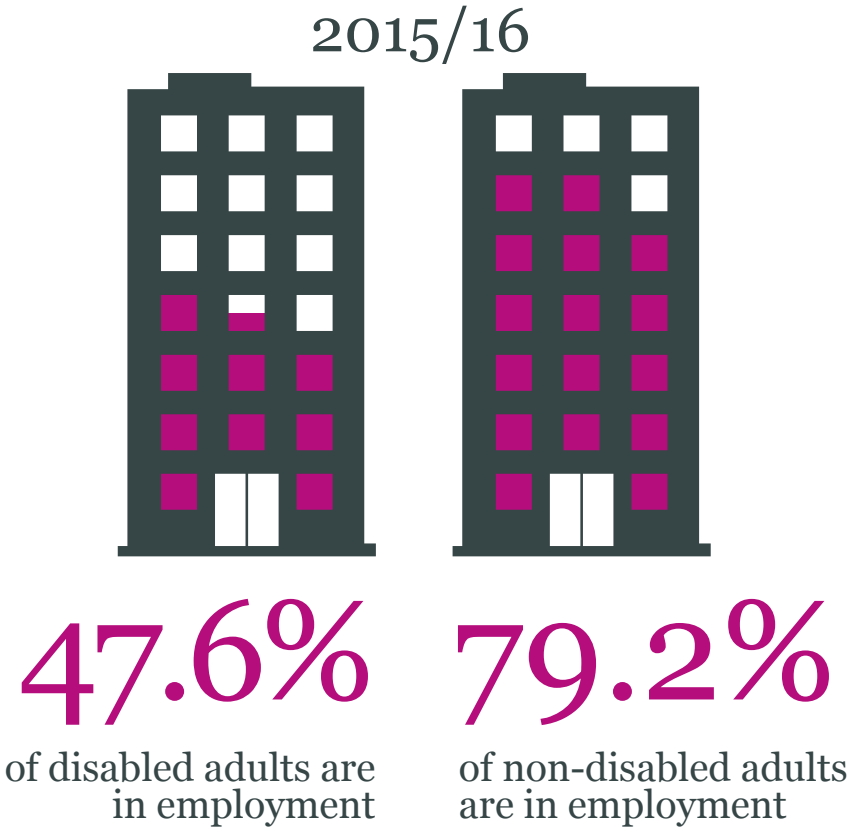
TUC research (2015) has found that disabled people with invisible impairments, such as mental health conditions, are often overlooked for employment or put at disadvantage because of ignorance about their conditions. Not only are these individuals not viewed as being disabled and may face discrimination, but they may also face challenges when it comes to obtaining reasonable adjustments as a part of their employment. As a consequence, many are discouraged from coming forward (TUC, 2015a).

Employment and unemployment

Unless otherwise stated, the figures reported here, on working-age adults (16-64 years) in employment, are from analysis specifically for this report using data from the Annual Population Survey. See online data table EG1.1.

GB

Between 2010/11 and 2015/16, there was an increase in the proportion of both disabled and non-disabled adults in



employment. Despite this, the proportion of disabled adults in employment remained lower (47.6%) compared with that of non-disabled people (79.2%) in 2015/16, and the gap between these groups had widened since 2010/11. This is not the case across all impairment types, and for those with 'mental health conditions' and those with 'physical disabilities' the gap between them and non-disabled people had narrowed during this time. In 2015/16, the employment rate was lowest for those with 'learning difficulties or disabilities' (19.9%).

Allowing for the combined effects of age, disability, ethnic group, gender, religion, socio-economic group, whether in a couple, and region, the employment rate in 2015/16 was lower for non-disabled 55-64-year-olds and disabled people aged 25-54, and lowest for disabled 55-64-year-olds. Non-disabled people in all ethnic groups (apart from the Indian group) had a lower employment rate than White people, while disabled Pakistani and Bangladeshi people had the lowest employment rate overall.

Between 2001 and 2012 UK employment trends for disabled people were largely driven by more disabled people remaining in the workforce. There was an increase in the employment rate[18] for disabled people over the age of 50 (from 34.9% in 2001 to 41.7% in 2012), and trends in quarterly flows showed the number of people in employment aged over 50, who acquire a disability and remain in employment, increased by 160,000 (58%) since 2001 (Office for Disability Issues, 2012).

Disabled people who have had more than a year out from the workforce are much less likely than their non-disabled counterparts to be able to re-enter employment. Only 2.4% of disabled people in this situation do so in any one quarter, compared with 16% of non-disabled people (Gardiner and Gaffney, 2016).

A report published by the National Autistic Society has called on employers to help close the 'autism employment gap', after revealing that only 16% of those with autism are in full-time paid work. The research also highlighted that just 32% are in some kind of paid work, compared with 47% of disabled people overall and 80% of non-disabled people. Four in 10 of those with autism say they have never worked, despite three-quarters stating that they want to and are willing to work (NAS, 2016).

England

Between 2010/11 and 2015/16, there was an increase in the proportion of both disabled and non-disabled adults in employment in England. Despite this, the proportion of disabled adults in employment remained lower (48.6%) compared with non-disabled people (79.2%) in 2015/16, and the gap between these groups had widened since 2010/11. This is not the case across all impairment types, and for those with 'mental health conditions' and those with 'physical disabilities' the gap with non-disabled people had narrowed during this time. In 2015/16, the employment rate was lowest for people with 'learning difficulties or disabilities' (20.5%).

Wales

Between 2010/11 and 2015/16, there was an increase in the proportion of both disabled and non-disabled adults in employment in Wales. Despite this, the proportion of disabled adults in employment remained lower (42.6%) compared with non-disabled people (78.1%) in 2015/16, and the gap between these groups had widened since 2010/11. This is not the case across all impairment types, and for those with 'physical disabilities' the gap with non-disabled people had narrowed during this time. However, the employment rate was

lowest for those with 'learning difficulties or disabilities' (18.7%) in 2015/16 compared with non-disabled adults.

Scotland

Between 2010/11 and 2015/16, there was an increase in the proportion of non-disabled adults in employment in Scotland but this was not reflected among disabled adults. The gap between disabled and non-disabled adults widened during this time, and the proportion of disabled adults in employment remained lower (41.8%) compared with non-disabled (79.6%) in 2015/16. This is not the case across all impairment types, and for those with 'mental health conditions' or 'physical disabilities' the gap with non-disabled people narrowed during this time. In 2015/16, the employment rate was lowest for those with 'learning difficulties or disabilities' (15.3%).

Whereas the gap in employment rates has stayed relatively constant in recent times, the gap in unemployment rates[19] between disabled and non-disabled people has recently increased. Unless otherwise stated, the figures reported here, on the economically active population (aged 16-64) who are unemployed, are from analysis specifically for this report using data from the Annual Population Survey. See online data table EG1.2.

GB

Between 2010/11 and 2015/16, there was a decrease in the proportion of economically active non-disabled people who were unemployed. The gap between disabled and non-disabled people widened during this time, and the unemployment rate was higher for disabled people (10%) compared with non-disabled people (4.6%). The unemployment rate was high for those with 'learning difficulties or disabilities' (26.1%) and decreased for those with a 'mental health condition' or 'physical disabilities'.

Allowing for the combined effects of age, disability, ethnic group, gender, religion, socio-economic group, whether in a couple, and region, in 2015/16 disabled men had a high unemployment rate compared with women and non-disabled men. By religion, the unemployment rate was highest for disabled people with no religious affiliation and for non-disabled people with a religious minority affiliation.

England

Between 2010/11 and 2015/16, there was a decrease in the proportion of economically active non-disabled people in England who were unemployed. The gap between disabled and non-disabled people widened during this time, and the proportion of economically active disabled people who were unemployed remained higher (9.7%) compared with non-disabled people (4.5%). Those with 'learning difficulties or disabilities' (25.3%) were particularly likely to be unemployed in 2015/16 compared with non-disabled people.

Wales

Between 2010/11 and 2015/16, there was a decrease in the proportion of economically active non-disabled people in Wales who were unemployed, but not for disabled people. The gap between disabled and non-disabled people widened during this time, and the proportion of economically active disabled people who were unemployed remained higher (10.5%) compared with non-disabled people (4.8%).

Scotland

Between 2010/11 and 2015/16, there was a decrease in the proportion of economically active non-disabled people in Scotland who were unemployed, but not for disabled people. The gap between disabled and non-disabled people widened during this time, and the proportion of economically active disabled people who were unemployed

remained higher (12.2%) compared with non-disabled people (4.9%).

Unemployment is associated with specific impairments and a worsening of mental health conditions (Davies, 2014). In particular:

- Being out of work was a particular challenge for those with a mental health condition, with a rising number of working days lost to mental health conditions. England's Chief Medical Officer's report for 2013 stated that 60-70% of disabled people with common mental health conditions such as depression and anxiety are in work (Davies, 2014).
- The UK unemployment rate for disabled people with a severe mental health condition is four times that of people with no condition, and the rate for more common mental health conditions is double that of people with no condition (OECD, 2014).
- Those whose choices have been constrained by illness, disability or perceived inability to get a full-time job have lower average personal wellbeing (ONS, 2013; 2013a).

Particular patterns are apparent for young disabled people:

- Young disabled people are more likely to leave education and become unemployed than their non-disabled peers. The employment rate gap between disabled and non-disabled people increases from around the age of 21 or 22 and by 25 has reached the average level for adults (ODI, 2012).
- However, having a degree-level qualification can significantly improve employment outcomes. In 2009/10, 60% of disabled graduates were in employment six months after graduating, compared with 65% of non-disabled graduates (ODI, 2012).

4.2. Access to apprenticeships

Legal and policy framework

Access to apprenticeship programmes varies across Britain. In England, apprenticeships are paid positions for those aged 16 and above, with a minimum of 30 hours a week and 20 days' paid holiday, plus bank holidays. An apprentice is entitled to the National Minimum Wage, calculated at a specific rate for apprentices aged 16 to 18, and those aged 19 or over who are in their first year.[20] All other apprentices are entitled to the minimum wage for their age (National Minimum Wage for those under 25 or the National Living Wage for those 25 or over).

The gaps between disabled and non-disabled people in their ability to obtain apprenticeships have been highlighted by monitoring bodies and NGOs. The EHRC (2012d) recommended that the DfE and BIS should explore how apprenticeships can be better opened up to disabled people.

The UK Government aims to create three million apprenticeships in England by 2020. In May 2016 several government departments, including the DfE, created a taskforce to improve the accessibility of apprenticeships, in particular for people with a learning disability (Gov.uk, 2016). The aims of the taskforce are: to reach an understanding of the issues and barriers that affect people with learning disabilities in accessing and completing an apprenticeship; to identify solutions that could help overcome these barriers and raise participation levels; and to make recommendations to both the Minister for Disabled People and the Minister for Skills on which options to pursue (Maynard, 2016).

The Scottish Government remains committed to delivering at least 30,000 Modern Apprenticeship starts each year from

2020 and a target of 26,000 new modern apprentices has been set for the year 2016/17. Its draft delivery plan for 2016-20 states it will encourage employers to take on modern apprenticeships and increase representation, for example, through work on the Developing the Young Workforce strategy. The Equalities Action Plan for Scotland addresses equalities issues across the Modern Apprenticeship programme, including specific improvement targets for participation among disabled people (Skills Development Scotland, 2015). The Employers' Equality Action Fund is also supporting seven projects aiming to reduce under-representation (Skills Development Scotland, 2016a).

Since July 2016, employers are able to have their say on how Scotland and Wales should use their share of the funding from the UK Government's apprenticeship levy[21] and employers stated, through the Scottish Government consultation, that Scotland's share of funding from the levy should be used to support the delivery of 30,000 Modern Apprenticeship starts by 2020 (Scottish Government, 2016b). The Scottish Government, industry representatives and the newly established Scottish Apprenticeship Advisory Board will meet to discuss the outcome of the consultation and how the levy will be spent in Scotland ahead of the Scottish Government's budget proposals for 2017/18 being published in the draft budget. The National Training Federation for Wales has called for a commitment that all money raised by the levy is fairly distributed across the UK for employers to spend on apprenticeships (*Campaign,* 2016).

The Minister for Education and Skills in Wales asked Estyn to carry out a two-year review (Estyn, 2015) into barriers to apprenticeships arising from any difficulties experienced by learners from ethnic minority groups and those with disabilities when entering apprenticeship programmes. Findings informed further development of the Welsh Government's equality and diversity guidance for work-based learning providers. In September 2016, the Welsh Government committed to a minimum of 100,000 quality, all-age apprenticeships, to be delivered over the next five years (Welsh Government, 2016a).

Outcomes

England

In the 2014/15 academic year, 499,900 apprenticeship programmes were started, compared with 440,400 in 2013/14; it was the first year since 2011/12 in which apprenticeship numbers increased. In 2014/15, 90% (449,140) of all apprenticeships were started by learners without any learning difficulty or disability. In contrast, 44,090 (9%) of apprenticeship starters were disabled learners (1% not known); an increase of 16% since 2013/14 (SFA and BIS, 2016).

Wales

In the 2014/15 academic year, 44,060 apprenticeship programmes were started, compared with 51,550 in 2013/14; this is the lowest recorded (previously this was 2012/13 with 44,815).

In 2014/15, 98.6% (43,425) of all apprenticeships were started by learners without any learning difficulty or disability. In contrast, 575 (1.3%) of apprenticeships were started by disabled learners (Statistics for Wales, 2016).

Estyn (2015) identified the barriers that prevent learners with disabilities from engaging in apprenticeship programmes. These include: lack of awareness of apprenticeships by parents, employers and learners themselves; few apprenticeship role models from disabled groups; difficulties in finding suitable work placements, especially where employers

believe there will be a need to provide additional support for learners; real or perceived discrimination; and available support for learners not being accessed or fully utilised. The report also identified that, although the majority of providers have good arrangements to ensure compliance with the Equality Act 2010, they are unable to show that this translates into measurable improvement in reducing barriers or stereotyping.

Scotland

Analysis of Modern Apprenticeships undertaken by the EHRC showed uptake increased in 2011/12 (26,427), yet this increase was not seen in the number of disabled apprenticeships that were started (EHRC, 2013d). Data from Skills Development Scotland shows that in the second quarter of 2015, 7.6% of apprenticeship starters had a disability compared with 0.3% in 2012 (Skills Development Scotland, 2016).

4.3. Earnings

Legal and policy framework

The National Minimum Wage Act 1998 provides employees with protection from exploitative wages.[22] The UK Government is responsible for setting the National Minimum Wage each year and HM Revenue and Customs (HMRC) enforces this on behalf of the Department for Business, Innovation and Skills (BIS, 2013). The departments work together with unions, business representatives and others to ensure implementation of the National Minimum Wage compliance strategy is informed by their knowledge of what is happening in the workplace (BIS, 2013).

The UK Government's National Living Wage was introduced on 1 April 2016 for all working people aged 25 and over.[23] Contracts for payments below the minimum wage are not legally binding. The worker is still entitled to the National Minimum Wage or National Living Wage. Workers are also entitled to the correct minimum wage if they are part-time, casual workers, agency workers, workers and homeworkers paid by the number of items they make, apprentices, trainees, workers on probation, disabled workers, agricultural workers, foreign workers, seafarers and offshore workers.

The Equality Act 2010 provides a right to equal pay between men and women[24] and prohibits direct and indirect discrimination in pay because of protected characteristics. The EHRC's (2015e) core guidance on pay and benefits explains what the Act means by pay discrimination.

For Scotland, Section 149 of the Equality Act 2010 (the Public Sector Equality Duty), and the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 as amended, require each listed Scottish public authority to gather and use employee information on the recruitment, development and retention of disabled staff. Listed authorities must also publish an equal pay statement, including information on occupational segregation.[25] The first equal pay statements in relation to disability are due to be published no later than April 2017 (EHRC, 2016).

The Welsh Specific Public Sector Equality Duties include duties in relation to pay differences. There is a requirement to publish a gender pay objective or justify why a public sector organisation has not published one. However, there is no duty to specifically justify why a pay objective has not been set on any characteristic other than gender. Similarly, annual equality reports from public sector organisations tend to report on the gender pay difference, given the explicit requirement to do so, but

not the disability pay gap. This relates to the lack of evidence referenced in the Welsh Government annual equality report, which states: 'When it comes to pay differences for disabled people, we are constrained by the availability of Wales-specific data' (Welsh Government, 2015b, p.45).

Outcomes

Unless otherwise stated, the figures reported here, on pay gaps in median hourly earnings of employees (2015/16 prices), are from analysis specifically for this report using data from the Annual Population Survey. See online data table EG2.2.

GB

Between 2010-11 and 2015-16, the median hourly earnings for disabled and non-disabled employees decreased by 8.8% and 1.2% respectively. This decrease was particularly high for those with 'mental health conditions' and those with 'vision impairments', with decreases of 11.9% and 11.3%, respectively. The gap in median hourly earnings between disabled and non-disabled employees widened during this time, with median hourly earnings for disabled employees remaining lower (£9.85) compared with non-disabled employees (£11.41) in 2015-16. In 2015/16, the gap in median hourly earnings was widest for those with 'learning difficulties or disabilities' (36.0%), while disabled people with 'progressive health conditions' earned about the same as non-disabled employees.

Allowing for the combined effects of age, disability, ethnic group, gender, religion, socio-economic group, whether in a couple, and region, median hourly earnings in 2015/16 were lowest in the 16-24 age group, followed by the 25-34 age group for both disabled and non-disabled people; they were highest for non-disabled men and lowest for disabled women.

An EHRC report on pay gaps (Longhi, forthcoming) explores the differences in pay between disabled and non-disabled workers, drawing on Labour Force Survey data between 1997 and 2014. It identifies the characteristics that explain those differences, such as age, occupation and level of education (although discrimination

median hourly earnings 2015-16

Disabled people

£9.85

Non-disabled people

£11.41

should also be considered as an influence). Key findings include:

- The disability pay gap in the period 1997-2014 was 13% for disabled men and 7% for disabled women compared with non-disabled men and women, respectively.
- The size of the pay gap varies depending on the exact nature of the disability. The pay gaps for those with neurological conditions, mental health conditions or learning difficulties tend to be large.
- The pay gaps for those with physical impairments are substantial. Men with physical impairments experience pay gaps in the range of 15% to 28%, depending on the nature of the disability, and women with physical impairments experience pay gaps in the range of 8% to 18%.
- The extent to which a disability affects daily activities and work has a bearing on the size of pay gaps. Those with an activity and work-limiting disability tend to experience large pay gaps. Among men it is 24% for those with a physical impairment and 40% for those with a mental impairment. Among women it is 14% for those with a physical impairment and 19% for those with a mental impairment.
- Disabled people are more likely to be in low-paid jobs than non-disabled people: 30% of disabled men and 35% of disabled women are paid below the National Living Wage compared with 25% of non-disabled men and 29% of non-disabled women.
- Where ethnic pay gaps exist, they tend to become larger when disability is factored in. Disabled Bangladeshi and Pakistani men experience particularly large pay gaps of 56% and 36% respectively, and disabled Black African men a gap of 34%, compared with White British non-disabled men.
- Disabled people are more likely to work part-time – such work pays less per hour, on average, than full-time work. This may be because of a limitation to the amount of work they can do, their skills levels, the jobs that they are offered by employers or difficulty in gaining promotion to senior roles (or a combination).
- Disabled people are less likely to have a qualification equivalent to National Vocational Qualification (NVQ) level 4 or higher. Lower levels of qualifications could result from barriers and reduced opportunities for education, particularly for those with an impairment from an early age.
- Factors providing a pay advantage for disabled people include being older and having a longer job tenure, and having an NVQ level 2 or 3 qualification

England

Between 2010-11 and 2015-16, the median hourly earnings for both disabled and non-disabled employees in England decreased by 9.5% and 1.3%, respectively. The gap in median hourly earnings between disabled and non-disabled employees widened during this time, with median hourly earnings for disabled employees remaining lower (£9.90) compared with non-disabled employees (£11.50). This decrease in median hourly earnings was particularly high for those with ‘mental health conditions’ and those with ‘vision impairments’, with a decrease of 14.2% for both, and a widening of the gap was observed for both these impairment types. In 2015/16, the gap in median hourly earnings was widest for those with ‘learning difficulties or disabilities’

(35.8%) and those with 'mental health conditions' (22.7%) compared with non-disabled employees.

Wales

Between 2010-11 and 2015-16, the median hourly earnings for disabled employees in Wales decreased by 9.2%, while there was no change for non-disabled people. The gap in median hourly earnings between disabled and non-disabled employees widened during this time, with median hourly earnings for disabled employees remaining lower (£9.10) compared with non-disabled employees (£10.50). In 2015/16, the gap in median hourly earnings was widest for those with 'vision impairments' (23.6%) compared with non-disabled employees.

Scotland

Between 2010-11 and 2015-16, the median hourly earnings for both disabled and non-disabled employees in Scotland did not change. In 2015-16, median hourly earnings for disabled employees were lower (£10.30) compared with non-disabled employees (£11.40). In 2015-16, the gap in median hourly earnings was widest for those with mental health conditions (13.2%) compared with non-disabled employees.

4.4. Welfare reforms

Legal and policy framework

GB

Since the Spending Review in 2010 the UK Government has undertaken extensive reform to the welfare system, cutting the social security budget by reducing or removing a wide range of welfare benefits. A number of House of Commons briefing papers that have looked in detail at welfare reform and disabled people suggest disabled people have been particularly affected by the reforms (Kennedy, 2016; Kennedy *et al.*, 2016; Murphy and Keen, 2016). In response, the Scottish Government and Welsh Assembly have introduced their own mitigating policies that enable top-ups on housing benefit for those affected by the 'bedroom tax'. The Scotland Act 2016 devolved significant areas of social security to the Scottish Parliament.

The EHRC report on monitoring the rights of disabled people noted how the welfare benefit system has been reformed at the same time as reductions in local government budgets, and changes to the funding of health and social care and the support provided to assist disabled people into the workplace have taken place. It also cites research that suggests the reforms will disproportionately affect disabled people through reductions in income and services, while the transition from Disability Living Allowance to the Personal Independence Payment could result in a reduced income for many disabled people. It is estimated that in Britain, by May 2018, there will have been a 28% reduction in the number of individuals in receipt of Personal Independence Payment compared with those who would have received Disability Living Allowance (EHRC, 2014).

In its International Covenant on Economic, Social and Cultural Rights (ICESCR) submission, the EHRC noted that many concerns, such as the impact of social security reforms on disabled people, 'may not have been proposed or implemented if decision-makers had paid due regard to the desirability of reducing socio-economic disadvantage when exercising their functions' (EHRC, 2016a, p.14).

An assessment by the EHRC (2015b) of the extent that the UK Government's 2010 Spending Review complied with the requirements of the Public Sector Equality

Duty found weaknesses in the decision-making process. The impact of decisions, including on welfare and public services affecting disabled people, was not always fully assessed.

The EHRC carried out follow-up work with HM Treasury to improve the way that equality evidence is collected and used across government departments to make budget decisions. The EHRC continues to call for the UK Government to carry out a cumulative Equality Impact Assessment to make the combined effect of policies clear so that mitigating steps can be put in place. In 2015, the EHRC commissioned the development of cumulative Equality Impact Assessment modelling methodology and found that such assessments are both feasible and practicable. The research found the impact was more negative for families containing at least one disabled person, particularly a disabled child, and particularly for low-income families. It pointed to the significant reductions to working-age welfare, and the high proportion of working-age welfare spent on disabled people, particularly those on low incomes, as the likely reason (EHRC, 2015b).

In July 2016, the UN Committee on Economic, Social and Cultural Rights concluding observations were critical of the UK Government's austerity measures and the impact they are having on certain disadvantaged people, including disabled people. The Committee reminded the UK of its obligations to progressively achieve the full realisation of economic, social and cultural rights using the maximum of its available resources and recommended it carried out a comprehensive assessment of the cumulative impact of these measures on those groups (UN Economic and Social Council, 2016).

The Welfare Reform and Work Act 2016 reduced the benefit cap to £20,000, except for £23,000 in Greater London. The Act froze most working-age benefits for four years while the Welfare Benefits Up-rating Act 2013 limited increases in benefit levels to 1% a year for three years, below inflation level. The Institute for Fiscal Studies has estimated that the cumulative effect of these limits and the freeze will be an 8% cut in real terms between 2012 and 2019 (Hood, 2015).[26]

The UN Committee on Economic, Social and Cultural Rights expressed its concern about the Welfare Reform and Work Act 2016 and the adverse effect of these changes and cuts on certain groups. The UK Government has acknowledged that the gap between the employment rates of disabled people and non-disabled people remains too large, and it remains committed to halving that gap. The Committee's justification of changes centres on providing incentives to encourage people to participate in work-related activity and therefore return to work more quickly (EHRC, 2016a).

The House of Commons Public Accounts Committee drew upon a report by the National Audit Office and evidence from a range of organisations, including mental health charity Mind, Citizens Advice and the Disability Benefits Consortium, to examine how the disability and health assessments process was operating.[27] It found that, although backlogs and delays had been reduced: there were unacceptable local variations in the performance of the contractors; claimants still did not receive an acceptable level of service, particularly those with mental health conditions; too many assessments did not meet the required standard although the unit cost had increased; and the DWP appeared to have misjudged what could be delivered (Kennedy *et al.*, 2016, pp.18-19).

A Joseph Rowntree Foundation report looking specifically at disability and poverty in later life stressed the additional living costs that people face and considered alternative ways of targeting support. It found that targeting does not necessarily require an extension of means-testing and the current system falls short of full support for the most severely disabled (Hancock *et al.*, 2016).

Successful legal challenges have been (and continue to be) brought in relation to welfare reforms. These include High Court rulings that the Secretary of State for Work and Pensions had unjustifiably indirectly discriminated against unpaid carers for disabled family members by failing to exempt them from the housing benefits cap (see *Hurley & Ors v Secretary of State for Work And Pensions*); and that the UK Government acted unreasonably and unlawfully in failing to award a Personal Independence Payment to disabled claimants within a reasonable timescale (see *S C & Anor, R (On the Application Of) v Secretary of State for Work and Pensions*).

In December 2016, the UK Independent Mechanism wrote to the UK Government to raise its concerns about the recently published CRPD Committee UK inquiry report (CRPD, 2016) and UK Government's response rights (UK Government, 2016). The inquiry examined the impact of law and policy changes since 2010 on disabled people's CRPD rights to: living independently and being included in the community, work and employment; and adequate standard of living and social protection. The inquiry concluded that: 'There is reliable evidence that the threshold of grave or systematic violations of the rights of persons with disabilities has been met in the State Party' (CRPD, 2016, para. 113). However, the UK Government strongly disagreed with the conclusions reached in the report and did not accept there were grave violations of CRPD rights (UK Government, 2016).

England

The Independent Living Fund was available to those receiving the higher rate of Disability Living Allowance, providing access to a package of joint Independent Living Fund/local authority care to enable them to live in the local community rather than in residential care. It closed on 30 June 2015. Responsibility in England has been passed to local authorities; each received a monetary transfer from the Independent Living Fund, however, none of this was ring-fenced, allowing local authorities to spend it as they pleased (Inclusion London, 2016). There is also considerable inconsistency in how Independent Living Fund recipients have been treated. An Inclusion London report concludes that this is a clear step back in independent living for disabled people and puts forward a number of recommendations, including establishing a national system based on need, independent of local authorities, and for previous Independent Living Fund transfers to be ring-fenced for provision of independent living support (Inclusion London, 2016).

Wales

The Welsh Government set up the Welsh Independent Living Grant in July 2015 following closure of the Independent Living Fund. Its draft budget for 2016-17 earmarked £27 million for the grant to enable it to continue until the end of March 2017. Future arrangements have yet to be put in place for when the current grant ends (Welsh Government, 2016b). The Welsh Government has been critical of the UK Government's policies on welfare reform and their impact on disabled people, and estimated that approximately 37,000 people in Wales will receive around £1,500 less each year due to changes to the

Employment and Support Allowance, with low-income households likely to be hit the hardest (Welsh Government, 2016c).

A study undertaken by the Institute for Fiscal Studies and commissioned by the Welsh Government found that working-age disabled households lose substantially more income, on average, than working-age non-disabled households (Phillips, 2014). A Welsh Government report (2013a) analysing the effect of the welfare reforms on people in Wales concluded that although some protections had been put in place for disabled people through exemptions and discretionary housing payments, there would be a significant impact, especially as a result of the relatively higher dependency on disability and sickness benefit compared with the UK.

Citizens Advice Cymru noted that the most common enquiries it received about welfare reform in Wales were in connection with entitlement and eligibility (Citizens Advice, 2016).

A study by the Public Policy Institute for Wales (2015) investigating the effects of the welfare reforms in Wales found that a lack of smaller dwellings meant that it was difficult for tenants to downsize in response to the 'spare room subsidy'. This is particularly relevant to disabled tenants, as was outlined in the 2014 Wales and West Housing report, when half of disabled tenants questioned were in arrears following the removal of the 'spare room subsidy'. The report also found a lack of smaller properties, and the high cost of making home adaptations, detracted from any savings made by the removal of the subsidy (Wales and West Housing, 2014). Those with mental health conditions were likely to have greater difficulty in coping with the changes. Also, the introduction and administration of Universal Credit predominantly through digital means would be a particular barrier for many who receive these benefits as they are 'ill equipped' to use online systems (PPIW, 2015).

Scotland

In May 2014 the UK Government transferred competence to the Scottish Government to enable it to lift the cap on housing benefit payments established under the 'bedroom tax' regime. This had the effect of enabling up to 72,000 Scottish households affected to apply for Discretionary Housing Payments to mitigate the reduction in housing benefit.

The Scotland Act 1998, amended by the Scotland Act 2016, gives Scotland the power over a considerable part of the social security system. A number of benefits have been devolved to the Scottish Parliament, including the Disability Living Allowance, Personal Independence Payment, Carers' Allowance and Attendance Allowance. Universal Credit will remain the UK Government's responsibility but the Scottish Parliament will have new regulation-making powers in relation to housing costs and support, and Discretionary Housing Grants will be devolved in full.

In March 2015, the Scottish Parliament's Welfare Reform Committee documented for the first time the cumulative impact of the welfare reforms on different types of household across Scotland. It shows that when the current welfare reforms come to full fruition, they can be expected to reduce incomes in Scotland by £1.5 billion a year, or £440 for every adult of working age. Claimants with health conditions or disabilities will be particularly affected. Reductions in incapacity benefits are estimated to average £2,000 a year, and some of the same people also face big losses in Disability Living Allowance as well as reductions in other benefits. Overall, the average losses in Scotland are just below the average for Britain (Scottish Parliament Welfare Reform Committee, 2015).

In July 2015, the Scottish Government set up a new organisation, Independent Living Fund Scotland, to administer support for existing recipients of the fund. It currently provides support to over 3,000 people in Scotland. The Scottish Government has announced that work on developing the fund for new users is underway (Scottish Government, 2016c).

Outcomes

In research by OPM and Ipsos MORI, disabled participants described how changes to the welfare system have been stressful and have had a negative impact on the amount of choice and control they are able to exercise in their lives and on health and wellbeing. They described the insensitivity of the benefits application and assessment process; it can be alienating and disempowering. The benefits process was seen as particularly insensitive to the complex nature of many impairments, particularly for those people where the invisibility of their condition means the application process does not recognise their needs (such as mental health conditions). They also described how the welfare system imposes unrealistic work expectations on disabled people and how returning to work does not always ensure people will be better off financially (Copestake *et al.*, 2014).

Research shows that the reforms are having a huge impact on disabled people in Wales, in particular the potential to increase poverty and isolation (Bevan Foundation, 2013). Similarly, the Scottish Government (2014c) has also concluded that disabled people in Scotland face a disproportionate loss of income compared with other groups.

Specific outcomes are presented for the following welfare reforms: Employment and Support Allowance, Personal Independence Payment and Universal Credit.

Employment and Support Allowance

Employment and Support Allowance is for disabled people or those with a health condition who are unable to work, and is designed to cover day-to-day living costs. A person must undergo a Work Capability Assessment to determine whether they have a limited capacity for work and if they are capable of 'work-related activity'.

A number of issues related to Employment and Support Allowance are of concern, notably: the Work Capability Assessment; the abolition of the Work-Related Activity Component; Employment and Support Allowance conditionality and sanctions; and the impact on disabled people once Employment and Support Allowance has ended.

Changes have been made to the Work Capability Assessment following internal and independent reviews, but it still attracts strong criticism.

- Claimants with serious health conditions or disabilities have been found 'fit for work'. While there has been a relatively high success rate for appeals against decisions, there are concerns that the impact of assessments, reassessments and poor decisions has had a negative effect on the physical and mental health of claimants (Kennedy *et al.*, 2016, p.7). The assessment method has also been successfully challenged in the courts on the grounds that it puts those with mental health conditions at a disadvantage.[28]
- The time limit for receipt of contributory Employment and Support Allowance, which is now 12 months, is highly controversial as it undermines the contributory principle and, it has been argued by disability and welfare rights organisations, will increase poverty for those with long-term conditions (Kennedy *et al.*, 2016, p.8).

The abolition of the Work-Related Activity Component from April 2017 for new claimants has been particularly controversial.[29] As of April 2017, the Work-Related Activity Component paid to those in the 'Work-Related Activity Group' will be abolished, as will the equivalent element in Universal Credit. At the time of writing, this will be a reduction of £29.05 per week. It was stated this will 'remove the financial incentives that could otherwise discourage claimants from taking steps back into work', a point that has been fiercely disputed (Murphy and Keen, 2016, pp.23-5).

- A critical review in the House of Lords argued this would hinder disabled people from moving toward work by causing stress and anxiety as people were pushed into debt and poverty (Lord Low of Dalston *et al.*, 2015).
- The House of Commons overturned opposition to the proposals, but the UK Government has announced 'new funding for additional support to help new claimants return to work' with Green Paper proposals out for consultation until February 2017 (Murphy and Keen, 2016, p.3).

Though safeguarding measures have been outlined by the DWP to protect Employment and Support Allowance claimants from sanctions, they do not appear to be fully in force or complied with. Those with mental health conditions were more likely to be punished than helped into work on Employment and Support Allowance (Mind, 2015).

- Of the 15,955 Employment and Support Allowance sanctions imposed between January and March 2014, there were 9,851 (60%) sanctions imposed on customers diagnosed as having a 'Mental or Behavioural Disorder' (Disability Rights UK, 2014). Disability Rights UK has subsequently suggested that safeguards should be expanded to protect Jobseeker's Allowance claimants with mental health conditions, learning disabilities, and conditions affecting cognition. They also suggest that when a claimant is without an income and has 'severe mental ill health', a learning disability, or a condition affecting cognition that is particularly severe, the DWP should make an effort to collect safeguarding information direct from the claimant's GP (Disability Rights UK, 2014).
- Nearly 20,000 benefits sanctions were received by people who were out of work because of a mental health condition during 2014-2015. During the same period only 6,340 were successfully supported into employment. Specific data does not presently exist on the number of individuals in Wales receiving Employment and Support Allowance due to their mental health condition who have also been sanctioned (Mind, 2015).

Mortality statistics reporting the number of deaths of people after their claim for Employment Support Allowance ended because they were found fit for work, were widely reported in the UK national press in 2015. There is a growing body of anecdotal evidence that welfare reform, such as Work Capability Assessments, is causing significant harm and distress, particularly to people with mental health conditions, and that in some cases being found ineligible for Employment Support Allowance has resulted in suicide (Telling it as it is, 2017; DNS, 2017; DNS, 2017a; Cowburn, 2016).

The DWP does not hold information on the reason for a person's death and stated that 'no causal effect between the benefit and the number of people who died should be assumed from these figures' (DWP, 2015c, p.9).

A report by Barr *et al.* (2016) links Work Capability Assessments, introduced as part of welfare reforms after the 2010 election, to 590 suicides and 275,000 cases of deteriorating mental health between 2010 and 2013.

In an investigation of the suicide of Ms DE following a failed assessment for continuing eligibility of welfare benefits, the Mental Welfare Commission Scotland (2014a) recommended that the Scottish Government commission a study examining the impact of the Work Capability Assessment process on people with a mental health condition, learning disability or related condition, and put in place the support necessary to address this impact. Their investigation found serious flaws in the way Work Capability Assessment was being administered and concluded that attendance at the Work Capability Assessment should not be used as evidence of being able to function in the workplace. The report recommended that Work Capability Assessment be reviewed with expert input from occupational health and psychiatry specialists, to increase the ability of the Assessment to identify functional level in individuals with a mental health condition. It also recommended that the DWP ensure that their communication with claimants is compliant with the requirements of the Equality Act 2010.Two prevention of future deaths letters written in 2010 and 2014 by Coroners in England to the DWP link flaws in the Work Capability Assessment process to the deaths of benefit claimants with mental health conditions (DNS, 2015a; 2015b).

Disability campaigning organisations claim the impact of welfare reform and the Work Capability Assessment is a systematic violation of disabled people's human rights and are among those calling for urgent Government acknowledgment of and action to tackle the impact of welfare reform on disabled people (Rethink Mental Illness, 2014; DNS, 2017b). The CRPD Committee raised similar concerns about the continuing negative impact of Work Capability Assessments on the rights of disabled people in its inquiry report published in November 2016 (CRPD Committee, 2016). In its 2017 submission to the CRPD Committee, the UK Independent Mechanism states that 'further independent assessment' of Work Capability Assessments is needed, and recommends that reform of the system address the concerns raised (UKIM, 2017).

Personal Independence Payment

The Personal Independence Payment is designed to help with some of the extra costs associated with a long-term condition or disability and is replacing Disability Living Allowance for people of working age (those aged 16-64). It is not means-tested and has mobility and daily living components.

The DWP has estimated that all existing working-age Disability Living Allowance claimants will have been reassessed for Personal Independence Payment by 2019/20. A UK Government consultation was launched in December 2015 on possible further changes to Personal Independence Payment, tightening eligibility criteria and limiting payments for aids and appliances to reflect actual costs incurred. In March 2016, the UK Government announced reductions in the number of points awarded for certain aids and appliances in the Personal Independence Payment assessment (Kennedy, 2016).

There has been an increase in the number of enquiries about Personal Independence Payment to Citizens Advice (England, Wales and Scotland) with the roll-out of the benefit. Major increases in enquiries were about renewals and reviews, eligibility, appeals and challenging a decision. During 2015/16, the number of people contacting

Citizens Advice Wales with a Personal Independence Payment-related problem was 32% higher than the previous year; the number of Personal Independence Payment-related advice issues rose by 37% in just one quarter (Citizens Advice, 2016). Citizens Advice Scotland stated that despite improvements to waiting times, fundamental problems remain around assessments, medical evidence, length of awards, accuracy of decision making and mandatory reconsideration. Personal Independence Payment is the single biggest issue that Citizens Advice Scotland provides advice on, and in 2015/16 this made up 20% of the total benefits advice given. It is expected that advice in relation to Personal Independence Payment will continue to grow (CAS, 2016).

Universal Credit

Universal Credit is a single monthly payment for those in or out of work, merging together, and intended to eventually replace, a number of benefits and tax credits. Universal Credit is not expected to be fully introduced until 2021 and people who claim income-related Employment and Support Allowance are expected to be one of the last groups moved to Universal Credit. Universal Credit is designed to rationalise support for disabled people but concern has been raised by disability organisations that some disabled people will receive less than they do now, and that families with a disabled child could get significantly less (Kennedy *et al.*, 2016).

Citizens Advice Scotland is concerned that people face confusion about eligibility and have to wait too long to receive their payments, and that this would have a disproportionate impact on claimants with disabilities. It also recommends that Jobcentre Plus must ensure that the support provided to those who lack computer skills (for example, to make benefit applications online) is appropriate and that alternatives are provided for those who may never be able to use digital services due to illiteracy, disabilities or other complex needs (CAS, 2016a).

Data gaps

The UK Government's Work Choices scheme is available in Wales; however, there is no specific legislation or provisions for Wales. Furthermore, there is a distinct lack of legislation, guidance and advice in Wales for disabled employees and for employers seeking to recruit disabled staff. There is also a lack of research, data and statistical analysis of disabled people's employment rates and pay and no information on different industries, sectors or locations in Wales.

There are considerable data gaps on apprenticeships (not just relating to disability) including: a lack of information on the quality (as opposed to the quantity) of apprenticeships; a lack of data on adult apprenticeships, for example, those filled by the 25 and over age group; and a lack of data on completion rates (as opposed to starts) and the reasons why some apprentices fail to complete.

There is no cumulative impact assessment of welfare policies currently undertaken by the UK Government. The EHRC and the Scottish Human Rights Commission (SHRC) are assisting the Scottish Government in looking at the potential cumulative impacts of those benefits devolved to the Scottish Government in 2016.

"Only 16% of councils in England had data on how many of the homes in their area were wheelchair accessible"

5. Standard of living

This chapter is concerned with the opportunity for individuals to enjoy an adequate and secure standard of living with adequate support. Measuring poverty and material deprivation helps us to assess a person's ability to live with independence, dignity and self-respect. An adequate income is essential to enable an individual to enjoy a secure standard of living, including all aspects of life that this entails, such as housing, food, warmth, social security, social services and utilities, and being cared for and supported when necessary. For disabled people and those with a long-term condition, adequate housing means living in homes that are adapted to specific needs and close to services, care and facilities that allow them to live their lives in dignity and freedom.

Three specific indicators were chosen to assess how well disabled people's rights to an adequate standard of living are protected in Britain. These are:

1. Poverty and material deprivation
2. Availability of support
3. Housing

This chapter covers government responsibilities that are devolved (for example, tackling poverty and housing) across England, Wales, and Scotland. Where a matter is devolved, we cover the legal and policy framework separately for England, Wales and Scotland. Where a matter is reserved, we present the legal and policy framework for Britain as a whole.

5.1. Poverty and material deprivation

Outcomes

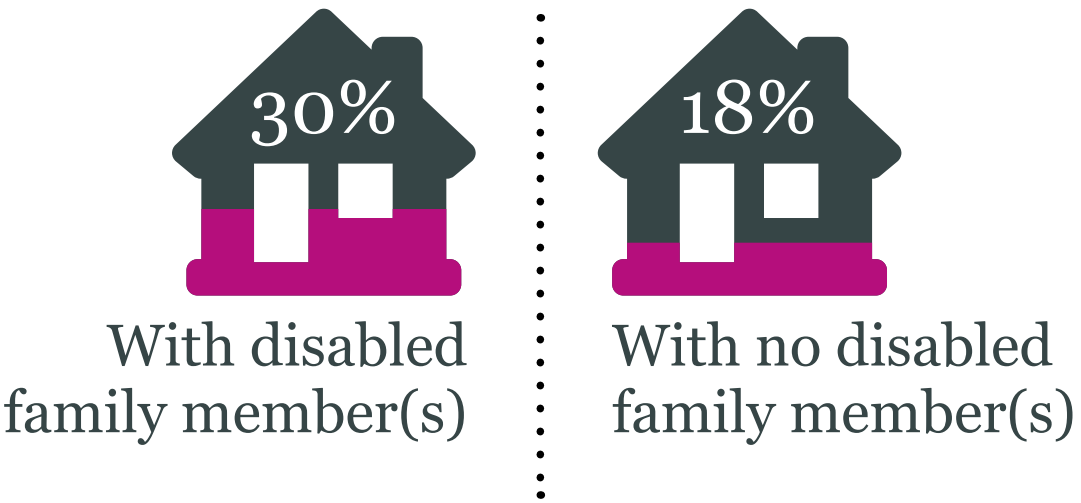
GB

The figures reported here, on the percentage of individuals living in households below 60% of contemporary median income after housing costs ('relative poverty'), are from analysis carried out specifically for the 'Is Britain Fairer?' review. See online data table EF2.1.

In 2012/13, 19.4% of adults were living in households with below 60% of contemporary median income after housing costs. In the same period, 24.0% of disabled people were in poverty compared with 18.0% who were not disabled. In 2007/08 the rates were 26.6% and 18.5% respectively. The poverty rate for disabled people fell by 2.7 percentage points between the two years, as did the gap between those who were and were not disabled (by 2.2 percentage points).

In 2012/13 poverty rates were higher for disabled adults compared with non-disabled adults across all three countries (England 24.0% compared with17.9%, Scotland 21.4% compared with 17.3%, and Wales 27.5% compared with 21.3%).There was a narrowing of the gap between those who were and were not disabled between 2007/08 and 2012/13 in England and Scotland but not in Wales.

UK data from 2014/15 shows the percentage of working-age adults in families where at least one member is disabled, and who were living in households with below 60% of contemporary median income after housing costs, was 30% compared with 18% for those living in families with no disabled members. These latest figures show 5.3 million individuals in households with below 60% of contemporary median income after housing costs and living in families where at least one member is disabled (DWP, 2016).



New intersectional analysis was drawn from data from the Family Resources Survey for 2014-15. Allowing for the combined effects of age, disability, ethnic group, gender, socio-economic group, whether in a couple, and region, in 2014/15 living in poverty was most common for disabled people aged 25-34, followed by those aged 35-44, and among disabled people was lowest for those over 65, who have similar poverty levels as non-disabled people aged 25-54. The lowest rates were for non-disabled people aged 16-24 or 65 and over.

By looking at the income of households with a disabled person by housing tenure, a recent study suggests that the rise in poverty among households that contain someone who is disabled is linked to rising housing costs for rented accommodation (MacInnes *et al.*, 2015).

GB

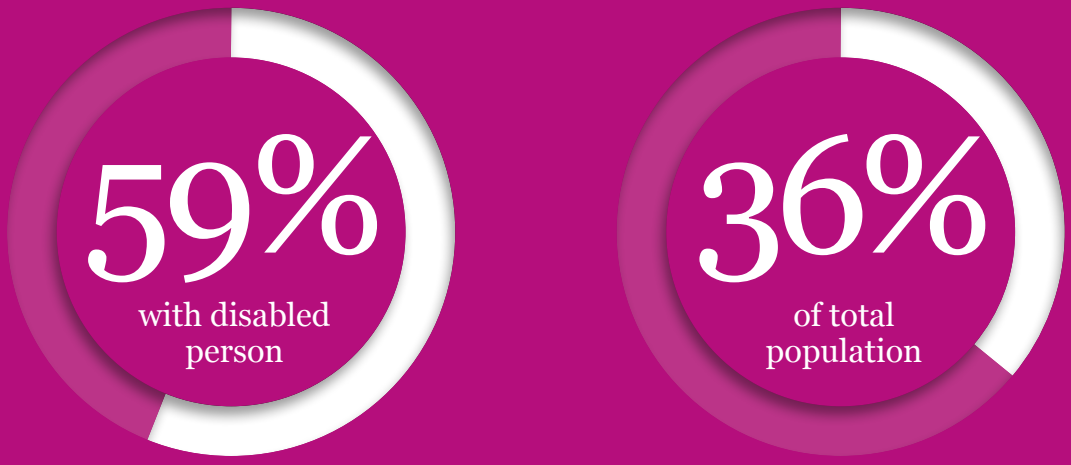
Material deprivation is a measure of what households can afford, and so better reflects the standard of living than income alone; it is measured by the mean deprivation score (the higher the score, the greater the deprivation). The figures reported here on the mean deprivation score among working-age people above the income poverty threshold are from analysis specifically for the 'Is Britain Fairer?' review. Intersectional analysis is from new analysis specifically for this report using data from the Annual Population Survey. See online data table EF2.2.

There was a difference in material deprivation between disabled and non-disabled people, and an increase in deprivation over time for both groups. Furthermore, the gap in the mean deprivation score between disabled and non-disabled working-age people widened over time. In 2012/13, the mean deprivation score for working-age people above the income poverty threshold of 60% of contemporary median income after housing costs was 0.9. For disabled people it was 1.7 and for non-disabled 0.8. This gap widened over time (in 2007/08 it was 1.4 and 0.7 respectively). In 2012/13 material deprivation was worst for disabled people in Wales than non-disabled people (2.0 and 0.9 respectively) compared with England (1.7 and 0.8) and Scotland (1.7 and 0.6).

Allowing for the combined effects of age, disability, ethnic group, gender, socio-economic group, whether in a couple, and region, the mean deprivation score in 2014/15 for 16-64-year-olds increased from age 16-24 and was highest for disabled people in the 35-44 age group before declining in the two older age groups. For both disabled and non-disabled people, the Black/African/Caribbean group had the highest mean deprivation score. Among the non-disabled, Pakistani and Bangladeshi people and those from 'Other' ethnic groups also had high scores, while among the disabled the next highest scores are for the Mixed and Pakistani and Bangladeshi ethnic groups.

An Institute of Fiscal Studies report on poverty and inequality looked at the relationship between material deprivation, income poverty status and disability from 2012-13 to 2014-15. It found households with at least one disabled person and above the poverty line were still more likely than the average household to be materially deprived. The material deprivation rate for families with children, in income poverty and that contained a disabled member, was 59% compared with 36% where no one

The material deprivation rate for families with children, in income poverty and that contained a disabled member



in the family was disabled. The material deprivation rate for families who were not in income poverty and had a disabled member was 25%, compared with 9% where no family member was disabled. The average material deprivation rate overall was 20% (Belfield *et al.*, 2016).

Fuel poverty

Evidence from the Fuel Poverty Advisory Group to the House of Commons Energy and Climate Change Committee (2013) indicated that nearly 34% of 'fuel-poor' households contained someone with a disability or long-term condition.

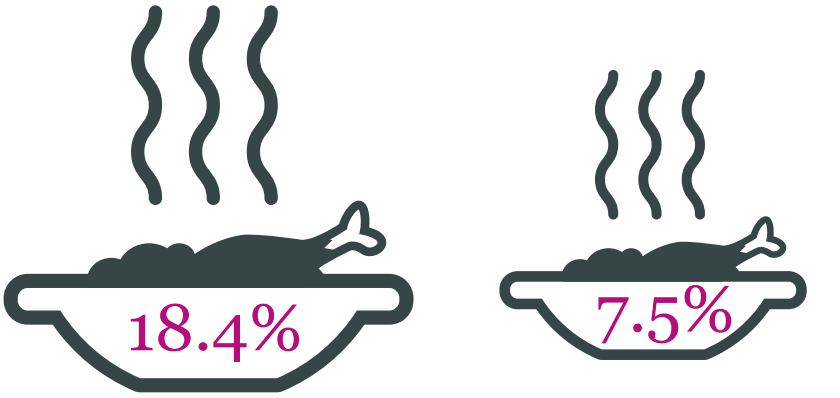
In a study of fuel poverty and disability, receipt of benefits was often found to go hand-in-hand with high energy needs. It was argued that official measures did not assess the actual energy needs of some people, which could fluctuate over time. The assumption that disability-related benefits could be used to meet fuel bills was said to be flawed and, for disabled people, the use of prepayment meters was thought to be inappropriate in terms of their usability, and also given the elevated risks associated with self-disconnection (Snell *et al.*, 2014).

Another study from 2013 showed how disability is associated with additional energy use. Increased energy use was associated not only with physical conditions but other factors such as increased laundry costs and recharging costs for specialist electrical equipment (George *et al.*, 2013).

Families with a disabled child face additional needs. Disability benefits are regarded as income in the measurement of fuel poverty and other official statistics, suggesting that the prevalence of fuel poverty is, therefore, likely to be underestimated (George *et al.*, 2013). Estimates from existing research include:

- In 2013, the Department of Energy and Climate Change reported 2.35 million households in England were thought to be in fuel poverty when disability benefits were included in the calculation (DECC, 2015).
- A review of fuel poverty in Scotland in 2012 found that 36% of people classified as being 'long-term sick' or disabled lived in fuel poverty compared with 29% of all people in Scotland. Levels of extreme fuel poverty were also slightly higher

People aged 16-64 considered to be in food poverty



for 'long-term sick' or disabled people compared with the general population (Scottish Government, 2012).

- In 2014, The Association for the Conservation of Energy estimated that over six million households were fuel poor in Britain: 4.8 million in England; 890,000 in Scotland; and 450,000 in Wales. The number of households in England that were fuel poor had increased by 51% between 2011 and 2014; for Scotland and Wales the increase was in the region of 43%. However, there was no disability data (ACE, 2014).

Food poverty

In 2014 in the UK, 18.4% of disabled people with impairments aged 16-64 were unable to afford 'a meal with meat, chicken, fish (or vegetarian equivalent) every second day' (above the EU average of 16.1%, and compared with just 7.5% of non-disabled people of similar age). The risk of food poverty among disabled people over the age of 65 is half the EU average (although it is still twice that of non-disabled people in the same age group, 6.8% compared with 3.3%) (Eurostat, 2016).

Difficulty in making ends meet

Unless otherwise stated, the figures reported here, on people who live in households that have difficulty in making ends meet, are from analysis specifically for this report using data from the Life Opportunities Survey. See online data table EF2.4.

The percentage of people[30] who lived in households that have difficulty in making ends meet changed little between 2009-11 and 2012-14. The percentage of disabled respondents who had difficulty in making

People aged over 65 considered to be in food poverty

ends meet was much higher in both periods (41.0% in 2009-11 and 42.4% in 2012-14) than for non-disabled people (28.1% in 2009-11 and 2012-14), with the exception of those with a hearing impairment. High percentages of people with 'mental health conditions' (67.3% in 2012-14) or 'behavioural impairments' (68.1% in 2012-14) lived in households that had difficulty making ends meet.

Allowing for the combined effects of age, disability, gender, access to a car, and size of household, in 2012-14 difficulty with making ends meet decreased with age for non-disabled people, but remained high up to the 45-54 age group for disabled people and only decreased after this age. People without access to a car are also more likely to live in a household that has difficulty making ends meet. By household size, difficulty making ends meet is less common for non-disabled people in two-person households and then increases for larger households. The impact of disability is high for people in one or two-person households, reducing the difference between large and small households, while disabled people in large households of six or more are most likely to say their household has difficulty making ends meet.

Disabled people earn less than non-disabled people and face extra costs, referred to as 'the disability penalty' (McKnight, 2014). The charity Scope estimates this penalty to be on average £550 a month (Scope, 2014). Someone with a neurological condition will spend on average almost £200 a week on costs related to their disability, while someone with a physical impairment will spend almost £300 (Extra Costs Commission, 2015).

5.2 Availability of support

Outcomes

Research looking at social connections and the ability of disabled people to live independently showed disabled people identified their social and community lives as a challenging area for them, particularly those with low incomes. Disabled people's organisations and other local community groups were important in enabling them to connect with people and to make friends, but evidence suggests that funding to support these organisations is under threat, specifically the fall in the number of support workers. These findings indicate that the standard of living is deteriorating as resources become scarcer and funding for these types of service disappears. Disabled people are finding it more and more difficult to establish and maintain a sense of connectedness with others (Copestake *et al.*, 2014).

GB

The figures reported below, on the availability of support, are from analysis specifically for this report using data from the Life Opportunities Survey. See online data tables EH1.1 and EF3.1. Specific measures used are: percentage of people meeting with relatives or friends at least once a week; and percentage who say they are limited in one or more areas, because of poor services, lack of help or assistance, or lack of special aids or equipment.

In Britain, almost everyone meets with relatives or friends at least once a week; a small increase in this among disabled adults between 2009-11 and 2012-14, from 98.1% to 98.7%, closed the gap with non-disabled people (98.8% in 2012-14). Only disabled people with a mental health condition were less likely to meet with relatives or friends at least once a week

(96.6%). Allowing for the combined effects of age, disability, gender, access to a car, and size of household, women and people with access to a car were more likely to meet with relatives or friends at least once a week in 2012-14. Disabled people in households comprising five people were less likely to report meeting with relatives or friends at least once a week than people in smaller households.

The percentage of non-disabled and disabled people[31] who said they are limited in one or more areas of life, because of poor services, lack or help or assistance, or lack of special aids or equipment decreased between 2009-11 and 2012-14. Despite this decrease, in 2012-14, the percentage of disabled people remained higher (9.1%) than the percentage of non-disabled people (4.0%). This was the case for all impairments, but those with 'a social or behavioural impairment' were particularly likely to say they were limited in one or more areas of life (34.4%).

Allowing for the combined effects of age, disability, gender, access to a car and size of household, limitations due to the reasons given were more common for women than for men, and for people without access to a car than for people with access. By age, the effect of disability is high for the youngest age groups, 16-24 and 25-34, then reduces with age up to the 65-74 age group.

England

Responses to freedom of information (FOI) requests from 151 out of 152 local authorities in England by learning disability charity Mencap (2012) show that almost one in three local authorities had closed day services for people with a learning disability in 2012, with alternatives either not provided or unclear from the responses. Furthermore, six in 10 local authorities said they had increased the charges that day service users had to pay to attend. As part of the same study, Mencap (2012) carried out an online survey of 280 people with a learning disability and found that over half did not receive any day service provision, and that over a quarter felt isolated or lonely. Mencap has highlighted that the regressive reductions in opportunities to participate in the community and increasing social isolation go against Article 19 of the CRPD, which places an emphasis on giving disabled people greater access to community life, supporting inclusion and preventing isolation. These findings are underlined by the Office for National Statistics (ONS) Life Opportunities Survey, which found that having an impairment seems to be associated with lower levels of social contact (ONS, 2015a).

Research commissioned by Sense (2015), a national disability charity for deafblind people, shows that nearly one in four disabled people (23%) feels lonely on a typical day, rising to well over a third (38%) of young disabled people aged 18-34. More than three-quarters (77%) of young disabled adults also feel they face greater barriers than non-disabled people in making and sustaining friendships. The research focused on disabled people with a range of impairments, not just those who are deafblind. Other findings reveal: 6% of respondents said they had no friends at all; 29% of respondents reported seeing their friends just once a month or less; 41% said that being able to get out and about more would enable them to see friends more often; 22% said more accessible transport would help them to meet up with friends more.

Wales

In Wales, one of the Welsh Government's key community and social life priorities is how to prevent social isolation. However, there is very limited data available.

Scotland

Drawing on emotional and practical support from family and friends can be more problematic for people who are isolated from social networks, for example, because they live in a rural area with limited public transport (Scottish Government, 2015a).

Historic data from the Scottish Household Survey found specific barriers exist for young disabled people, for example: a lack of accessible transport, being able to travel on their own, no support to continue friendships when they left school and being denied access to the settings where other teenagers spend their free time, such as clubs and fast-food outlets (JRF, 2002).

5.3. Housing

Legal and policy framework

The under-occupancy penalty (also known as the 'bedroom tax') is a key part of the Welfare Reform Act 2012. It applies to working-age people in the social rented sector, whereby if a household is deemed to have too many bedrooms, the amount of housing benefit is reduced. Disabled people living in adapted accommodation are not generally exempt from the under-occupation ruling and the deduction is applied irrespective of whether an adult couple can share a bedroom, or whether a room is required for disability-related equipment.

The DWP's Equality Impact Assessment of the under-occupancy ruling clearly indicated that a higher proportion of disabled people would be affected than those who were not disabled (DWP, 2015a).

The National Housing Federation stated that disabled people living in adapted accommodation who were forced to move into properties unsuitable for their needs could face their Article 8 rights to respect for private or family life being breached, and that this was also potentially discriminatory (Wilson, 2015).

Families with a disabled child have also been affected by the ruling. Since December 2013 an additional bedroom has been allowed for a non-resident overnight carer and for certain cases that involve disabled children. Exemptions have been introduced, for example, for certain temporary absences from home, such as in the case of students, and for approved foster carers (Wilson, 2015).

The Scottish Government and Welsh Assembly have put in place measures to mitigate the effect of the UK Government's under-occupancy penalty policy by contributing further funding to Discretionary Housing Payment allocations to local authorities.

The impact of the under-occupancy ruling on disabled people continues to be challenged in the courts. In January 2016, a case was taken to court by grandparents caring for their severely disabled grandson who were penalised for having a third bedroom that was used by overnight carers and to store disability equipment. Although the family was in receipt of discretionary housing payments to cover the shortfall in rent, the Court of Appeal found this inadequate as there was no guarantee that payments would continue. It found that the ruling discriminates against disabled children in breach of the Human Rights Act 1998 and that the failure of the Secretary of State to make provision in the regulations for the carers of a disabled child was unlawful discrimination contrary to Article 14 of the European Convention on Human Rights (*Rutherford v. and A. v. Secretary of State for Work and Pensions [2016];* Child Poverty Action Group, 2016).

In November 2016, the Supreme Court appeals panel upheld the claims of two

families who said that the 'bedroom tax', which restricts housing subsidies, was unfair to disabled people. Claims brought by five other families were dismissed. Despite the outcome, the judgment recognised that disabled children who need overnight care and adults with disabilities who cannot share a room should not have their housing subsidy removed. This is an important clarification and will make a significant difference for disabled people and their right to independent living.[32]

England

The Housing and Planning Act 2016 made provision about housing, estate agents, rent charges, planning and compulsory purchase in England. It requires local authorities to grant new social housing tenants a fixed-term tenancy of between two and five years and restricts the right of family members to succeed to social housing tenancies.

The Equality Impact Assessment on lifetime tenancies noted that fixed-term tenancies were a cause of considerable concern, especially to disabled people or people with health needs:

- Fifty per cent of existing households in social housing contained at least one disabled member. There was an expectation in the sector that those with longer-term needs (a disability or long-term condition) would be offered longer fixed-term tenancies of up to 10 years and a further social tenancy at the end of the fixed term, if their circumstances had not changed.
- Landlords can move people to more suitable accommodation where this is appropriate and could be helpful to those with access needs who may require adapted accommodation (Parkin and Wilson, 2016).

Wales

Though there are no specific requirements relating to disability stated under the Housing (Wales) Act 2014, the Act feeds into a number of standards that do relate to the support of disabled tenants. Homelessness acceptances[33] by Welsh local authorities in 2014-15 had increased by 24% for those with a mental health condition or learning disability (Fitzpatrick *et al.*, 2015).

The Renting Homes (Wales) Act (2016) includes estate management provisions specifically intended to support timely access for disabled people to adapted properties. Landlords can repossess adapted properties when the tenant no longer needs the adaptations, if a suitable alternative property is provided to the tenant.

It is difficult to say how successful the most recent Welsh Housing Quality Standard will be. Disabled people may be more likely to be subject to shortfalls as they have additional housing requirements and adaptations. Part 7.7 requires social landlords to meet the specific requirements of households with disabilities (Welsh Government, 2016d). The previous standard (set in 2002) was criticised by the Wales Audit Office (WAO, 2013), which claimed that the Welsh Government would not meet the 10-year housing targets by 2017. In fact, only 79% of properties would be up to standard by 2017.

The Welsh Housing Quality Standard also refers to the Lifetime Homes Standard, which states that when it is practical and cost effective to do so, landlords should consider incorporating some of the Lifetime Homes Standard criteria into dwellings. Lifetime Homes Standard specifications include those aimed at improving accessibility. As these were only introduced

in 2016, it is difficult to say what the impact will be for disabled people in Wales (Habinteg, 2015).

Some local authorities have compiled Accessible Housing Registers. These identify disabled people in need of an accessible home, identify suitable properties by location and type, and match the person with the property. People can apply to be on the register even if they own their own home (Dewis Cymru, 2016). A Welsh Government report found extensive variation between all of the Accessible Housing Registers and how they operated. Evidence suggested that social landlords who use an Accessible Housing Register were more likely than those who did not to: have an effective system for identifying accessible or adapted properties; ensure staff have specialist training to match people to accessible homes; work in a more joined-up way across departments; and consider a range of holistic needs (Welsh Government, 2013).

Scotland

The Scottish Government's 2015 annual report on welfare reform reported that by February 2015 just over 82,500 households had been affected by the under-occupancy ruling in Scotland and that of these, around 80% contained a disabled adult, as defined by the Equality Act (Scottish Government, 2015b). It raised a number of concerns, including the lack of one-bedroom accommodation available in the social rented sector, the ability of households to meet arrears in their rents and possible increases in arrears.

Under the Scotland Act 1998 as amended, Discretionary Housing Grants will be devolved in full by 2017, and the Scottish Parliament will have new powers in relation to housing costs and support.

Aids and adaptations are administered by local authorities in Scotland, each of which has the power to develop specific local criteria for assistance. Common areas of assistance include replacing the bath with a walk-in shower, constructing a ramp to aid access, and fitting lower work surfaces to make the kitchen easier to use. Mandatory grants are available should an applicant be classed as being in priority need.

Disabled people have called on the Scottish Government to take steps to ensure that existing social housing stock is better used by requiring housing providers to maintain a register of accessible housing (Inclusion Scotland, 2014). Although the Scottish Government has committed to building 50,000 affordable homes, there is no statutory requirement that a proportion of these new homes are accessible (Scottish Government, 2016d). The Scottish Government has identified five areas to test a more personalised and tenure-neutral approach to home adaptation services. This project began in November 2014 and is scheduled to continue until the end of 2016-17 when it will be evaluated and evidence used to shape new guidance (Scottish Parliament, 2016a).

Outcomes

GB

Unless otherwise stated, the figures reported here, on people who own their home, are from analysis of housing tenure specifically for this report using data from the Life Opportunities Survey. See online data table EF1.3.

The percentage of adults[34] who live in owner-occupied accommodation (with or without a mortgage) increased between 2009-11 (68.3%) and 2012-14 (72.3%). This was also the case for non-disabled people, who saw an increase of 4.8

percentage points between 2009-11 and 2012-14. Disabled people were less likely to own their own home in 2012-14 (62.6%) than non-disabled people (76.2%). This was true for all impairment categories with the exception of those with a 'hearing impairment' (69.3% in 2012-14). The gap between non-disabled people and those with a 'mental health condition' decreased by 1.9 percentage points between 2009-11 and 2012-14, but people with 'mental health conditions' remained far less likely to live in accommodation that was owner-occupied.

Allowing for the combined effects of age, disability, gender, access to a car, and size of household, in 2012-14 one-person households were least likely to own their own home, while non-disabled people with access to a car were more likely to live in owner-occupied accommodation than those without access to a car and/or disabled. Home-ownership increased with age while the negative impact of disability increased up to the age groups 35-44 and 45-54 and then decreased for older age groups.

England

Disabled people face problems in finding adequate housing and this is a major barrier to independent living. Two studies from Leonard Cheshire Disability (2014a; 2014b) concluded there could be up to 300,000 disabled people on housing waiting lists in England. Furthermore:

- Disabled people with mobility impairments commented on the particular difficulties they faced in finding adequate housing.
- Standards for incorporating low-cost design criteria that can be applied to new homes show that costs for adapting a home for wheelchair use are higher than other design criteria for adapting a home to the required specifications.
- Only 16% of councils had data on how many of the homes in their area were wheelchair accessible, and of the councils with a housing plan in place, fewer than 17% had set out strategies to build disabled-friendly homes in 2015.

A Centre for Analysis of Social Exclusion study (Provan *et al.*, 2016) examined the quality of life for disabled people with accessible housing needs. A number of participants in a survey used for this study indicated that their unmet needs affected their ability to work, train for a job or move elsewhere for work. The wider impact of unmet need on dignity, control and social contact was also highlighted, with people stating they felt trapped in their homes, had no social life, or were heavily dependent on the support of others.

Research by Ipsos MORI showed (Copestake *et al.*, 2014) that a majority (59%) of disabled people aged 65 and over thought they would need accessible housing features in the next five years compared with 46% of all disabled people and 20% of the general public. Similarly, 47% of carers said the person they cared for would need accessible housing features within the next five years.

English Housing Survey 2014-15 data (DCLG, 2016) shows that around 1.9 million households contained someone with a 'long-term limiting disability' who required adaptations to the home, and that this has not changed since 2011-12. Eighty-one per cent of households that required adaptations reported their home was suitable for their needs. The remaining 19% (around 365,000 households, or around 2% of all households in England) considered their accommodation was unsuitable. People in private rented accommodation were more likely than those in other tenures to say their accommodation was unsuitable: 32% in private rented compared with 23%

local authority, 22% housing association and 15% owner-occupiers. There has been some improvement since the earlier survey in the percentage of homes requiring adaptations that already have them installed: 55% compared with 51%.

2012 data from the English Housing Survey shows that in nearly 10 million homes in England, work to make the property even 'visitable'[35] (rather than liveable in) by a disabled person would be expensive or not physically possible. The survey shows why demand for grant funding to adapt existing housing is very high, and will remain high: for example, 21.5 million homes (95%) were not fully visitable by disabled people, including wheelchair users. This report implies there will be a widening mismatch between available housing and the needs of the population unless more housing in future is built to adequate accessible design standards (DCLG, 2014).

A House of Commons briefing paper (Kennedy *et al.*, 2016) summarised benefit changes introduced since 2010 affecting disabled people and their families and noted that the DWP has not published any information on the number of disabled people subject to housing benefit deductions. The latest data suggests that at least 47% of housing benefit claimants affected by the under-occupancy charge have a disability.[36]

The DWP's evaluation of the under-occupancy ruling acknowledged that disabled people had experienced particular difficulties in downsizing. It reported how landlords and local authorities involved in the research said that many claimants who had been affected by the removal of the 'spare room subsidy' were unable to move because of a shortage of smaller homes. Respondents emphasised that moving to a smaller property was not just a matter of insufficient numbers of properties, and that for disabled people the availability of suitable smaller homes was even further limited. Disabled claimants were concerned that local authorities would be unable to find a suitable property for them that was adapted to their needs, and that, if they did move into something that was unsuitable, they would have to wait a long time for the authority to install the adaptations needed (DWP, 2015a).

Wales

A report focusing on Disabled Facilities Grants[37] found that in 2014:

- 62% of councils across England and Wales failed to fund agreed adaptations within the one-year deadline.
- 44% of councils had people waiting over two years for a grant, with eight councils reporting waits of over four years.
- Over 2,500 disabled people each year wait over 12 months for adaptations to make their homes accessible.
- Applications for Disabled Facilities Grants have risen by 6% since 2011/12, but the number of adaptations funded has only risen by 3% over the same period.
- Applications are means-tested and concerns have been voiced they are only available to those in greatest need (Leonard Cheshire Disability, 2014).

Scotland

Scottish data on housing and disability shows higher levels of social renting and overcrowding and a decrease in local authority wheelchair-adapted housing:

- People who reported a limiting long-term health condition or disability were more likely to live in a flat. People who

recorded that their day-to-day activities were 'limited a lot' by their long-term health condition or disability (87%) were more likely to social rent than those who were 'limited a little' (80%) and those who were 'not limited' (56%).

- Compared with the general population, British Sign Language (BSL) users were almost twice as likely to live in social rented accommodation (37% of BSL users compared with 21% of all people) and were less likely to be home owners – 50% of BSL users owned their home, compared with 67% of all people.
- Social renters were more likely to have a limiting, long-term physical or mental health condition (38.6%) than the population as a whole (22.6%).
- The amount of wheelchair-adapted local authority housing for physically disabled people decreased from around 2,525 units in 2006 to 2,062 in 2015. The number of houses had been increasing and peaked in 2013 at 3,239 before declining over the following two years (Scottish Government, no date). More recent data from the Scottish Household Survey 2015 shows adults in social rented properties are more likely to be 'permanently sick' or disabled (13%) compared with adults in private rented households or owner-occupier households (Scottish Government, 2016e).
- There is not a common and shared recording method of demand for accessible and wheelchair-suitable housing at local authority level. Research undertaken for Horizon Scotland and the Chartered Institute of Housing estimated a total number of 119,800 wheelchair users in Scotland; 17,000 of them had unmet housing needs (14.2% of all wheelchair users). However, it was not possible to produce estimates at lower geographies due to the sample sizes of the Scottish House Condition Survey, which was the principal data source (Watson, Lynn *et al.*, 2012).
- The Scottish House Condition Survey reports that around 5% of households identify a need for adaptations.
- Data on supported housing for older people from the Scottish Government indicates that local authority provision of very sheltered housing[38] and wheelchair-adapted housing increased between 2010 and 2015, although the amount of sheltered housing for this group decreased. In contrast, the amount of local authority-provided supported housing for physically disabled adults decreased over the same period for wheelchair-adapted, ambulant disabled and other adapted housing (Scottish Government, 2016f).

Data gaps

There is limited data on food poverty, fuel poverty and disability; any available data does not seem to be disaggregated.

There is very little information on the levels and impact of social isolation experienced by disabled people in Wales.

Disaggregated housing data on Wales is very limited.

"In 2014, 28.2% of disabled adults in England reported their current health status as bad or very bad compared with 0.9% of non-disabled people"

6. Health and care

This chapter is concerned with the health of disabled people and their use of and access to health and social care services.

This involves disabled people's capability to attain the highest possible standard of physical and mental health. It also involves having access to timely and impartial information about health and healthcare options. The ability of disabled people to have access to healthcare without discrimination, and in a culturally sensitive way, is also crucial to their experience of healthcare, as is giving informed consent to receiving medical treatment or participating in medical experimentation. Maintaining a healthy lifestyle and being able to live in a healthy and safe environment are also discussed in this chapter. Where health is poorer for some groups than others, the evidence may indicate a need for policy or practice to address such inequalities and to ensure that all groups can enjoy sufficient and similar levels of health and healthcare.

Five specific indicators were chosen to assess how well the rights of disabled people relating to health and care are protected in Britain, including a spotlight issue for closer attention. These are:

1. Health inequalities
2. Obesity
3. Mental health
4. Social care and support
5. Spotlight: Healthcare for people with a learning disability

England, Wales and Scotland have different legislative, regulatory and public policy frameworks in place, all of which make provisions for protecting rights relating to health and care though not necessarily in the same way. However, the Equality Act 2010 and Human Rights Act 1998 have implications for health and social care and apply across all three countries.

6.1. Health inequalities

Legal and policy framework

Since 1999, health has been a devolved matter, with the Scottish Government and Welsh Assembly determining the budget for most healthcare (within a block grant from the UK Government) and how services are organised. Over the last decade health provision has been reformed in each of the three countries. Addressing and monitoring health inequalities have become key priorities; however, inconsistent data collection remains an issue.

England

In England, the NHS Outcomes Framework was designed to enable disaggregation of outcome data by protected characteristic. However, there is very limited data being collected by NHS providers and commissioners about outcomes for disabled people generally, or by specific impairment. This failure to collect data makes it very difficult for the UK Government, Clinical Commissioning Groups and NHS Trusts to assess the extent of inequalities experienced by disabled people generally, and disabled people with specific impairments, in access to, experience of, and outcomes from NHS provision at both a national and a local level.

The Public Health Outcomes Framework sets out outcome measures that could be used to identify where different groups experience health inequalities. As with the NHS Outcomes Framework, however, data collection on outcomes for disabled people is very limited, making it difficult to identify inequalities experienced by disabled people.

In England, the 2012 Health and Social Care Act aimed to put equality at the heart of a reformed healthcare system, including a duty on the Secretary of State for Health, NHS England and Clinical Commissioning Groups to have regard to the need to reduce health inequalities.

The Act also introduced duties and powers for health and wellbeing boards in relation to Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies. The purpose of both is to improve the health and wellbeing of local communities and reduce inequalities. The Department of Health (2013b) has developed statutory guidance that urges health and wellbeing boards to specifically assess current and future health and social care needs for those in disadvantaged areas, children and young people with Special Educational Needs or a Disability, and people with a learning disability or autism who also have a mental health condition or behaviours viewed as challenging. Local authorities have adopted different approaches on the types of group to include in their assessments. Many local health and wellbeing boards conduct Joint Strategic Needs Assessments that specifically look at people with a learning disability, but some other types of impairment are rarely covered.[39]

Wales

In Wales, one of the seven inter-related wellbeing goals of the Well-being of Future Generations (Wales) Act 2015 is to create ‘a society in which people’s physical and mental wellbeing is maximised and in which choices and behaviours that benefit future health are understood’. In combination with the goals for ‘a more equal Wales’, health services are required to more actively identify and address health inequalities and inequities for disabled people in Wales (NHS Wales, 2015).

To support the introduction of the national indicators for the Wellbeing of Future Generations (Wales) Act 2015, a Public Health Outcomes Framework is used to measure and monitor the health of the Welsh population (Welsh Government, 2016e). The Welsh Government's Primary Care Plan and Public Health Wales have created a delivery framework for local health boards and neighbouring GP practices to set specific goals, including reducing health inequalities (Welsh Government, 2015e). The Social Services and Well-being (Wales) Act 2014, which came into force in April 2016, changes the way health and social care is provided, giving disabled people and carers more control.

Scotland

System reform in Scotland has brought health inequalities high up the agenda and strives towards an integrated health, equality, human rights and health inequalities approach. The National Performance Framework reports on how well people fare in Scotland, and attempts to provide a data breakdown of disabled and non-disabled people if possible. Indicators include premature mortality, general health and wellbeing, healthy life expectancy and smoking prevalence, and these are used to monitor population health over time as well as progress in reducing health inequalities.

Outcomes

In this section, we present outcome evidence on health inequalities. Unless otherwise stated, the figures reported here, on poor current health status, are from analysis specifically for this report using data from the Health Survey for England, Scottish Health Survey and Welsh Health Survey. See online data table EB2.1.

England

In 2014, disabled adults in England were more likely than non-disabled adults to report their current health status as bad or very bad (28.2% compared with 0.9%), with no change compared with 2012. This disparity was seen for all impairment groups in 2014, including those with an impairment affecting their memory (43.7% of whose current health status was bad or very bad), dexterity (42.1%), stamina or breathing or fatigue (40.8%), learning or understanding or concentrating (40.0%), mental health (38.9%) or vision (33.1%). The percentages reporting bad or very bad health were reduced for two of these groups since 2012, those with impairments affecting memory and vision, although it should be noted that some of these groups have relatively small sample sizes, which means that only large changes over time would be statistically significant.

Allowing for the combined effects of age, disability, gender, use of a car, and whether the person is a carer, bad or very bad health was more common for all in the 65-74 and 75 and over age groups, and the increase associated with disability was higher for disabled people in the 35-44, 45-54 and 55-64 age groups. Use of a car was associated with lower levels of bad or very bad health, and the difference between disabled and non-disabled people was greater for those without use of a car. Disabled people without use of a car were most likely overall to report bad or very bad health.

Wales

In 2013 & 2014,[40] disabled adults in Wales were more likely to report their current health status as bad (17.0%) compared with non-disabled adults (0.4%). The percentage for both groups had dropped since 2009 & 2010, and the gap between

them decreased by 2.3 percentage points. In 2013 & 2014, a high percentage of adults with cancer or benign growths (35.0%) reported bad health. Compared with 2009 & 2010, several impairment groups in 2013 & 2014 reported lower rates of bad health. These were people with: mental health conditions or learning difficulties (decrease of 5.9 percentage points to 18.8%), physical disabilities (decrease of 1.7 percentage points to 14.4%) and those with 'other health conditions' (decrease of 2.6 percentage points to 20.9%).[41]

Allowing for the combined effects of age, disability, gender, whether a carer, socio-economic group, and region of Wales, bad health was highest for the 75 and over age group and the effect of being disabled was reduced for this group. However, the effect of disability was higher in the 35-44, 45-54 and 55-64 age groups and reported ill health was particularly high for the 45-54 and 55-64 age groups. Bad health was more common in Mid and West Wales; however, the effect of disability was less in this region, and bad health was reported at a similar level in South East, Mid and West Wales.

The Welsh Government (2015c) conducted a review of the evidence on inequalities in access to health services in Wales and identified several gaps for disabled people:

- The difference in non-disabled life expectancy between the most and least deprived in Wales was 14.8 years for men and 12.5 years for women.
- A link can be drawn between poor health literacy and adverse health outcomes. Those with 'long-term limiting illnesses' or a disability are more likely to have lower levels of health literacy.
- Carers had disproportionately poorer health in comparison to the general population.
- Only 24% of people with depression and anxiety disorders had received any form of treatment, only 8% of patients with depression had seen a psychiatrist and only 3% of patients with depression had seen a psychologist.
- Many deaf people or those with a hearing impairment were forced to make contact with their GP using a method that was not the best for them, and 90% of GP surgeries in Wales did not offer suitable alternatives for making appointments.
- There were significant geographic variations in access to healthcare services for disabled people across Wales, particularly mental health and rehabilitation services.
- There were seen to be negative and disproportional effects on the health outcomes of disabled people as a direct result of the Welfare Reform Act (Welsh Government, 2015c).
- There was a severe lack of published evidence in terms of access to healthcare services for disabled people in Wales (Smith, 2015).The 2015 Children in Need census found that over one-fifth (21%) of children in need in Wales were disabled (Welsh Government, 2015c).

Scotland

In 2013 & 2014, a higher percentage of disabled adults in Scotland reported their current health status as bad or very bad (25.1%) compared with non-disabled adults (0.5%), with no change identified from 2009 & 2010 levels. In 2013 & 2014, rates of bad or very bad health were particularly high for adults with cancer and benign growths (40.1%) and those with a mental health condition or learning difficulty (36.3%).

Allowing for the combined effects of age, disability, gender, use of a car, and socio-economic group, bad or very bad health was less common for 16-24-year-olds, for women, for those that had the use of a car, and more common for the socio-economic groups covering lower supervisory and technical, semi-routine and routine occupations.

An inquiry by the Scottish Health and Sport Committee (2015) found that disabled people were a key group affected by health inequalities. They experienced health inequalities in two ways, by living in poverty and through the discrimination that exists in access to health services. Many disabled people found it difficult to access mainstream transport so often needed to rely on more expensive transport, such as taxis, making it difficult and/or more expensive to get to appointments. Flexible systems such as phone appointments were often not available to disabled people, either because they were not accessible options for them or because surgeries did not use them.

Analysis of the Scottish Inpatient Survey 2010[42] (Scottish Government, 2010b) shows that patients with 'deafness or a severe hearing impairment' were less likely to report a positive experience of their time in accident and emergency, having not been told what was happening in a way they could understand. 'Visually impaired and blind' patients had similar experiences to non-disabled people, although they were less likely to know how and when to take their medicines, and were less confident of being able to look after themselves once they got home. Patients with a learning disability were less likely to answer positively about being involved in decisions about their care; this may be because family and hospital staff were more likely to be involved in these decisions. Patients with a mental health condition were generally less positive compared with others (Scottish Government, 2010).

The EHRC supported a profoundly deaf patient to raise a claim of discrimination under the Equality Act against NHS Tayside in 2014 after she spent seven days in hospital without any British Sign Language interpretation services made available to her. This greatly limited her ability to understand what treatment she was receiving, to participate in her care or even to ask questions. NHS Tayside admitted liability and entered into a formal agreement with the EHRC, which has resulted in change for over 900 deaf NHS users in Tayside (EHRC, 2016b).

6.2. Obesity

Under this indicator, we present policies and statistical outcomes measures on obesity. Unless otherwise stated, the figures reported here, on adult and child obesity, are from analysis specifically for this report using data from the Health Survey for England, Scottish Health Survey and Welsh Health Survey. See online data tables EB4.1e and CB4.3. Specific measures used include the percentage who are living a healthy lifestyle, covering body mass index, and the percentage of children and young adults who are overweight or obese.

England

The UK Government's call to action on obesity sets out the national ambition for a sustained downward trend in obesity by 2020 (HM Government, 2011). The corresponding equality analysis highlights that there is no population-level data on obesity prevalence in physically disabled people, and that monitoring can be problematic because of difficulties with weighing and measuring disabled people (DH, 2011a).

In 2014, disabled adults in England were more likely to be overweight or obese (71.2%) than non-disabled adults (59.1%), with little change compared with 2012. In several of the impairment groups, a higher percentage of disabled people were overweight or obese, such as adults with impairments affecting their hearing (75.7%), stamina or breathing or fatigue (75.4%), and mobility (74.3%). An improvement was seen in the group with mobility impairments, with a decrease of 5.0 percentage points, which narrowed the gap between this group and non-disabled people.

Allowing for the combined effects of age, disability, gender, whether in a couple, and whether a carer, the percentage who were overweight or obese increased with age and was high in the four oldest groups (aged 45 and over); however, the effect of disability on weight was greatest in the 16-24 age group. Men were more likely than women to be overweight or obese, and while it was most likely for disabled men, the effect of disability on being overweight or obese was greater for women.

In 2013 & 2014, disabled children and young people (aged 2-15) in England were more likely to be overweight or obese (41.8%) than non-disabled children and young people (29.4%). This difference between the groups had not changed compared with 2009 & 2010. Data from 2012, 2013 & 2014 shows that children and young people with a dexterity impairment (for example, lifting and carrying objects, using a keyboard) (53.3%), a memory impairment (49.7%), and a 'learning or understanding or concentrating impairment' (43.0%) were more likely to be overweight or obese compared with non-disabled children and young people (28.7%). Allowing for the combined effects of age, disability and gender, being overweight or obese was higher for the 11-15 age group.

Wales

The All Wales Obesity Pathway works with health boards and local authorities to tackle the obesity problem in Wales. However, it does not address the needs of disabled people specifically and only states that people with a learning or physical disability may need additional services and planning, without specifying how this would be implemented.

In 2013 & 2014, disabled adults in Wales were more likely to be overweight or obese (67.1%) than non-disabled adults (53.3%). There was an increase in the proportion of disabled people who were overweight or obese from 65.4% in 2009 & 2010 and the gap between disabled and non-disabled adults widened during this time.

The percentage of people who were overweight or obese was higher for adults with a physical disability (70.5%), a mental health condition or learning difficulty (63.8%), or with 'other health conditions' (64.7%).

Allowing for the combined effects of age, disability, gender, whether a carer, socio-economic group, and region of Wales, being overweight or obese was least common for those aged 16-24, increasing to the 45-54 age group and then decreasing at older ages. Men were more likely than women to be overweight or obese, and while it was most likely for disabled men, the effect of disability on being overweight or obese was greater for women. It was also least common for those people in higher managerial and professional occupations compared with other socio-economic groups. Carers were more likely to be overweight or obese than non-carers and those in South East Wales compared with those in North Wales.

In 2011 & 2012, 45.3% of disabled children and young people (aged 2-15) in Wales were overweight or obese, compared with 34.0% of non-disabled children and young people. There was no change compared with 2009 & 2010. Allowing for the combined effects of age, disability and gender, being overweight or obese was more common for both the 4-12 and 13-15 age groups than for the youngest age group.

Scotland

Scotland has one of the highest levels of obesity in OECD countries and has identified a national indicator to increase the percentage of children aged 2-15 years whose body mass index lies within a healthy range. It has announced plans to work towards developing a further indicator covering the whole population. However, its obesity prevention plan does not specifically discuss the needs of disabled people (Scottish Government, 2010a).

In 2013 & 2014, disabled adults in Scotland were more likely to be overweight or obese (73.0%) compared with non-disabled adults (61.5%); however, there was little change compared with 2009 & 2010. Almost all impairment groups had a greater percentage who were overweight or obese than non-disabled people, including adults with cancer or benign growths (79.5%), those a hearing impairment (76.8%) and those with a physical disability (75.5%).

Allowing for the combined effects of age, disability, gender, use of a car, and socio-economic group, the percentage who were overweight or obese increased with age and was high in the four oldest groups (aged 45 and over). Men were more likely than women to be overweight or obese, and while it was most likely for disabled men, the effect of disability on being overweight or obese was greater for women. Being overweight or obese was also more common for people in Intermediate or semi-routine occupations.

In 2013 & 2014, disabled children and young people (aged 2-15) in Scotland were more likely to be overweight or obese (37.6%) compared with non-disabled (29.1%). This reflected no change compared with 2009 & 2010. Allowing for the combined effects of age, disability and gender, the effect of disability is mainly seen in the 11-15 age group, with being overweight or obese most common for young disabled people in this age group.

6.3. Mental health

The term ‘mental ill health’ covers a wide range of conditions that affect mood, thinking processes and behaviour, from mild depression and anxiety to severe, acute psychosis. Mental health conditions are among the largest single sources of disability and mental health can be more debilitating than chronic physical conditions. Yet only a quarter of all those with ‘mental ill health’ are receiving treatment, compared with the vast majority of those with physical health conditions (Centre for Economic Performance, 2012). The life chances of people with mental health conditions are greatly reduced compared with the general population. On average, men with mental health conditions die 20 years earlier, and women die 13 years earlier, than the general population; the majority of deaths in this group arise from preventable causes and could have been avoided by timely medical intervention (BMA, 2014).

England

The Health and Social Care Act 2012 includes the principle that mental health must be given equal priority to physical health in England. The concept of ‘parity of esteem’ has been actively promoted

People with mental health conditions die earlier than the general population

since then (DH, 2013c; NHS England, 2014; Parliamentary Office of Science and Technology, 2015). The better integration of mental health and physical healthcare is consequently seen by the UK Government as a policy priority (DH, 2014a). In 2014, the Department of Health and NHS England acknowledged a treatment gap, with most people with mental health conditions receiving no treatment, and severe funding restrictions on mental health services compared with physical health services (DH and NHS England, 2014).

In March 2015, the All-Party Parliamentary Group (APPG) on Mental Health inquiry into parity of esteem reported that, although progress had been made in some areas, there was still a long way to go before parity would be achieved. It highlighted that mental health conditions affect more than one in four people and cost the English economy an estimated £105 billion a year. However, only £3 million is currently spent annually on mental health promotion, which is less than 0.03% of the mental health NHS budget (APPG on Mental Health, 2015).

In March 2015, NHS England set up an independent Mental Health Taskforce, with the aim of developing a five-year national strategy for mental health, covering services for all ages (NHS England, 2015). Its national strategy was published in February 2016 and implementation plan in July 2016 (NHS England, 2016a). It signifies a strategic approach to improving mental health outcomes across the health and care system, in partnership with the health sector arm's length bodies (NHS England, 2016b). Recommendations revolve around: achieving the ambition of parity of esteem between mental and physical health; access to good quality mental health care wherever people are seen in the NHS; and a focus on tackling inequalities, for example, mental health conditions disproportionately affect people living in poverty, those who are unemployed, and those who already face discrimination (NHS England, 2016b). The five-year forward view for mental health focuses largely on access to treatment and therapy. Apart from employment support, it says little about improving the life chances

of people with mental health challenges. This is important because the social care section of the Annual Community Survey shows that 43% of people using mental health services wanted help or advice with finances or benefits, accessing local activities, and work, but did not receive it. This is in contrast to the 26% who said they wanted help or advice with finding support for physical health needs but did not receive it (CQC, 2016).

Mental health services in England vary greatly in their ability to provide an appropriate, timely and high-quality response to people experiencing a mental health crisis, with many people dissatisfied with the help they are given (CQC, 2015). Sector regulator the Care Quality Commission (CQC, 2014; 2015a) and Mind (2012) have highlighted problems in access to care during a mental health crisis.

There are promising signs of progress. NHS England is piloting a range of new approaches to service provision to inform future progress, and the Care Quality Commission has committed to monitor how services develop. In its response, the UK Government has committed to provide £1 billion of additional funding for mental healthcare by 2021. This will include providing support for up to one million more people, more services for children and young people and an end to the practice of sending people out of their area for acute inpatient care.

Research shows that people with poor mental health use more emergency hospital care than those without. In 2013/14, this was 3.2 times as many A&E attendances and 4.9 times as many emergency inpatient admissions. Only a small part of this emergency care was explicitly to support mental health needs. In 2013/14, 19% of emergency inpatient admissions for those with 'mental ill health' were to explicitly support their mental health. This means that the majority of care was used to support other health concerns (Quality Watch, 2015).

In England and Wales, governments have provided substantial funding for access to psychological therapies (NHS Wales, 2014). Over 1.1 million patients were referred to the Improving Access to Psychological Therapies programme in England in 2013/14 (HSCIC, 2014b). The waiting time target for treating people experiencing 'mental ill health' was cut to 28 days to ensure faster access to treatment,

Target waiting time

Improving Access to Psychological Therapies programme in England

Waiting time for some people

health and social services. However, the proportion of those patients who started treatment within 28 days varied between 3.0% and 96% in 2013-14, depending on the Clinical Commissioning Groups concerned. Eleven per cent of patients waited for over 90 days. The Improving Access to Psychological Therapies programme has been hailed a success, with annual increases in the numbers of people treated and achieving improvements in anxiety and depression (*Pulse*, 2013). Some commentators, though, have questioned the drop-out rates and whether the programme is reaching those patients who need help the most, such as those with chronic depression (*Pulse*, 2013). In addition, the funding provided to expand the programme in England has not been ring-fenced, raising concerns about whether the national ambition is reflected consistently in local spending decisions (King's Fund, 2015).

Some people need the specialist help available in inpatient mental health units but there has been a reduction in mental health inpatient provision in England, which decreased by 10% between December 2010 and December 2014, from 23,740 beds to 21,446 (NHS England, 2015c). This reduction results in part from policies to introduce a more community-based model of services (CAAPC, 2015); however, this has come at a time when community mental health services and the voluntary sector have undergone major cuts. When combined with other social determinants of mental health that are worsening, such as poverty, unemployment and social isolation, people have less support to prevent crisis and maintain living in the community, therefore putting more pressure on beds.

The Commission on Acute Adult Psychiatric Care (CAAPC) in England suggested that the reduction in bed numbers may have 'gone too far' (CAAPC, 2015, p.7). It stressed the need to view inpatient psychiatric care as part of the wider system, especially as NHS Trusts that focus on improving the overall acute care pathway had fewer difficulties with their acute care bed base. In addition, some of the evidence received by the CAAPC emphasised the need for investment in better quality community services rather than inpatient beds. This is especially the case for people with a learning disability or autism, who can be in inpatient psychiatric care due to a lack of suitable support services in the community.

A CAAPC report in England (2015, pp.6-13) referred to units with 'demoralised staff who are trapped in a constant process of crisis management' and patients 'stuck in locked wards with nothing to do'. Inspection reports included concerns about the inappropriate use of blanket rules (such as limiting access to the internet or outside areas and rigid visiting times) as practices that 'have no basis in law or national guidance on good practice and are unacceptable' (CQC, 2014, p.3). Inadequate regard for patients' privacy and 'controlling practices that only seem to serve the hospital's needs' have been criticised as infringing patients' human rights, particularly the right to dignity (CQC, 2013, p.33).

In 2015, Quality Watch reported that bed occupancy in inpatient facilities is frequently well above recommended levels, with community services, in particular crisis resolution and home treatment teams, often unable to provide sufficient levels of support to compensate for reductions in beds. This is having a negative impact on safety and quality of care (Quality Watch, 2015). Furthermore, only 14% of patients say that they received appropriate care in a crisis, and there has been an increase in the number of patients who report a poor

experience of community mental health care (Quality Watch, 2015). The lack of available beds is leading to high numbers of out-of-area placements for inpatients, which are costly, have a detrimental impact on the experience of patients, and are associated with an increased risk of suicide (Quality Watch, 2015).

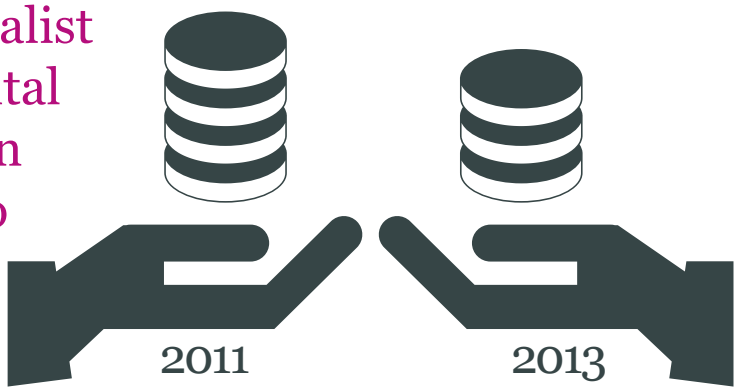
The House of Commons Committee of Public Accounts (2016) reported that the number of people in long-term placements has remained broadly stable at 3,200, and that children and adults are continuing to go into mental health hospitals because of a lack of good quality alternatives in their local community. The Committee highlighted evidence that over a third of patients are placed in hospitals over 50km from their homes, and that a fifth of people in inpatient settings had been there for over five years. It concluded that inadequate levels of community services are exacerbated by current commissioning practice and the lack of pooled health and social care budgets.

The use of physical restraint in hospitals has been flagged up as a cause for concern. Mind reported in 2013 on huge variations in the use of physical restraint in hospitals in England: over one year, one trust reported 38 incidents, while another reported over 3,000. The report noted nearly 1,000 incidents of physical injury following restraint during the year. CQC's Mental Health Act Monitoring Report for 2012-13 repeated earlier criticisms of restraint and called for cultures that support therapeutic practices instead (CQC, 2014). Since then, UK Government policy papers in England have set out the need for a reduction in the use of restraint (DH, 2014a) and an end to 'planned or intentional restraint of a person in a prone/face down position' – while accepting that some prone restraint may still occur (DH, 2014c; 2015). The recording of data on restraint incidents is, however, incomplete, with only 46 out of 67 mental health organisations submitting returns in 2013/14 (HSCIC, 2014c). Without this, it is difficult to monitor practice, either locally or nationally (CQC, 2015). However, from 2016, data on the use of restraint and other restrictive interventions will be included in the NHS Digital Mental Health Services Data Set. Additional work has focused on increasing the number of complete returns and improving definitions to strengthen robustness and comparability between organisations (DH, 2014c).

Reduced funding in specialist child and adolescent mental health service provision in England has amounted to

25% cuts

between 2011 and 2013 in some areas



There are considerable shortcomings in the provision of mental health services for children and young people. In 2017 the results of a review of care and support for children and young people with complex needs involving mental health, learning disabilities and/or autism stated that despite the numerous programmes to help this group of children, together they have not added up to a definitive coherent strategy (Lenehan, 2017). The House of Commons Health Select Committee (2014) reported on problems with the commissioning and provision of child and adolescent mental health services (CAMHS). Dedicated CAMHS for looked after children had disappeared in some areas because of pressures on local authority funding (EPI, 2016). Extensive disinvestment in specialist CAMHS provision in England since 2011 has amounted to 25% cuts in some areas (NHS Benchmarking Network, 2013; YoungMinds, 2013).

Funding for CAMHS is generally organised through schools and colleges. As a result, looked after children who are over 16 and not in education rarely receive CAMHS, even if they require it (Adolescent and Children's Trust, 2016).

The UK Government's report to the UN Committee on the Rights of the Child in May 2014 noted that it was making improvements to CAMHS and improving access to therapies for children (HM Government, 2014b). Support would be provided to schools to help them identify mental health issues sooner (DH, 2014a). Actions to follow up the earlier pledge to improve children's mental health through early and effective treatment (DH, 2013a) included: £54 million from 2011-12 to 2014-15 to fund the Children and Young People's Improving Access to Psychological Therapies programme; the development of interactive e-learning programmes on mental health to extend the skills of those working with children in universal settings; and £1.6 million per year (since 2007-8) to support the implementation of targeted CAMHS within the HM Prison Service young people's estate (under-18s). In 2015/16, the Government invested £1.4 billion to transform CAMHS; however, there are concerns that this has not been spent on the frontline (Frith, 2016).

The Chief Medical Officer for England reported an increase in waiting times within CAMHS; this occurred with a three-week median wait for urgent access to services (Davies, 2014). The NHS reports an increase in average waiting times to 15 weeks for CAMHS since 2011 (NHS Benchmarking Network, 2013).

Problems with access to inpatient mental health services means children and young people's safety could be compromised while they wait for a bed to become available. The House of Commons Health Select Committee reports that when beds are found, they might be in distant parts of the country, making contact with family and friends difficult, and leading to longer stays (The House of Commons Health Select Committee, 2014). Furthermore, the increased waiting times for CAMHS means increased referral thresholds; 'battles' (according to young people and their parents) to access services, with only the most severely affected young people receiving appointments (The House of Commons Health Select Committee, 2014). The national director of the Care Leavers Association supported this view by adding that the level of assessment that CAMHS used was 'too high' (Data.parliament.uk, 2016). The result of high thresholds for treatment can mean that young people are placed at the end of lengthy waiting lists. The 'Access denied' report by the Children's Society states that some children (9%) do

not even get a proper assessment and are discharged from services if they miss an appointment with a specialist mental health worker. Further research shows that one-fifth of all children referred to local specialist NHS mental health services are rejected for treatment. For those who can access services, the Children's Society commented that waiting times are a 'postcode lottery', with the average waiting time ranging from 13 to 140 days (Children's Society, 2015).

Evidence obtained by the Children's Commissioner (2016) shows that three-quarters of CAMHS did not gather data on whether children referred had a disability, and the majority of the CAMHS that did only gathered data on children and young people with learning disabilities because they offered specialist provision in this area. This suggests that these CAMHS may not be considering how services could be made accessible. However, since 1 January 2016 this information is being collected by all trusts as part of the new Mental Health Services Data Set. In addition, 46% of CAMHS stated that they only cater for certain conditions. This means that children and young people with mental health needs who did not have these conditions would not be offered CAMHS provision (for example, 'severe, complex and persistent diagnosable disorders') or tier 4 (for example, the most serious conditions).

The transition from children's to adult services was highlighted by the UN, which expressed concern that children are sometimes treated on adult psychiatric wards. In England, there has been some further hospitalisation of children on adult wards; this can include children as young as 12 (CRAE, 2014; BBC, 2014a). The resultant exposure to frightening conditions can itself lead to further distress and traumatisation (BBC, 2014a). Staff on these wards may not be trained in child and adolescent mental health, and the young people themselves may be denied their right to education (CRAE, 2014). The National Society for the Prevention of Cruelty to Children described the withdrawal of CAMHS at 18 as a 'cliff edge' in care (NSPCC, 2016).

Wales

The Welsh Government Equality Objectives call for the needs, rights and contributions of people with protected characteristics to be at the heart of the design and delivery of all public services, in particular health and mental health services (Welsh Government, 2016f). As of 2015, the Welsh Government announced that an extra £15.6 million will be invested every year in mental health services in Wales, taking the total investment to more than £600 million per year (Health in Wales, 2015).

A report by the Welsh Government (2016h) looked at the number of patients in mental health hospitals and units. According to the report, there were 1,430 resident patients, a decrease of 560 (28%) since 31 March 2006, and of 11 (1%) since 31 March 2015. Of all resident patients, 580 patients (41%) were detained under the Mental Health Act 1983 and other legislation, an increase of 52 (10%) from 2006. Overall, there were fewer female patients (625) than male patients (805).

The total number of admissions to mental health facilities (excluding place of safety detentions) in Wales in 2015-16 was 9,570, a slight decrease of 2% compared with 2014-15. Of these the vast majority (7,569) were informal admissions, meaning people agree to their admission and can leave hospital at any time, a decrease of 272 (3%) from in 2014-15. However, the number of people admitted to hospital under a section of the Mental Health Act and compelled to remain in hospital (formal admissions)

has risen from 1,453 in 2012-13 (1,921 in 2014-15) to 2,001 in 2015-16 (Statistics for Wales, 2016).

Similar to the issues in England, several organisations have expressed concerns about the continued hospitalisation of children on adult wards (Health Inspectorate Wales, 2013). An inquiry by the Children, Young People and Education Committee in 2014 stated that there had been a 100% increase in demand for CAMHS in the previous year and concluded that current services did not have sufficient capacity to meet this level of demand (National Assembly for Wales, 2014). The Committee noted that the CAMHS National Improvement Plan, published in March 2014, would not have sufficient impact to deliver the scale of change needed. The Committee believed that the Mental Health (Wales) Measure 2010 might have had a negative impact on children and young people, given evidence of disruption to previously established referral pathways and adult mental health staff not having the skills and experience needed for work with children and young people. The Committee also expressed concern about the increasing use of prescription medicine to manage young people's conditions in the absence of other support being available.

The number of referrals to CAMHS in Wales nearly doubled from 1,204 to 2,342 between April 2010 and July 2014.

The Welsh Government established a project board of key stakeholders to oversee implementation of the CAMHS National Improvement Plan. It announced a £7.6 million annual investment in CAMHS from 2015-16 to improve provision and support service change. Part of the Welsh Government's CAMHS investment includes plans to enhance provision for children and young people under the Local Primary Mental Health Support Services established under the measure.

To improve awareness, knowledge and understanding of suicide and self-harm among the public and professionals in Wales, the 'Talk to me 2' campaign was launched in 2015 and is set to run until 2020 (Welsh Government, 2015d). It continues the work conducted under 'Talk to me' during' 2009 to 2014 (Welsh Assembly Government, 2009).

Scotland

People with poor mental health have an increased risk of physical illness, and a much higher mortality rate, dying on average more than 10 years earlier than the general population (Scottish Government, 2012).

The importance of access to primary care has been highlighted by the Scottish Government whose research shows that 25% of those with common mental health conditions receive treatment, and much of this is provided in primary care. As a consequence, a significant proportion of GP consultations are for mental health conditions. Stigma and the nature of service provision, as well as other factors, can, however, act as barriers to seeking help. Demand for specialist mental health services for both adults and children in primary care is increasing and primary care is not always able to meet this need. Prevention strategies and early intervention are therefore essential (Scottish Government, 2016j).

The Scottish Government is currently consulting on a Mental Health Strategy for 2016-26. Responses from key stakeholders have highlighted the need for a more ambitious transformational vision, criticising a lack of strategic vision, a lack of co-production in developing the strategy, and a focus on services rather than broader

considerations of mental health. There has also been criticism of a failure to evaluate the previous strategy and to follow up on numerous recommendations made under that strategy, leading to a series of outputs rather than any real change in outcomes (Inter alia, The Alliance, Mental Welfare Commission and Royal College of Psychiatrists, 2016). These recommendations include a review of mental health services that would provide views on future development and reflection on the successes and challenges of the mental health system in Scotland, based on the perspectives and experiences of service users, carers and professionals, for the Scottish Government to take forward in relation to human rights and mental health (SHRC and MWCS, 2015).

The Scottish Government announced an extra £54 million to improve NHS services and increase the capacity to treat up to 20,000 patients a year by 2020 (Scottish Government, 2016). This brought the total additional pool of investment in mental health services up to £150 million, to be spent over a total of almost five years. As a point of comparison, NHS spending on CAMHS across Scotland represented £45.2 million in 2013/14 (Scottish Parliament 2015). A Mental Health Access Improvement Support programme was established to help health boards identify factors affecting access to mental health services, and support them to meet waiting time targets (Scottish Parliament, 2016).

Access to psychological therapies remains a concern. Scotland has a target to ensure faster access to psychological therapies for all patients (Scottish Government, 2014b). The target is 18 weeks from referral to treatment; however, the majority of Health Boards in Scotland failed to meet this target.[43] There are also a range of unmet needs in intensive psychiatric care units: a lack of activities, rehabilitation or a therapeutic environment; a 'one size fits all' approach to risk management; and a lack of opportunities for meaningful involvement in the care process (NHS Quality Improvement Scotland, 2010).

There are also concerns in relation to chemical restraint. In a review of units providing longer-term care for people with dementia, the Mental Welfare Commission for Scotland (2014) found high levels of use of antipsychotics, anxiolytics and sedative antidepressants in the management of stressed and distressed behaviours. They were often used in combination and without evidence of a regular review of the necessity for these medications. There is no systematic collection of data on the use of physical restraint in care settings.

The provision of adequate mental health services for children and young people is problematic. In relation to Scotland, the Committee on the Rights of the Child (2016) expressed concern that:

- Children with a mental health condition are often treated far away from home, do not receive adequate child-specific attention and support, and are placed in adult facilities, or may even be detained in police custody owing to a shortage of places in mental health clinics.
- The new shortened waiting period targets may not be realised in practice owing to a lack of infrastructure (number of specialists and clinics/centres).
- The significant investments in improving mental health services will not necessarily lead to an improvement in the quality of services.
- Therapeutic community-based services have not been sufficiently developed.

In 2009, the Scottish Government introduced a target of a maximum 26-week wait from referral to treatment for specialist CAMHS from March 2013, reducing to 18 weeks from December 2014 (ISD Scotland, 2015). It also determined that the target should be delivered for at least 90% of patients. As of March 2016, 4,436 children and young people started treatment at CAMHS in Scotland, which is similar to the previous quarter (4,483) and higher than the same period the previous year (4,269). 84.2% were seen within 18 weeks and half started their treatment within eight weeks (ISD Scotland, 2016). In focusing on access to medical services, however, the Scottish Government targets do not measure the outcome or effectiveness of interventions, nor do they capture how well children and adolescents with mental health conditions are supported.

The Mental Welfare Commission for Scotland's 2016 review of mental health services in Scotland found participants reported improvements in transitions between CAMHS and adult mental health services. However, it also noted that access to specialist services for young people, such as Early Intervention in Psychosis teams, and support focused on looked after young people, was limited, particularly outside major cities. Some review participants felt that links between CAMHS and paediatric services could improve. In March 2016, the Scottish Youth Parliament held a mental health discussion event. Participants offered a range of perspectives on transitions from CAMHS to adult mental health services. Many indicated support for a 'bridging service' or other transitional arrangements that would minimise disruption to care and smooth pathways to adult mental health services (SYP, 2016a). The Scottish Youth Parliament's research found several respondents 'asserted the need for a mental health service tailored to 16-26-year-olds' (SYP, 2016b). The report notes guidance produced by the Mental Health Foundation and Paul Hamlyn Foundation suggesting that adult mental health services are often not 'young person friendly' and young people aged 16-25 have 'their own distinct mental health needs' (Right Here, 2014, p.4).

Outcomes

Unless otherwise stated, the figures reported here, on adults and children who report poor mental health and wellbeing, are from analysis specifically for this report using data from the Health Survey for England, Scottish Health Survey and Welsh Health Survey. See online data table EB1.2 and CB1.2.

England

In 2014, a third of disabled adults in England reported poor mental health and wellbeing (a 12-item General Health Questionnaire (GHQ-12) score of 4 or more) compared with one in 10 non-disabled adults (9.8%). There was no change compared with 2012, and no change in the gap between the groups during this time.

In 2014, poor mental health was more common for all impairment groups, for example: adults with a mental health impairment (68.2%), those with a social or behavioural impairment (for example, associated with autism, attention deficit disorder or Asperger syndrome; 63.6%), and those with a learning or understanding or concentrating impairment (57.3%). The percentage of adults with a memory impairment who reported poor mental health and wellbeing decreased between 2012 (61.6%) and 2014 (51.7%).

Allowing for the combined effects of age, disability, gender, sexual identity, use of car,

whether a carer and whether in a couple, poor mental health was more common for: younger age groups, women, people who identified as lesbian, gay or bisexual or other sexual identity, those without use of a car, carers, and those not in a couple. However the increase in poor mental health associated with disability was less for women than for men and for non-carers compared with carers.

The percentage of disabled children and young people aged 13-15 who reported poor mental health in England in 2012 & 2014 (GHQ-12 score of 4 or more) was higher (20.0%) than the percentage of non-disabled children and young people (8.8%). There was no significant change in poor mental health for the non-disabled age group compared with 2009 & 2010; however, the small samples in the disabled group means that it is not possible to say whether there has been a change over time for this group or in the gap between the groups.

Allowing for the combined effects of age, disability and gender, poor mental health was more common for girls than for boys, but there was no significant difference in the effect of disability between these groups.[44]

Wales

In 2013 & 2014, disabled adults in Wales were more likely to report poor mental health and wellbeing[45] (44.7%) than non-disabled adults (16.5%). There was no change compared with 2009 & 2010. All six groups of disabled people analysed were more likely to report poor mental health and wellbeing compared with non-disabled adults; for example, around nine in 10 adults with a mental health condition or learning difficulty (92.6%) and half those with a hearing impairment (52.5%). The percentage of adults with a mental health condition or learning difficulty who reported poor mental health increased between 2009 & 2010 (88.5%) and 2013 & 2014 (92.6%) and the gap with non-disabled people widened.

Allowing for the combined effects of age, disability, gender, use of car, region of Wales, socio-economic group, and whether a carer, poor mental health was more common for: the under-45s, women, most socio-economic groups compared with people in higher managerial and professional occupations (with the exception of small employers and own-account workers), those without use of a car and people living in South East Wales. However the increase in poor mental health associated with disability was less for women than for men and for non-carers compared with carers. The effect of disability on mental health was higher for: small employers and own-account workers, and people in lower supervisory and technical, semi-routine and routine occupations.

The percentage of disabled children and young people aged 13-15 who reported poor mental health and wellbeing in Wales in 2013 & 2014 (SDQ score of 20 or more) was higher (30.3%) than the percentage of non-disabled children and young people (4.3%). There was no change for either group compared with 2009 & 2010, and the gap between these groups did not change during that time. Allowing for the combined effects of disability and gender, poor mental health was more common for boys than for girls, and the effect of disability was also greater for boys.

Scotland

In 2013 & 2014, disabled adults in Scotland were more likely to report poor mental health and wellbeing (a GHQ-12 score of 4 or more; 27.9%) compared with non-

disabled adults (10.3%). This had not changed compared with 2009 & 2010. Of the six groups of disabled people analysed, poor mental health was higher for all of them than for non-disabled people. For example, over half of adults with a mental health condition or learning difficulty (55.5%) reported poor mental health and wellbeing. However, this percentage decreased from 61.9% in 2009 & 2010 and the gap with non-disabled people narrowed by 7 percentage points.

Allowing for the combined effects of age, disability, gender, use of car, and socio-economic group, poor mental health was more common for: 16-24-year-olds, women, people in routine occupations and those without use of a car. However the increase in poor mental health associated with disability was less for women than for men.

The percentage of disabled children and young people aged 13-15 who reported poor mental health in Scotland in 2013 & 2014 (GHQ-12 score of 4 or more) was higher (19.3%) than the percentage of non-disabled children and young people (10.9%). There was no significant change in poor mental health for the non-disabled group compared with 2009 & 2010; however, the small samples in the disabled group mean that it is not possible to say whether there has been a change over time for this group or in the gap between the groups.

Allowing for the combined effects of age, disability and gender, poor mental health is seen to be more common for 15-year-olds.[46]

The number of admissions of young people under 18 in Scotland with 'mental ill health' to non-specialist – mainly adult – hospital wards reduced significantly from 2015-16, from 207 to 135. The number of young people involved reduced from 176 to 118. The difference between the two figures is due to repeat admissions (MWCS, 2016b).

6.4. Social care and support

In this section, we discuss adult social care, including inpatient care, with a separate section on 'do not attempt resuscitation' (DNAR) orders. There is another indicator that relates to this area, availability of support, which is discussed in the 'Standard of living' chapter.

England

The Care Act 2014, which came in to force in April 2015, represents a wholesale reform of care and support in England. Among other things its purpose is to integrate health and social care services and give disabled people and carers more control over their care. Most of the Act applies only to England, although some sections also apply to Wales, for example, cross-border placements, and some of the sections relating to the Human Rights Act apply to England, Scotland and Wales.

The Adult Social Care Outcomes Framework is the Department of Health's main tool for setting direction and strengthening transparency in adult social care, and publishes information on outcomes for people using social care services or carers; however, the data is not currently disaggregated by disability.

Data shows that gross expenditure by Councils with Adult Social Services Responsibilities in England in 2014/15 on adult social care was £17 billion. This was a decrease of 1% in cash terms from £17.2 billion in 2013-14, but in real terms was the equivalent of a 3% decrease (HSCIC, 2015).

The Care Quality Commission (2016) reported on the state of healthcare and adult social care in 2015/16 and recognised that the sector is under pressure due to significant cuts to the amount of funding available for adult social care at a time of rising demand. In addition, introduction of the National Living Wage in April 2016 will put further pressure on the sector, which struggles to appoint and retain the staff needed.

Financial pressures on providers are causing care-providing businesses to close or withdraw from council contracts. In a survey of 492 homecare providers in the UK, 93% of providers trading with councils had faced a real-terms decrease in the price paid for their services in the last 12 months, and 74% said that they would reduce the amount of publicly funded care they delivered, estimated to affect 50% of all the service users they support (UKHCA, 2015).

NHS Digital data shows that, in 2014/15, 65% of people in receipt of adult social care and support services said they were either extremely or very satisfied with the services they received. The percentage saying this was higher for those who completed the easy read questionnaire (93%) than other respondents (63%). A far higher percentage of people with a learning disability were extremely satisfied than those with other support reasons. Similarly, a higher proportion of those in residential care compared with those in receipt of community or nursing care were extremely or very satisfied. However, the data needs to be treated with caution as the survey results are unlikely to be representative of the experiences of people with severe learning disabilities, severe mental health conditions or advanced dementia, who are often unlikely to be able to participate in surveys meaningfully (NHS Digital, 2016a; 2016b).

Councils have experienced a rapid growth in Deprivation of Liberty Safeguards[47] applications as a result of the Cheshire West Supreme Court Judgment in 2014 which clarified what amounts to a deprivation of liberty.[48] The Care Quality Commission (2016) reported a variation in the effective application of Deprivation of Liberty Safeguards both between providers and within individual providers, which could lead to individuals not receiving care that is in their best interests. The report also stated that not enough providers were applying capacity assessments effectively and many providers made assumptions that individuals lacked capacity without having carried out or documented assessments.

Wales

The Social Services and Wellbeing (Wales) Act 2014, which came in to force in April 2016, changes the way health and social care is provided, giving disabled people and carers more control.

The Welsh Government has set up the Intermediate Care Fund. £60 million is being invested in 2016-17 to join up health and social care services and improve coordination of care between social services, health, housing, education and the charitable, voluntary and independent sectors. It specifically includes aims to develop integrated services for people with a learning disability and children with complex needs, and to develop an integrated autism service, focusing on a multidisciplinary team to support autism in adults and enhancing existing children's neurodevelopmental services (Welsh Government, 2016i).

Assessments and social services for adults for 2015-16 showed that 82% of adults in Wales were receiving community-based services (Statistics for Wales, 2016a).

In Wales, most adult care services provided reasonable care, but in a number of cases the quality of care was not acceptable. Fourteen per cent of adult care homes were issued with a non-compliance notice while a further 1.9% gave cause for concern. For domiciliary care, 7% were issued a non-compliance notice and a further 1% were of concern (CSSIW, 2016). The report notes that the volume, complexity of need, and the frailty of those being cared for is increasing. At the same time, local authority and health board budgets are being squeezed. The challenge facing commissioners is to develop and sustain preventative services in the face of both increased demand and rising costs for intensive long-term care.

Scotland

Regulation of care in Scotland is the responsibility of the Care Inspectorate, which regulates 13,982 care services. The bulk of these are childminders, care homes, care at home, day care of children, and housing support, adoption and fostering services, secure care, school accommodation, nurse agencies, and offender accommodation. The majority of these services perform well: 88% of services that had been inspected by the end of the year had grades of good or better for every theme. Over the year, 95% of those services that started the year with grades of good or better for every theme had maintained or improved on those grades (Care Inspectorate, 2016).

Gross expenditure on adult social care services in Scotland was £2,908 million in 2013/14, of which 44% went on community-based services, 42% on accommodation-based services and 14% on support services and assessment (Scottish Government, 2015c). Analysis of the latest Census shows that 16% of people who provide unpaid care to a relative, friend or neighbour are deaf or have 'partial hearing loss', 16% have a physical disability and 11% have a mental health condition (Scottish Government, 2015d).

In 2015, 61,500 people of all ages were in receipt of homecare (domiciliary care) in Scotland compared with 66,220 people in 2010 (Scottish Government, 2015e). Of those in receipt of care, 400 were children, 10,940 adults aged 18-64 and 50,160 people aged 65 and over. The number of people with mental health conditions in receipt of homecare has fluctuated over the past few years but is currently at its highest since 1998 (the first date in the table). The number of people with a learning disability receiving care has also increased over time, although the number was slightly lower in 2015 than in the previous year.

The Mental Welfare Commission for Scotland has identified common issues in its monitoring of hospitals, care homes and prisons in relation to people with a mental health condition or learning disability. Evidence shows that, while decreasing, 37% of its recommendations to wards relate to certificates authorising involuntary physical healthcare[49] not being appropriately completed and care staff having insufficient awareness of the powers of welfare guardians/attorneys (MWCS, 2015).

There is an ongoing shortage of mental health officers, who perform an essential safeguard under mental health and incapacity legislation. The overall shortfall is at its highest since this data was first collected in 2008, with 21 of Scotland's 32 local authorities reporting a shortfall in their mental health officer staff resources (SSSC, 2015). Among other functions, mental health officers provide a critical review of any proposal to detain an individual, considering alternatives and explaining the individual's rights to them. However, only

DNAR notices are placed on patients' files without their consent or knowledge

56% of emergency detentions are being carried out with the safeguard of consent by a mental health officer, following a downward trend (MWCS, 2016c). Without this safeguard, some people may be detained unnecessarily and others may find the experience of being told they will be detained much more traumatic. The Mental Welfare Commission has recommended that the Scottish Government encourages areas with lower rates of mental health officer consent to develop action plans to improve rates of consent.

'Do not attempt resuscitation' orders

Hospitals and other care providers have a duty to take steps to protect the lives of people for whom they provide care under Article 2 (right to life) and Article 8 (right to private family life) of the Human Rights Act and the European Convention on Human Rights. This includes not placing 'do not attempt resuscitation' (DNAR) notices on patients' files without the person's consent or knowledge (CQC, 2014).

There are concerns that DNARs are not always appropriately used on disabled patients in England and Wales. Research by Mencap (2012) has found cases of DNAR orders being inappropriately applied to people with a learning disability. In Scotland, the Scottish Public Services Ombudsman report for May 2016 (SPSO, 2016) highlighted four complaints/ investigations into the application of 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders (SPSO, 2016). The EHRC has successfully intervened in a legal case that clarified that at-risk people in hospital and their families have the right to be consulted about any proposal to place a DNAR notice in their notes. In the specific case, the hospital failed to do so and the Court found them to have breached Article 8 of the European Convention of Human Rights.[50] The EHRC also welcomed the landmark 2015 High Court judgment that a decision to impose a DNAR order on a 28-year-old man with cerebral palsy, without the knowledge of his family, was a violation of his ECHR Article 8 rights (*Elaine Winspear (Personally and on behalf of the estate of Carl Winspear (Deceased) v City Hospitals Sunderland NHS Foundation Trust)*.

6.5. Healthcare for people with a learning disability

This indicator looks particularly at the experiences of people with a learning disability because they face a number of barriers when accessing healthcare, including:

- a failure to identify people with a learning disability in health systems so that reasonable adjustments can be made in advance
- discriminatory attitudes and a lack of expertise on the part of healthcare staff

- a failure to make reasonable adjustments in light of the literacy and communication difficulties experienced by many people with a learning disability[51]
- 'diagnostic overshadowing' (symptoms of physical ill health being mistakenly attributed to a behavioural problem or seen as being inherent in the person's learning disability) (Emerson *et al.,* 2011; NHS Health Scotland, 2004; Scottish Government, 2013; Slowie and Martin, 2014).

People with a learning disability have considerably poorer health than the general population (BMA, 2014; Emerson *et al.*, 2012; Glover, 2014; NHS Health Scotland, 2004; Scottish Government, 2013). They are also more likely than others to be exposed to common causes of poor health such as poverty, poor housing, lack of employment and social isolation (Scottish Government, 2013).

The life expectancy of people with a learning disability is lower than in the general population by up to 20 years (Rethink Mental Illness, 2013). This varies according to the severity of the learning disability. While there is evidence that people with a mild learning disability have a life expectancy approaching that of the national average, mortality rates among people with moderate to severe learning disabilities are three times greater than in the general population (BMA, 2014). Respiratory disease, linked to pneumonia, swallowing and feeding impairments, remains the leading cause of death: it is estimated to be responsible for between 46% and 52% of deaths compared with 15% in the general population (BMA, 2014).

According to the British Medical Association (BMA), excess morbidity and premature mortality predominantly result from a failure to adequately diagnose, treat and prevent comorbid physical health conditions in people with a learning disability. In the worst cases, people receive less than optimal medical care and unnecessarily have unmet health needs (BMA, 2014).

A number of studies (summarised by Emerson *et al.*, 2012) have reported low uptake of health promotion or screening activities among people with a learning disability, such as: assessment for vision or hearing impairments; routine dental care; cervical smear tests; breast self-examinations and mammography; and bowel and prostate screening. Access to health promotion may be considerably poorer for people with more severe learning disabilities.

Health checks have been found to be an effective way of improving the health of people with a learning disability by identifying previously unrecognised health needs, including life-threatening conditions (DH, 2007; Felce *et al.*, 2008; Robertson *et al.*, 2011; Scottish Government, 2013). Across Britain, annual learning disability health checks are available as a directed enhanced service.[52]

England

In England, in 2013/14, 94,647 adults had a learning disability health check. However, the rate of increase in the number of checks reported has slowed down and did not keep pace with the increase in numbers of people identified as having a learning disability. While a fifth of Clinical Commissioning Groups achieved a rate higher than 57%, a fifth failed to achieve 35% and four Clinical Commissioning Groups recorded no checks at all.[53]

A study found that people with a learning disability in England had a higher rate of admission to hospital for conditions that

should normally be managed within primary care: 76 admissions for every 1,000 adults per year, compared with 15 per 1,000 population for adults without learning disabilities (Glover and Evison, 2013). This suggests that primary care for people with a learning disability was not as effective as for other people.

Reports have also highlighted major concerns about the quality of healthcare people with a learning disability have received in hospital, sometimes leading to unnecessary deaths. Following an earlier report into the deaths of six people as a result of apparent failings within the healthcare system (Mencap, 2007), Mencap received details of a further 74 deaths, which it believed were only a small proportion of the actual number of such cases (Mencap, 2012a).

As a result of an independent inquiry following the earlier Mencap report, a confidential inquiry was established into the premature deaths of people with learning disabilities. This reviewed the deaths of people with learning disabilities in five Primary Care Trusts in the South West of England in 2010-12 (Heslop *et al.*, 2013). Of the 238 deaths for which agreement was reached by an overview panel, 100 (42%) were assessed as being premature. The most common reasons were delays or problems with diagnosis or treatment, and problems with identifying needs and providing appropriate care in response to changing needs. A national review in England was subsequently announced in June 2015 (NHS England, 2015a).

The UK Government's response (DH, 2012) to the serious case review report (Flynn, 2012) into the abuse of patients at Winterbourne View hospital highlighted that many people with a learning disability and or/autism were being placed inappropriately in psychiatric hospitals in England. A commitment was made to move those people to community-based support by June 2014. In 2012 an estimated 3,400 people with a learning disability and/or autism were inpatients in psychiatric hospitals in England (DH, 2012). More recent figures show that at the end of February 2016 there were 2,650 people with a learning disability and/or autism receiving inpatient care in psychiatric hospitals in England, 895 of whom had been inpatients for over five years (NHS Digital, 2016). The 2013 Learning Disability Census reports that six in 10 service users (60% or 1,949) had been inpatients for a year or more, and around one in six (17.6% or 572) had been inpatients for five years or more (HSCIC, 2013).

The Transforming Care and Commissioning Steering Group acknowledged that some people with a learning disability and/or autism with challenging behaviour and/or a complex mental health condition may need to be admitted to inpatient settings to be assessed and treated, but found that many are admitted when their admission could have been prevented or shortened had they received better support in the community. Furthermore, people with a learning disability and their families have too little influence on decisions affecting their admission to mental health hospitals, their treatment and care and their discharge (House of Commons Committee of Public Accounts, 2016).

In *Somerset County Council v MK and Others [2014],* Somerset County Council was found to be in 'serious breach' of its obligations under European Convention on Human Rights Articles 5, 6 and 8, protecting rights to freedom, a fair hearing and a private family life, after removing a 19-year-old woman with autism and a severe learning disability from her family home

and keeping her in residential care with restricted access to her family. The judge in the Court of Protection highlighted systemic failures by the local authority, including delays in bringing the matter to the attention of the Court of Protection and failing to consult with the family. While the case involving Somerset County Council relates to a single family, the CQC's inspections of learning disabilities services in England in 2012 found that 'assessment and treatment services admit people for disproportionately long spells of time and that discharge arrangements take too long to arrange' (CQC, 2012, p.8).

The use of psychotropic medication for people with a learning disability, often as a form of chemical restraint for behaviour management rather than to treat mental health conditions, was also highlighted in the Winterbourne View serious case review (Flynn, 2012) and response from the Department of Health (DH, 2012). A study was commissioned into the overuse of antipsychotic and antidepressant medicines for people with learning disabilities and/or autism in primary care in England (Glover and Williams, 2015). This found that, between 2009 and 2012, 13% of people with a learning disability (around 23,800 people) were being prescribed antipsychotic medication in the absence of a 'psychotic illness', and 10% were being prescribed antidepressants in the absence of a 'depressive illness' (roughly 19,500 people). In addition, the authors believed they were likely to have overestimated the proportions of people prescribed drugs who had relevant conditions. The 'Lethal discrimination' report by Rethink Mental Illness (2013) indicated that the use of antipsychotic medication leads to rapid weight gain, which explains in part why people with a learning disability or mental health condition are prone to being overweight or obese.

In July 2015, NHS England announced that it was taking urgent steps to reduce the inappropriate use of antipsychotic and antidepressant medication for people with a learning disability (NHS England, 2015b), and in 2016 called for reducing the use of inappropriate psychotropic drugs as a 'chemical restraint' for people with a learning disability to control challenging behaviour to be made a priority (NHS England, 2016).

Wales

A report by the Welsh Government (2016h) looked at the number of patients with a learning disability in mental health hospitals and units. According to the report, in 2016 there were 117 resident patients, of whom 77 were male (66% of the total) and 40 female. This was eight (6%) fewer than in 2015, and 53 (31%) fewer than in 2006. Of all people with a learning disability in mental health hospitals and units, 28 patients (24% of the total) were detained under the Mental Health Act 1983 and other legislation, a decrease of three from 2015 but an increase of 11 from 2006. Seventy-four patients (63%) had been resident for two years or more.

Scotland

People with a learning disability experience particularly significant health inequalities in accessing healthcare and services. People with a learning disability have as many health conditions at age 20 and over as the rest of the population do aged 50 and over (Mental Welfare Commission for Scotland, 2016). Compared with other mental health patients, patients with a learning disability or autism are likely to have longer stays in mental health, addiction or learning disability inpatient beds. The average time since admission for adult patients with a learning disability or autism is 33 months,

compared with five months for other mental health patients (Scottish Government, 2015f).

The Mental Welfare Commission for Scotland, based on its inspection of people with a learning disability in hospital, reported that the outstanding issue for individual patients, carers and the service as a whole was the number of people whose discharge was delayed (32% of current inpatients across Scotland were experiencing long waits for discharge). The main reasons cited for delays in discharge were a lack of funding, accommodation or an appropriate care provider, or a combination of these issues (MWCS, 2016).

In mental healthcare, those with a learning disability or autism experience delays in accessing appropriate community services and are accordingly likely to have longer stays in hospital than other mental health patients. The Mental Welfare Commission for Scotland has identified that mental health services need to respond better to those who do not fit current service approaches. Its visits and investigations repeatedly show worse services and poorer outcomes for people with complex needs or needs considered out of the ordinary, including people with autistic spectrum disorders, acquired brain injury, a personality disorder label, a dual diagnosis (for example, a learning disability plus mental health condition), or women and young people needing secure care. The Mental Welfare Commission's investigation into the death of Ms MN, an individual with complex needs, recommended that the Scottish Government should audit the availability of specialist services for individuals with highly complex needs who are not appropriately accommodated in learning disability or mental health settings, and identify how gaps can be filled (MWCS, 2016a).

Data gaps

There is very limited data being collected by NHS providers and commissioners about outcomes for disabled people, particularly by impairment, making it difficult for the UK Government, Clinical Commissioning Groups and NHS Trusts to assess the extent of inequalities experienced by disabled people.

Joint Strategic Needs Assessments specifically look at people with a learning disability; some other types of impairments are rarely covered.

It is difficult to monitor restraint incidents because the information provided by mental health organisations is often incomplete.

In Wales, there is a severe lack of published evidence about access to healthcare services for disabled people.

The Department of Health's Adult Social Care Outcomes Framework does not currently disaggregate data by disability.

"In Scotland in 2012-13, the prevalence of civil legal problems was higher for disabled people at 32% compared with 23% in the general population"

7. Justice and detention

This chapter examines the extent to which disabled people live in security and liberty and are free from cruel, inhuman or degrading treatment or punishment. In particular, it looks at the experiences of disabled people in detention, including in prison, police custody, health and social care settings, and immigration detention. It reports on how disabled people experience and perceive crime, particularly hate crime, and explores how confident disabled people are in the criminal justice system. It also looks at how disabled people are protected by the law and if they are treated fairly.

Four indicators were chosen to assess how well disabled people's rights in relation to security, liberty and freedom from abuse are protected in Britain. These are:

1. Detention
2. Experience and perceptions of crime and the criminal justice system
3. Disability hate crime
4. Legal aid

Justice and policing is a devolved matter in Scotland. Therefore, process and outcome evidence is reported separately for England and Wales and for Scotland.

7.1. Detention

Under this indicator, we examine conditions of detention for disabled people in four settings: prisons; police custody; health and social care; and immigration detention.

Outcomes

Prisons

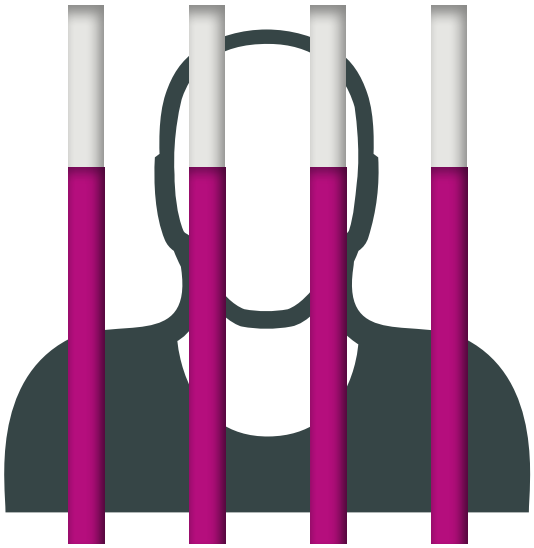
England and Wales

Mental health is a key issue within prisons as prisoners are more likely to have mental health conditions and their needs must be met by the prisons, as individuals are not able to access treatment and support elsewhere. The Prisons and Probation Ombudsman (PPO) has said that there is a need for an up-to-date study of prisoner mental health that is comprehensive in scope (PPO, 2016).

Research for the Ministry of Justice found that 49% of female and 23% of male prisoners in England and Wales had been identified as having anxiety and depression (compared with 12% of men and 19% of women in the general UK population). The research also found that 46% of female prisoners had reported attempting suicide at some point in their lives. In contrast, the rate for male prisoners was 21%, and 6% for the wider UK population (Light, Grant and Hopkins, 2013).

In relation to the care of disabled prisoners, HM Inspectorate of Prisons reported in 2016 that one in five prisoners had declared a disability. It found that disabled prisoners had more negative experiences of prison than those without disabilities. There was a lack of effective care plans for disabled prisoners, which should be widely used and proactively shared between staff. The report also examined the role of 'peer carers', whereby the needs of disabled prisoners are met with the help of other prisoners. It identified that the peer carer's role was not always clearly defined, and that they were insufficiently monitored by staff. This left disabled prisoners at risk of exploitation (HMIP, 2016)

Deaths in custody are an area of concern, particularly if they stem from non-natural causes. For example, the PPO examined information[54] about prisoners who died in prison custody between 2012 and 2014, finding that of those who died from self-inflicted means (199), 70% had been identified with mental health needs. Of those who died of natural causes (358), 22% had mental health needs. The report



70% of prisoners

that died from self-inflicted means had an identified mental health condition

in England and Wales between 2012 and 2014

identified a number of concerns, including: inappropriate mental health assessments; inadequate staff training; a lack of coordinated care; and a lack of joined-up work between prison and healthcare staff, and between primary healthcare, mental health and substance misuse services. It pointed out that some mental health conditions cause sufferers to present very challenging behaviour that staff may deal with as a behavioural rather than a mental health problem, which may lead to a punitive rather than a therapeutic response (PPO, 2016).

Scotland

Data suggests that 80% of all prisoners have two or more mental health conditions – most commonly in combination with a diagnosed illness or substance misuse (Gillies *et al.*, 2013). The Commission on Women Offenders estimated that 80% of women prisoners in Scotland had a mental health condition (Scottish Government, 2012a).

The Scottish Prison Service does not publish information on mental health conditions, it is only captured for internal review purposes. Most non-natural deaths from 2010 to 2013 were suicides (or considered apparent suicides). Of these, only one was a female prisoner. In nearly half of these suicides the person was on remand. The risk of suicide is higher in the initial period in prison – a quarter of suicides in 2010-13 occurred in the first three days in prison and over half in the first month. Prisons are also reporting increasing numbers of suicides in older prisoners (EHRC, 2015c).

A High Care Needs Assessment conducted for the Scottish Prison Service indicated that a small proportion of the prisoner population have high care needs, including severe physical disabilities, and some of them may not be able to cope with the prison regime and require assistance with activities of daily living. While the report did acknowledge that the challenges associated with high care needs are likely to increase in future years, it did not consider a broader base of high care needs, such as those arising from: cognitive impairment; post-traumatic stress disorder; mental health conditions; and conditions associated with ageing (Figure 8, 2014).

Police custody

England and Wales

There is no statutory regulation of police powers of control and restraint. Although there is specific guidance and training for all officers on restraint, the extent to which this is adopted is a matter for individual police forces, resulting in little consistency in the use of control and restraint across different police forces.

Considerable concern has been expressed about the use of police cells as a place of safety for people who have committed no crime but are detained because they require a mental health assessment or treatment, and there is a lack of more appropriate, health-based alternatives (HMIC, HMIP, CQC and HIW, 2013; CQC, 2014; Home Affairs Select Committee, 2015).

In 2014, the UK Government announced the phasing out of the use of police cells as places of safety for children. It set a target of a decrease of at least 50% in the use of police cells as places of safety for adults between 2011/12 and 2014/15 (HM Government, 2014).

In February 2016, the UK Government announced that changes would be made to the Mental Health Act under the Policing and Crime Bill that would include

banning police cells as a place of safety for under-18s, creating regulations to limit the circumstances in which police cells can be used a place of safety for adults and widening the current definition of a place of safety to increase local capacity and flexibility, and reducing the maximum duration of detention for the purposes of an assessment under the Act from 72 to 24 hours (with the possibility of extension to 36 hours in certain circumstances) (HM Government, 2016a). In evidence submitted to the Public Bill Committee by the Royal College of Psychiatrists in March 2016, it was recommended that the Bill include provision for a detailed assessment of what provisions each local area has to support people in mental health crisis (Public Bill Committee, 2016).

In England and Wales, between 2013/14 and 2014/15, the use of police custody as a place of safety for people detained under section 136 of the Mental Health Act 1983 fell by 32% from 6,667 times to 4,537. The number of times people aged under 18 were taken to police custody as a place of safety also fell during this time by 37%, from 256 to 161. In 2014/2015 it fell further and there were 3,996 instances in England where section 136 of the Mental Health Act was used and the place of safety was a police station (National Police Chiefs' Council, 2015). In Wales during 2014/15, there were 706 detentions in police stations using section 136 of the Mental Health Act 1983 .

The Department of Health has committed £12 million to extend roll-out of liaison and diversion services in police custody suites and criminal courts across England. Currently 50,000 people a year are assessed by liaison and diversion services following arrest, and almost 70% require mental health support. This new funding will extend NHS England liaison and diversion services from 50% population coverage to 75% by 2018 (HM Government, 2016b).

Scotland

In Scotland under section 297[55] of the Mental Health (Care and Treatment) (Scotland) Act 2003, a police station may only be used as a place of safety if no other option is immediately available. Although a concern has been raised about the effect of this on people who have not committed a crime but need to be moved to a safe space, HM Inspectorate of Constabulary in Scotland (HMICS, 2014) found little evidence that police stations were being used as a place of safety for people in mental health crisis. Exceptions included where there was a lack of cooperation from local mental health services and a reluctance by local hospitals to accept people brought in under section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

The Mental Welfare Commission for Scotland found that the number of notifications received in 2015/16 (795) had risen by 21% from 2014/15 (657) – this was a 35% rise since 2011/12. The proportion of incidents where the place of safety was a police station decreased in the same period from 106 (18%) in 2011/12 to 46 (7%) in 2014/15 and seven (1%) in 2015/16 (MWCS, 2016).

Health and social care settings

England and Wales

The ability for those detained on mental health grounds to review their detention has been found to be insufficient and further affects their vulnerability. For example, in the case of *MH v UK [2013]*, the UK was found to be in breach of Article 5 of the ECHR because a man who was detained under the Mental Health Act 1983 did not have the capacity to appeal the decision

within the 14-day time limit and so could not access the review mechanism as required under Article 5. Similarly, the Court of Protection held that[56] a failure to provide an independent advocate to an incapacitated man meant that he was deprived of an effective means of challenging his detention under Article 5.[57] Subsequently, in 2014 the Supreme Court clarified that in England there must be some form of independent review of the conditions of detention under the Mental Capacity Act 2005 for those who lack capacity to consent.[58]

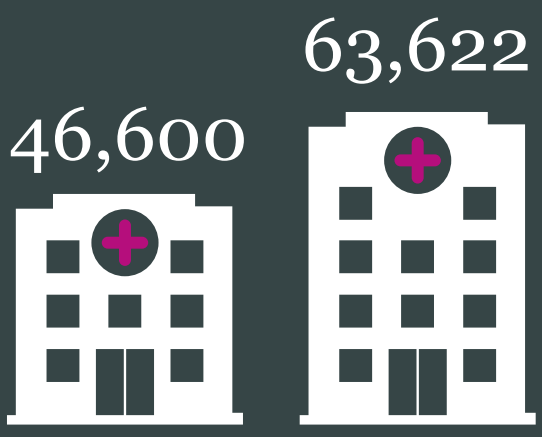
The number of detentions under the Mental Health Act in NHS and independent hospitals increased from 46,600 in 2009/10 to 58,399 in 2014/15 (HSCIC, 2015a). There was a further 10% increase between 2013/14 and a 9% increase to 63,622 in 2016. The use of section 136 of the Act (under which people were brought to hospital as a 'place of safety') also increased by 18% to 22,965 in 2016 (NHS Digital, 2016c). With the recent decrease in the use of police cells as a place of safety, this suggests that more cases are being referred directly to health-based places of safety (NHS Confederation, 2016).

However, a continued rise in the number of detentions in hospitals may lead to capacity and staffing issues.

The HSCIC (now NHS Digital) (2014a) has advised that: 'The fact that so many inpatients are spending months in hospital reduces hospitals' capacity to accept new admissions'. The CQC Mental Health Act monitoring report for 2013/14 reported that the decrease in available beds was putting mental health professionals under extreme pressure to secure access to hospital treatment, including through the potentially unlawful use of detention powers (CQC, 2015).

There is evidence that increasing numbers of patients are being compulsorily detained far from home (DH, 2014a; HM Government, 2014a; CQC, 2015). A lack of contact with family, friends and community can increase distress and potentially impede an individual's recovery (DH, 2015). One investigation found that overall the number of patients sent out of area more than doubled between 2011-12 and 2013-14 from 1,301 to 3,024 (BBC, 2014).

Detentions under the Mental Health Act in hospitals



The use of section 136 of the Act

since 2013/14 to 22,965 in 2016

Scotland

The Mental Welfare Commission for Scotland (MWCS, 2015) has advised that observation of individuals who are detained under the Mental Health (Care and Treatment) (Scotland) Act) can have a negative impact on their privacy and dignity. It found that national good practice guidance on observation did not reflect changes in practice and that the guidelines could be interpreted whereby people are subject to potentially restrictive levels of observation for longer than necessary. In response, the Scottish Government commissioned Healthcare Improvement Scotland to review the guidance.

In 2012-13, 78 deaths were reported to the Mental Welfare Commission in Scotland where people had died while subject to compulsory treatment. Information on 73 of these deaths was provided. Over half (53) were from natural causes, six had no explanation or relation to mental health, 11 were suicides and three recorded as delirium. Of the 11 suicides, five individuals were in hospital at the time, three were subject to compulsory community treatment and the remaining three were in the community under suspension of detention (EHRC, 2015c).

Immigration detention

The UN Committee against Torture has urged the UK to stop detaining asylum seekers with mental health conditions except as a last resort (UN Committee against Torture, 2013). However, new guidance on detention of 'adults at risk', issued in August 2016 by the Home Office, appears to give potentially weaker protection than previous guidance (Home Office, 2016a).

A number of cases where violations of Article 3 ECHR have been determined indicate that immigration detention facilities are inadequately equipped to deal with detainees with a mental health condition (Garden Court Chambers, 2014). The EHRC is also concerned at the lack of a clear statutory requirement, or any Home Office policy or procedure to ensure immigration detainees who lack mental capacity are provided with the independent support they require to assert their legal right to challenge their detention contrary to Articles 12, 13 and 14 of the Convention on the Rights of Persons with Disabilities *(R (ota) VC v SSHD [2016])*.

7.2. Experience and perceptions of crime and the criminal justice system

Under this indicator, we examine three areas that relate to crime and the criminal justice system. These are: experience of crime, fear of crime, and confidence in the criminal justice system.

Outcomes

Experience of crime

GB

The figures reported here, on experiences of different types of crime, are from analysis specifically for this report using data from the Life Opportunities Survey. See online data table EC5.1.

In Britain, the percentage of adults[59] who experienced crime decreased between 2009-11 (18.9%) and 2012-14 (13.0%). This was seen for both disabled and non-disabled people and for most impairment groups. The exceptions were those who had an impairment relating to breathing, for whom there was little change, and those with a behavioural impairment, for whom the sample size was comparatively small.

Compared with non-disabled people in 2012-14 (12.0%), disabled people were more likely to have experienced crime (15.5%), with large gaps for those with behavioural impairments (27.0%) or impairments relating to learning or intellectual impairments (25.1%), mental health conditions (24.4%), and memory impairments (19.3%).

Allowing for the combined effects of age, disability, gender, access to a car, and size of household, experience of crime is seen more frequently for men than for women and for those without access to a car than for those with access. By age, experience of crime is more common for 25-34-year-olds and less common for 65-74-year-olds and the over-75s. Plus there is little difference in experience of crime between disabled and non-disabled people aged over 75, but in each of the other age groups disabled people were more likely than non-disabled people to have experienced crime. By size of household, experience of crime was lower for people in 2-4 person households than for people living alone, and then increased for larger households. Except in households with six or more members, disabled people were more likely to have experienced crime than non-disabled people.

Fear of crime

The figures reported here, on fear of crime, are from analysis specifically for this report using data from the Crime Survey for England and Wales and the Scottish Crime and Justice Survey (intersectional analysis only). See online data tables EC4.1 and EC4.2. The two specific measures are: percentage of people who feel very unsafe or unsafe when walking outside in the daytime; and percentage who feel very worried/worried about physical attack and acquisitive crime.

England

In 2014/15, disabled people in England were more likely to report feeling very unsafe or unsafe walking alone in the local area during the day (3.5%) compared with non-disabled people (1.6%), and this was lower than in 2012/13 (5.7% for disabled people), resulting in a narrowing of the gap during this period.

Almost all the impairment groups have a relatively small sample in England, and the estimates are not robust.[60] The exception is those with a 'mobility impairment', for whom the percentage decreased from 6.5% in 2012/13 to 3.8% in 2014/15. This reduced the gap between this group and non-disabled people by 3 percentage points.

In 2014/15, disabled people in England were more likely to report feeling very worried or worried about physical attack and acquisitive crime (43.4%) compared with non-disabled people (33.7%). The percentage of non-disabled people who reported feeling worried decreased between 2012/13 and 2014/15 by 3.8 percentage points.

Similarly, a higher percentage of each of the impairment groups felt worried compared with the non-disabled group. For example, people with a learning or understanding or concentrating impairment (60.3%), those with a mental health impairment (59.3%), and those with a memory impairment (54.4%).

Wales

Sample sizes for impairment groups in Wales were so small that data has been combined for 2012/13, 2013/14 and 2014/15. However, even the estimate for all disabled people is not robust, so further disaggregation of this group will not be reported. Overall, disabled people were

more likely to report feeling very unsafe or unsafe walking alone in their local area during the day (3.7%) compared with non-disabled people (1.5%).

In England and Wales, allowing for the combined effects of age, disability, gender, ethnic group, and socio-economic group, feeling unsafe or very unsafe when walking alone during the day was more common for women, for people in the Asian, Chinese and 'Other' ethnic groups, and for people in the routine occupations and never worked, and long-term unemployed socio-economic groups.

Sample sizes for impairment groups in Wales are small so data was combined for 2012/13, 2013/14 and 2014/15. Disabled people were more likely to report feeling very worried or worried about physical attack and acquisitive crime (34.0%) compared with non-disabled people (28.2%).

A higher percentage of people with a dexterity impairment (44.6%) and a stamina or breathing or fatigue impairment (40.1%) reported feeling worried or very worried about physical attack and acquisitive crime, compared with non-disabled people.

In England and Wales, allowing for the combined effects of age, disability, gender, ethnic group, religion, socio-economic group, urban/rural, region, and access to a car, feeling worried or very worried about physical attack and acquisitive crime was more common for women, for people whose ethnic group was Mixed, Black or Asian/Chinese/Other and for those whose religious affiliation was Christian or a religious minority. It was less common for those aged over 75, for those in the higher managerial and professional socio-economic group, for those living in rural areas, for those with access to a car, and for those in Wales or most areas of England (with the exception of the East Midlands and West Midlands) compared with London.

Scotland

Data from the 2014/15 Scottish Crime and Justice Survey shows that although disabled people are no more likely to be victims of crime than non-disabled people (rates of around 15% for each in 2014/15), disabled people are less likely to feel safe walking alone in their neighbourhood after dark (57% compared with 78% of those with no disability) (Scottish Government, 2016g).

In Scotland, allowing for the combined effects of age, disability, gender, urban/rural and use of a car, in 2012/13 feeling unsafe or very unsafe when walking outside after dark was more common for those living in urban areas and, compared with the 16-24 age group, a higher percentage of those aged 65-74 and 75 and over, and a lower percentage of those aged 25-34 and 45-54, felt unsafe or very unsafe walking outside after dark.

Women were more likely than men to feel unsafe or very unsafe walking outside after dark, and disabled people more likely than non-disabled people. Overall, disabled women were most likely to feel unsafe.

Allowing for the combined effects of age, disability, gender, and urban/rural, feeling worried or very worried about physical attack and acquisitive crime was less common for those living in rural areas and more common for women than men, although the effect of disability is greater for men than for women. The level of worry declines by age. It is highest in the 16-24 age group and lowest in the 75 and over age group. The effect of disability is also lower in the oldest age groups: 65-74 and 75 and over.

Confidence in the criminal justice system

The figures reported here, on confidence in the criminal justice system, are from analysis specifically for this report using data from the Crime Survey for England and Wales. See online data tables ED2.2. The two specific measures are the percentage who agree that the criminal justice system: (a) gives victims and witnesses the support they need; and (b) treats those who have been accused of a crime as 'innocent until proven guilty'.

England

In 2014/15, disabled people in England were less likely to agree that the criminal justice system gives victims and witnesses the support they need (54%) compared with non-disabled people (65.9%). The proportion of both disabled and non-disabled people who agreed increased compared with 2012/13 (by 6.6 percentage points and 3.4 percentage points, respectively). Apart from the small group with a social or behavioural impairment, all impairment groups were less likely to agree. The proportion of people with a mental health impairment who agreed had increased since 2012/13 (from 45.1% 57.0%), narrowing the gap between this group and non-disabled people.

In 2014/15, disabled people in England were less likely to be confident that the criminal justice system treats those who have been accused of a crime as 'innocent until proven guilty' (71.7%) compared with non-disabled people (76.0%). The percentage of non-disabled people believing the criminal justice system is fair decreased between 2012/13 and 2014/15 by 1.7 percentage points. Lower percentages of people with a mental health impairment (63.7%) and those with a memory impairment (66.3%) agree that the criminal justice system treats those who have been accused of a crime as 'innocent until proven guilty'.

Wales

Sample sizes for impairment groups in Wales are small so data was combined for 2012/13, 2013/14 and 2014/15. Disabled people were less likely to agree that the criminal justice system gives victims and witnesses the support they need (50.3%) compared with non-disabled people (60.8%). Examples of other impairment types include: those with a learning or understanding or concentrating impairment (41.3%) and those with a memory impairment (43.7%), who were also less likely to agree that the criminal justice system gives victims and witnesses the support they need compared with non-disabled people.

In England and Wales, allowing for the combined effects of age, disability, gender, ethnic group, religion, socio-economic group, region, and size of household, agreement that the criminal justice system gives victims and witnesses the support they need was less common in older age groups and least common for the 65-74 age group. It was more common for those in the Asian/Chinese/Other ethnic group, compared with White people, and more common for those with a Christian affiliation, compared with those with no religion. Agreement was also greater for people in the routine occupation socio-economic group, compared with the higher managerial and professional group, and lower in the North East, Yorkshire and Humberside, and East Midlands, compared with London.

There was no difference in the proportion of disabled people who were confident that the criminal justice system treats those who have been accused of a crime

as 'innocent until proven guilty' (76.0%) compared with non-disabled people (75.7%). However this was not the case across all impairment groups. Those with a learning or understanding or concentrating impairment (57.4%) and those with a mental health impairment (65.9%) were less likely than non-disabled people to agree that the criminal justice system treats those who have been accused of a crime as 'innocent until proven guilty'.

In England and Wales, allowing for the combined effects of age, disability, gender, ethnic group, religion, socio-economic group, urban/rural, region, and size of household, agreement grows as age increases and was highest for the over 75 age group. It is also higher for men compared with women, for those in the Asian/Chinese/Other ethnic group compared with the White ethnic group, and for those who had never worked or were long-term unemployed compared with those in the higher managerial and professional socio-economic group. By geographic area, agreement that the criminal justice system treats those who have been accused of a crime as 'innocent until proven guilty' is more common in rural than in urban areas, and in London compared with Wales and regions of England.

Scotland

The figures reported here, on confidence in the Scottish criminal justice system, are from analysis specifically for the 'Is Britain Fairer?' review. Specific measures shown below are percentage of people who are confident that the Scottish criminal justice system: (a) serves all communities of Scotland equally and fairly; (b) provides an appropriately high standard of service for victims of crime; and (c) provides an appropriately high standard of service for witnesses.

Intersectional analysis is from new analysis specifically for this report using data from the Scottish Crime and Justice Survey (CJS). Measures used are percentage of people who are confident that the Scottish CJS: (a) provides victims of crime with the services and support they need; and (b) treats those accused of crime as 'innocent until proven guilty'. See online data table ED2.2.

In 2012/13, a lower proportion of disabled people reported feeling confident that the Scottish criminal justice system serves all communities of Scotland equally and fairly (54.0%) compared with non-disabled people (66.3%). This was also the case in 2008/09 (47.0% and 55.2%, respectively). Between 2008/09 and 2012/13, the proportion of both disabled and non-disabled people increased (7.0 percentage points and 11.1 percentage points, respectively), and the size of the gap between these groups increased during this time.

In 2012/13, a lower proportion of disabled people reported feeling confident the Scottish criminal justice system provides an appropriately high standard of service for victims of crime (42.7%) compared with non-disabled people (54.4%). This was also the case in 2008/09 (31.7% and 39.3%, respectively). Between 2008/09 and 2012/13, the proportion of both disabled and non-disabled people increased (11.0 percentage points and 15.2 percentage points, respectively), and the size of the gap between these groups increased during this time.

In 2012/13, a lower proportion of disabled people reported feeling confident the Scottish criminal justice system provides an appropriately high standard of service for witnesses (47.5%) compared with non-disabled people (57.2%). This was also the case in 2008/09 (36.5% and 43.8%,

respectively). Between 2008/09 and 2012/13, the proportion of both disabled and non-disabled people increased (11.0 percentage points and 13.4 percentage points, respectively). The size of the gap between these groups did not change during this time.

Allowing for the combined effects of age, disability, gender, and urban/rural, in 2012/13 people in rural areas are more likely to be confident that the Scottish criminal justice system provides victims of crime with the services and support they need than those in urban areas, while older age groups are less likely to feel confident. The difference between disabled and non-disabled people is more visible for younger people and decreases with age.

Allowing for the combined effects of age, disability, gender, and urban/rural, confidence that the Scottish criminal justice system treats those accused of crime as 'innocent until proven guilty' grows as age increases and is higher for men than women and for those in rural areas compared with those in urban areas. Disabled people are less likely to be confident in the Scottish criminal justice system, but this effect is less in some age groups: 25-34, 55-64 and 75 and over.

7.3. Disability hate crime

Legal and policy framework

The legal frameworks for hate crime in England and Wales, and Scotland, are set out in the EHRC's report 'Causes and motivations of hate crime' (Walters, Brown and Wiedlitzka, 2016), which identified that the 'patchwork nature' of hate crime legislation means that disability and transgender hate incidents are not within the scope of 'stirring up of hatred offences' in England and Wales and in Scotland.

Instead, several Acts address the different facets of hate crime: disability, race, religion/belief, sexual orientation, and transgender identity. Substantive offences are covered by the Public Order Act 1986, the Criminal Justice and Immigration Act 2008, the Crime and Disorder Act 1998 (as amended by the Anti-terrorism, Crime and Security Act 2001), the Terrorism Act 2000, and the Terrorism Act 2006. In Scotland, The Offensive Behaviour at Football and Threatening Communications (Scotland) Act 2012 criminalises behaviour that is threatening, hateful or otherwise offensive at a regulated football match, and communication of certain threats.[61]

A full-scale review of the impact of the differential legislation in England and Wales has been recommended by the Law Commission, and in 2016 the EHRC called for a full-scale review of the UK's hate crime laws and strategies (EHRC, 2016c; Law Commission, 2014).

England and Wales

A new hate crime action plan was published in July 2016 by the UK Government (Home Office, 2016). This reports on progress in the reporting and recording of disability hate crime in England and Wales since it was first included in national policy in 2008. While some progress has been made, the plan acknowledges that the police must continue to identify disability hate crime correctly in their recording practices, including prioritising increasing reporting of hate crime through raising hate crime awareness and the provision of third-party reporting centres, improving police responses to hate crime, and victim support. The action plan does not cover actions in Scotland and Northern Ireland but intends to work with devolved governments to ensure that best practice is shared across the UK.

In March 2013, a joint inspection team from HMI Constabulary, HM Crown Prosecution Service Inspectorate and HMI Probation, found that different definitions of disability hate crime were being used in policies and legislation in England and Wales.[62] They advised that an agreed cross-agency definition of hate crime was needed, along with a better understanding of the Criminal Justice Act 2003 among police, Crown Prosecution Service and probation staff. The report found that criminal justice agencies did not always understand what forms disability hate crime can take, and emphasised the importance of talking to disabled stakeholders to understand their experiences, including the ways in which disabled people are targeted and the difficulties they face in getting public authorities to respond. The report also highlighted the need for the Crown Prosecution Service to improve its case preparation to ensure disability hate crimes are effectively prosecuted, and identified administrative flaws in the recording of disability hate crime (HMCPSI, HMC and HMI Probation, 2013).

The follow-up review published in May 2015 considered how the police, Crown Prosecution Service and probation service had progressed against the previous report's recommendations and found little to no progress had been made, other than a reduction in the number of cases that were flagged as disability hate crimes in error and some evidence of improvement in the sharing of information between agencies. The report stated that: 'Neither the police, Crown Prosecution Service nor NPS/CRCs [National Probation Service/Community Rehabilitation Companies] have regarded disability hate crime as a sufficient priority' (HMCPSI, HMC and HMI Probation, 2015, p.27).

Scotland

The Scottish Government's draft Delivery Plan 2016-2020 for meeting its obligations under the CRPD makes a commitment to 'encourage reporting of hate crimes against disabled people – the seven main criminal justice organisations have committed to work together for future publicity campaigns, to encourage disabled people to report hate crimes, and provide reassurance that a report will be taken seriously by these organisations' (Scottish Government, 2015g p.39). The final delivery plan was due to be finalised in Spring 2016 but at the time of writing had not been released.

The Scottish Government established an Independent Advisory Group on Hate Crime, Prejudice and Community Cohesion in 2015. It published its recommendations in 2016, including that the Scottish Government work with stakeholders to consider whether criminal law provides sufficient protections for those at risk of hate crime, and to consider how best to monitor hate crime and protect those at risk of prejudice and hate crime on public transport, online and in the workplace (Scottish Government, 2016g).

Outcomes

England and Wales

In England and Wales in 2015/16, 62,518 hate crimes were recorded by the police, an increase of 19% compared with the 52,465 hate crimes recorded in 2014/15. Of those recorded in 2015/16, 3,629 (6.0%) were disability hate crimes; this represents a 44% increase from 2014/15 (2,515) (Corcoran and Smith, 2016). The likely factors in the increases in hate crime were improvements in recording and awareness of hate crimes and willingness of victims to come forward. The Crime Survey for England and Wales,

reflecting self-reported experiences of crime, showed that after race, disability was the most common motivating factor for hate crimes, estimated at 70,000 incidents per year (Corcoran, Lader, and Smith, 2015).

The Crown Prosecution Service has reported an increase in prosecutions and convictions for disability hate crime, reporting 941 completed prosecutions for disability hate crime in 2015/16, compared with 666 in the previous year. Convictions increased by a similar rate during this time, from 503 to 707. The report acknowledged the need for the Crown Prosecution Service to improve its performance on conviction rate and sentence uplift[63] (CPS, 2016).

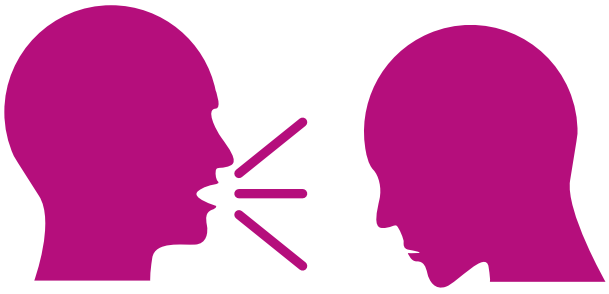
According to recent Crown Prosecution Service data, disability hate crime evidence shows high levels of sexual violence, property offences, and fraud and forgery compared with other forms of hate crime (CPS, 2016). The higher rates of property, fraud and sexual offences may reflect that a higher proportion of perpetrators will be personally known to their victim, and more likely to have access to the victim's finances and their home. Perpetrators of some types of abuse against disabled people can often act as 'pretend' friends (sometimes referred to as 'mate crime'). In other cases, perpetrators have been found to be carers and even relatives (Walters, Brown and Wiedlitzka, 2016).

Scotland

In 2016, disability hate crimes (crimes reported with an aggravation of prejudice relating to disability) were the second lowest type of hate crime reported. In 2014-15, 177 charges were reported with an aggravation of prejudice relating to disability, 20% more than in 2013-14, 86% of which proceeded to court. Police Scotland has recognised that this crime continues to be under-reported (COPFS, 2016).

Court proceedings were commenced in respect of 83% of charges reported in 2015-16. There were 167 court proceedings in 2015-16, compared with 151 in 2014-15. No action was taken in respect of 1% of charges reported in 2015-16, which is a lower proportion than in previous years. This is explained as being partly due to a decrease in the number of charges reported for which there was insufficient admissible evidence to take action (COPFS, 2016).

44%



increase in disability hate crime in 2015/16 compared with the previous year in England and Wales

7.4. Legal aid

Legal and policy framework

England and Wales

Reforms to legal aid in England and Wales were introduced by the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO). These aimed to reduce burdens on public services and took effect in April 2013. The Act excluded many areas of law from the scope of civil legal aid, including the majority of private family, housing, debt, welfare benefits, employment and clinical negligence matters. The Act (s38) also abolished the Legal Services Commission, an independent non-departmental public body previously responsible for legal aid (Ministry of Justice, 2012). The UK Government's assessment of the potential equality impact of the LASPO reforms showed that, in relation to many areas of law that would be removed from scope, those who are ill or disabled were more likely to be affected than the population as a whole (Ministry of Justice, 2011).

The Act introduced a mandatory telephone gateway service for legal advice on discrimination, debt and Special Educational Needs (Civil Legal Advice service). The EHRC (2015c) reported concerns about the impact of the telephone gateway service on disabled people's access to justice.

The Ministry of Justice evaluation of the Civil Legal Advice service during its first year of operation found some evidence of refusals to request reasonable adjustments to people using this service, such as support for hearing impairments (Ministry of Justice, 2014a).

The Public Law Project also found that the Civil Legal Advice service was not always identifying people who should be provided with face-to-face advice because of communication difficulties, mental health or mental capacity issues (Hickman and Oldfield, 2015).

In our response to the UN Special Rapporteur's inquiry into the right of disabled people to social security, the EHRC (2015c) stated that it considers the reforms to legal aid to raise issues for the protection and promotion of disabled people's rights under the CRPD and undermines redress in relation to these rights.

Scotland

Scotland's legal aid system is administered by the Scottish Legal Aid Board. Civil legal aid is means-tested alongside a merits and reasonableness test. The Scottish Government's draft Delivery Plan 2016-2020 consultation document makes a commitment to a 'review of legal aid contributions for disabled people to identify negative impacts on disabled people of the current legal aid framework for contributions and develop options for change. Consideration of the options by Ministers may be followed by a change to legislation' (Scottish Government, 2015g, p.39).

Outcomes

England and Wales

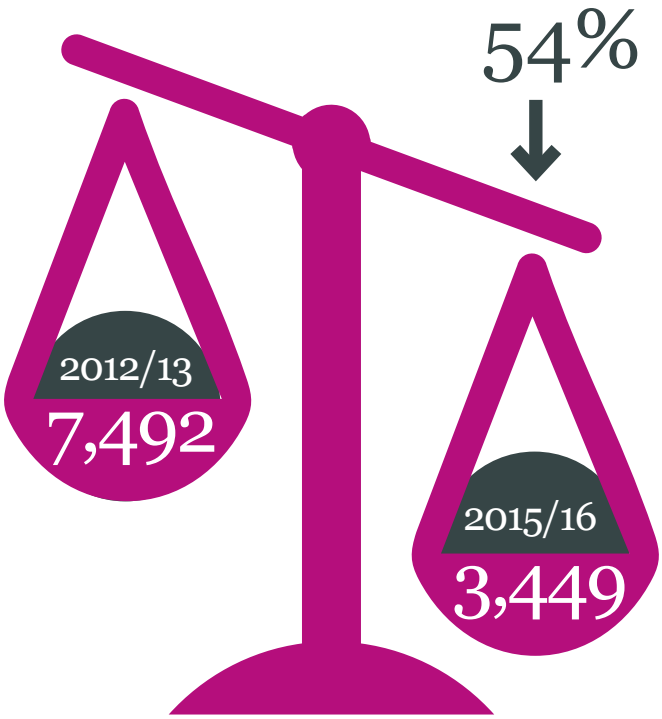
The reduction in scope of legal aid has resulted in a significant drop in the number of publicly funded cases. The year before the LASPO provisions came into force, the number of civil legal aid cases (that is, advice or representation) was 925,000. In 2013–14, the year after the reforms, assistance was given in 497,000 cases. This is a drop of 46% (Ministry of Justice, 2014b).

There is evidence that indicates a significantly lower volume of cases receiving advice through the Civil Legal Advice service during its first year of operation than estimated by the former Legal Services Commission, including advice on discrimination matters (Hickman and Oldfield, 2015; Ministry of Justice, 2014a). This last finding should be considered alongside the recorded drop in employment tribunal claims following the introduction of fees in July 2013. Compared with 2012/13, the number of claims dropped by 54% from 7,492 in 2012/13 to 3,449 in 2015/16 (Ministry of Justice, 2016).

Scotland

In Scotland in 2012-13, the prevalence of civil legal problems was higher for disabled people at 32% compared with 23% in the general population. In addition, only 37% of disabled people had solved their problems whereas 51% without a disability had done so (Scottish Government, 2015h).

Employment tribunal claims for disability discrimination



This last finding should be considered alongside the recorded drop in employment tribunal claims following the introduction of fees in July 2013

Data gaps

The 'patchwork nature' of hate crime legislation means that disability hate incidents are not within the scope of 'stirring up of hatred offences' in both England/**Wales and in Scotland.**

There are noticeable data gaps in the area of detention, including a lack of reliable figures for prisoner suicide related to mental health, and a lack of data available on the number of people who are detained in a police cell in Scotland after being removed from a public place under section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003. The Prisons and Probation Ombudsman has also made clear the need for a comprehensive and up-to-date study of prisoner mental health in England and Wales.

“Transport options for disabled people are very limited because of the need to use only transport forms that are accessible, and these tend to be expensive”

8. Participation and identity

This chapter is concerned with how disabled people realise their rights to take control of their own lives, to make their own choices, to develop their potential and have their needs fulfilled. This includes how disabled people engage with political processes and participate in democratic free and fair elections, and their capability to access public services, transport, schools and leisure activities. It also includes forming relationships and living an independent life free from stigma.

Three specific indicators were chosen to assess how well the rights relating to participation and identity are protected in Britain. These are:

1. Political participation
2. Access to services
3. Discrimination, abuse, attitudes and stigmatisation of disabled people

This chapter covers reserved and devolved government responsibilities. Where a matter is devolved (for example, access to devolved services in Scotland) we cover the legal and policy framework separately for England and Wales, and Scotland. Where a matter is reserved, we present the legal and policy framework for Britain as a whole.

8.1. Political participation

Under this indicator, we cover both voting and political representation.

Voting

Legal and policy framework

GB

Section 104 of the Equality Act 2010 enables registered political parties to reserve places on electoral shortlists for people with a specific protected characteristic such as ethnicity or disability. Section 106, which would require registered political parties to publish data on the diversity of party candidates seeking selection, was proposed by the Speaker's Conference on Parliamentary Representation.[64] It is prospective and has not been enacted.

The Electoral Registration and Administration Act 2013 amended electoral law and introduced Individual Electoral Registration, from June 2014 in England and Wales, and September 2014 in Scotland. Under the previous system, the head of a household was responsible for declaring the names of those residing at the household who were entitled to vote. In the new system, an individual must personally register to vote and provide identification. Despite widespread support for the principles underpinning individual registration, the Individual Electoral Registration has generated concern about the potential drop in registration levels for disabled people. For example, disabled people living in residential care settings are among those groups at a greater risk of falling off the register (Scope, 2011).

The House of Commons Political and Constitutional Reform Committee (2015) concluded that there was a particular problem with the accessibility of registration and voting for disabled people. It recommended that the UK Government consult with the Electoral Commission and publish clear proposals setting out how registration and voting would be made more accessible to disabled people. In response, the UK Government stated in November 2014 that it had held meetings with Mencap and the Royal National Institute of Blind People to identify options for making registration and voting easier for disabled people (House of Commons Political and Constitutional Reform Committee, 2015).

Other barriers to voting were highlighted by Papworth Trust disability charity, which suggested that local authorities aim to increase disabled access by piloting different options, such as making polling stations more accessible, online voting and continuing work by organisations such as Mencap to promote voter registration. The charity Dimensions called for clarification around the eligibility to vote of people with certain disabilities, such as autism and learning disabilities (House of Commons Political and Constitutional Reform Committee, 2015, paragraphs 34-6). The Cabinet Office and Mencap are working in partnership and have since produced an easy read guide on voting and registering to vote (Cabinet Office and Mencap, 2015).

Scope (2010) carried out a survey of 1,000 polling stations to assess how accessible the 2010 general election had been for disabled people, and found that two-thirds of polling stations had one or more significant access barriers. The Electoral Commission has since developed guidance for disabled voters and polling station staff, and noted in a news release prior to the 2015 general election that there should be no barriers to someone casting their vote (Electoral Commission, 2015). Acting returning officers have to ensure that the voting process is fully accessible while

polling station staff should have received training on the assistance they can provide to voters who wish to vote at a polling station.

Outcomes

The figures reported here, on the percentage who voted in the most recent general election, are from analysis specifically for the 'Is Britain Fairer?' review. See online data table EJ1.1.

GB

People with a long-standing physical impairment are more likely to be registered to vote than those who are not disabled (90% compared with 83%) whereas those with a long-standing mental health condition are less likely to be registered (76%). The higher registration rate for disabled people with physical impairments was linked to length of residency, as people are more likely to be registered the longer they have lived at their address and disabled people with physical impairments move less frequently.

Turnout at the 2015 general election overall in the UK was 66.1%, an increase of 1 percentage point compared with the 2010 general election. The British Election Study (BES, 2015) showed no significant difference between disabled and non-disabled people's voting in that year. In 2005 fewer than one in five people with a learning disability voted in the general election. In 2010, this went up to almost one in three people with a learning disability (Mencap, 2014).

Noting low voter turnout in the 2010 general election compared with other EU countries, the House of Commons Political and Constitutional Reform Committee (2014) announced an inquiry into voter registration and turnout in the UK and considered changes to re-engage British people with politics and elections. Evidence provided to the inquiry highlighted the specific barriers to registering to vote and participating in elections faced by disabled people and also the low level of participation, including 'a cultural exclusion from the democratic process, from politics in the way that Parliament and the Government often communicate to people'. Evidence was also provided on physical barriers (House of Commons Political and Constitutional Reform Committee, 2014, section 79).

England

On 1 December 2015, the local government electoral register was 90% complete for those with a physical impairment and 74% for those with a mental health condition. This compared with 83% complete for non-disabled people in England. In 2015, 92.0% of participants of the British Election Study internet panel stated that they had voted, an increase of 1.2 percentage points compared with 2010 and considerably higher than actual voter turnout in England, which was 65.8%. Disability data is only available from the British Election Study for 2015, and there was no significant difference between disabled and non-disabled people's voting in that year.

Wales

On 1 December 2015, the local government electoral register was 87% complete for those with a physical impairment and 78% for those with a mental health condition. This compared with 83% complete for non-disabled people in Wales. In 2015, 92.7% of British Election Study internet panel participants stated that they had voted, similar to the 2010 response of 91.5%, considerably higher than actual voter turnout in Wales, which was 65.7% in the last general election. Data for disability is only available for 2015 and there was no significant difference between disabled and non-disabled people's voting in that year.

Scotland

On 1 December 2015, the local government electoral register was 87% complete for those with a physical impairment and 83% for those with a mental health condition (although this had a small base size of 33). This compared with 85% complete for non-disabled people in Scotland. In 2015, 95.4% of British Election Study internet panel participants stated that they had voted, an increase of 6.1 percentage points compared with 2010. This is considerably higher than actual voter turnout, which was 71.1% in Scotland in the last general election. Disability data is only available for 2015, and a higher proportion of disabled (96.9%) than non-disabled people (94.9%) voted in that year, a difference of 2 percentage points.

Political representation

Legal and policy framework

GB

The EHRC's 2011 report 'Pathways to politics' was a comprehensive study summarising and evaluating an individual's ability to participate formally in politics through the use of 'push, pull and prevent' factors (Durose *et al.*, 2011). The report was based on the fact that, despite some progress over the last 30 years, elected politicians in Britain still remain highly unrepresentative of the population as a whole, and it set out comprehensive recommendations for increased participation. A lack of understanding and awareness of disability, and the difficulties faced by disabled people in seeking selection and election, were perceived to be widespread, both nationally and locally. These were identified as key barriers that prevented people from standing as, or becoming, elected representatives.

The UK Government's pilot Access to Elected Office for Disabled People (AEO) Fund ran for three years and closed in March 2015 (HM Government, 2015). The aim of the fund was to remove barriers from disabled people's participation in public life. It offered individual grants to disabled people who were planning to stand for election to help meet Additional Support Needs. In total, £417,203 was allocated through the fund to disabled people. The average award was £4,585, with the highest being £39,735 and the lowest £130 (UK Parliament, 2015). However the fund only covered expenses for candidates in the following elections: UK Parliament, English local government, Greater London Assembly, mayoral elections (England only), Police and Crime Commissioner, and English parish and town councils, and did not extend to Wales or Scotland beyond UK parliamentary elections.

There has been criticism that the pilot AEO Fund has not been evaluated since its closure in May 2015, as well as calls on the UK Government to reopen the fund (UK Parliament, 2016). In the EHRC submission to the inquiry by the UN Special Rapporteur on the rights of persons with disabilities, we advised that the UK Government should reopen the AEO Fund in England and work with the Scottish and Welsh Governments to explore options for making the scheme, or similar funds, available across Britain (EHRC, 2015d).

Recommendations from a Fundamental Rights Agency (2014) report on the participation of disabled people suggested, among other things, live-streamed online or video conferencing to allow MPs to participate in debates remotely.

Positive measures that have been taken to address inequality in political representation include the repeal, from 28 April 2013, of

section 141 of the Mental Health Act 1983 through the Mental Health (Discrimination) Act 2013. The repealed legislation allowed for the disqualification of MPs from office if they had been sectioned for more than six months.

Wales

The Welsh Government and the Welsh Local Government Association developed Step Up Cymru, a mentoring scheme for under-represented groups in which participants were mentored by local councillors and Welsh Assembly Members. The scheme attracted 40 disabled applicants and resulted in 12 mentees. Although the scheme ended in 2010, a subsequent report recommended its continuation (National Assembly for Wales Commission, 2011).

Scotland

In 2014, the Scottish Government funded a pilot Parliamentary Internship Scheme, which created a series of internships in the Scottish Parliament for disabled graduates. It has also supported an Access to Elected Office project through Inclusion Scotland, building on the Parliamentary Internship pilot, to investigate a number of areas, including barriers in the 'party career path' and the case for a Scottish version of the AEO Fund. A third round of parliamentary internships in Scotland was opened for disabled applicants in August 2015. Paid at the living wage, internships were available for 13 weeks or part-time over a longer period. The project was funded by the Scottish Government and organised through Inclusion Scotland, which placed a total of seven disabled graduate interns with Members of the Scottish Parliament (Inclusion Scotland, 2015).

In February 2016, the Scottish Government announced the launch of a new fund of £200,000 to assist disabled people to become involved in politics and stand as local councillors (Scottish Government, 2016h). The fund, being run on a pilot basis by Inclusion Scotland until May 2017, will help with transport accessibility and communication costs and is designed to support those who wish to seek selection and election as local councillors in the 2017 elections. No information is yet available about the success of this fund.

Outcomes

GB

Disabled people are under-represented as elected representatives. Reports suggest the proportion of self-declared disabled MPs fell following the 2015 general election (EHRC, 2015d) although the proportion of disabled members of the House of Lords is slightly more encouraging. Seven (11%) new appointments to the Lords since 2000 declared a disability and anecdotally there are many disabled members of the House of Lords (House of Lords Appointments Commission, 2013; Purvis, 2014).

The UK Government has suggested that, to be representative of the 11 million disabled people in the UK, the House of Commons ought to include at least 65 disabled MPs (GEO, 2010). However, the exact number of disabled parliamentarians is not known because an important recommendation of the Speaker's Conference – for the House of Commons to collect data about under-represented groups – has not been implemented (HoC, 2010). The House of Lords Appointments Commission does not survey current peers, or those it appoints. The Scottish Parliament and Welsh Assembly do not collect and publish this data either. Section 106 in the Equality Act 2010, for political parties to publish diversity data about their candidates, has also not been enacted.

Evidence to a House of Lords Select Committee on the disability provisions of the Equality Act 2010 noted the principal obstacles of disabled people who want to stand for election: the extra cost they may incur compared with non-disabled people; and being an MP is a full-time job, which may be difficult for some disabled people (House of Lords, 2016).

An EHRC report (2015d) 'Smoothing the pathway to politics for disabled people' presents a series of recommendations on disabled people's access to political office:

- regular collection of disability data from elected politicians and a confidential disability survey of all current members of the House of Lords
- enactment of s106 of the Equality Act 2010, so that political parties are required to publish diversity data about their candidates
- reopen the AEO Fund in England, and work with the Scottish and Welsh Governments to explore options for similar funds or to make the scheme available across Britain
- governments to introduce, or continue, evidence-based and targeted campaigns to tackle barriers and build confidence among disabled people interested in standing for elected office
- all elected bodies, at the national, regional and local level, should be leaders in making the practical changes needed to enable disabled people to participate fully in political life.[65]

England

Data from surveys of local councillors in England in 2008 and 2013 shows that there has been very little change in the proportion of councillors with a long-term condition or disability: 13.3% (2,602) in 2008 compared with 13.2% (2,383) in 2013 (LGA, 2014).

Wales

Comprehensive data about the diversity of Welsh Assembly Members is not collected and no data is available on the proportion of members who are disabled, nor whether that number increased or decreased at the 2016 election (EHRC, 2015d).

The Welsh Assembly announced plans for local authorities to conduct a survey of councillors and unsuccessful candidates after each election to monitor gender, sexual orientation, language, race, age, disability, religion or belief, health, education or qualification, employment, and work as a councillor. As a result, a survey of Welsh councillors was carried out in 2012 (Broomfield, 2013). A total of 3,201 responses were collected from 21 local authorities, which represented a response rate of 35%. The survey found that the proportion of both elected and unelected candidates who described themselves as having a disability was very similar (14% and 15% respectively).

In March 2014, a report of the Expert Group on Local Government Diversity, comprising a literature review and comparison of survey data from the local councillors' surveys across the UK made recommendations for the Welsh Government, local authorities, the Welsh Local Government Association, political parties and councillors to help improve the numbers of young people, women, people from ethnic minorities, lesbian, gay and bisexual people (Welsh Government, 2014).

In Wales in 2014/15, 7.2% of appointments and reappointments made by Ministers in Wales were of people who had a disability (CPA, 2015). The Welsh Government has committed to increase the number of people

from under-represented groups on public sector boards through a range of actions.

Scotland

Before the 2016 election for the Scottish Parliament, three Members of the Scottish Parliament (MSPs) were disabled. After the election, it appears that only one MSP is self-declared disabled. To be representative of the population, it has been estimated that there would have to be around 23 disabled MSPs (Meyer, 2016).

A survey of Scotland's councillors was carried out in 2013. Data on their health showed that 29.8% of councillors had a disability or health condition that limited them a little, while 3.2% were limited a lot. In addition, 59.2% of councillors who responded to the survey were not in paid employment, of which 1.7% were 'permanently sick' or disabled. 13.6% of councillors provided care to someone on a regular basis who was 'sick, elderly or disabled' and 26.2% of these councillors would have, or have had, to make special care arrangements in order to carry out their council business (Improvement Service, 2013).

8.2. Access to services

Under this indicator, we cover access to transport, public services and leisure, and discuss access to digital and financial services.

Legal and policy framework and outcomes

Transport

In the UK all buses must be accessible by January 2017, and coaches and trains by January 2020. The main legislation that applies to disabled passengers or people with reduced mobility using public transport is now consolidated in the Equality Act 2010, but much of the law as it relates to their treatment and the services they can expect derives from various EU legislative instruments (HoC Library, 2016).

Access to transport is an important part of independent living and participation in family and community. Transport options for disabled people are very limited because of the need to use only transport forms that are accessible, and these tend to be expensive. Disabled people report feeling 'trapped' by these high costs and limited options. Cuts to concessionary fares and local transport services have left some disabled people isolated (JCHR, 2012). A study looking at the impact of rail accessibility improvements found that 33% of wheelchair-users, 19% of passengers with a hearing impairment and 15% of passengers with a mobility impairment reported making increased trips following the improvements (Transport Scotland, 2016).

The House of Commons Transport Committee (2014) has published criteria that passenger transport has to meet if a community is not to risk isolation. It noted its concern about how the implementation of the Department for Transport Accessibility Action Plan was being monitored. The Committee recommended that the UK Government publish annual updates about implementation of the plan, including data on changes in the number and types of journeys made by disabled people.

The UK Independent Mechanism (2014) has acknowledged the steps put in place to improve accessibility of transport. However, it noted that: 'Disabled people continue to experience significant barriers when trying to use transport including the lack of accessible railway stations, difficulties getting in or out of transport, getting to and

from bus stops or bus/train stations, the lack of integration between the different modes of transport, and the attitudes of staff' (p.13). It also recommended that the UK Government needed better evidence of the effectiveness of legislation and public initiatives aimed at improving transport accessibility.

There are also attitudinal or psychological barriers that prevent or discourage disabled people from using transport services. This could involve the behaviour and attitudes of some transport staff or concerns that people have about using transport, such as fear of crime, abuse or attack (SATA, 2015).

The situation is similar in Wales and Scotland. Reports from the Public Transport Users' Advisory Panel to Welsh Government (2014) include accessibility aspects of public transport. This Panel commented that users reported the lack of disabled access. The Scottish Human Rights Commission (SHRC, 2012) highlighted the problem of lack of access to, and affordability of, transport, particularly in rural areas, in Scotland. This was identified as having a consequential impact on access to services, education, work and leisure.

GB

The figures reported here, on people who say they are limited using transport because of a health condition, illness or impairment; a disability; lack of help or assistance; lack of special aids or equipment; badly designed buildings; attitudes of others, are from analysis specifically for this report using data from the Life Opportunities Survey. See online data table EF6.1.

In 2012-14, around one in five disabled adults Hearing impairments in GB (18.2%) reported being limited using transport because of: a health condition, illness or impairment; a disability; lack of help or assistance; lack of special aids or equipment; badly designed buildings; or attitudes of others. This percentage was higher still for some impairment groups, including those with impairments affecting mobility (34.2%), dexterity (35.8%), memory (35.1%), and behavioural impairments (44.9%).

Allowing for the combined effects of age, disability, gender, access to a car, and size of household, limitations in use of transport for non-disabled people were highest for those aged over 75. The effect of disability was lower for the two oldest age groups (65-74 and 75 and over), but for the over-75s the combination of age and disability meant that the experience of transport limitations for the reasons above was as large as for working-age adults.

Rail

The number of disabled people travelling by train has increased sharply. The Office of Rail and Road (ORR) statistics show that disabled people were assisted to use a train 1,146,000 times in 2015-16, an increase of 7.7% on the previous year and a rise of 21% in just three years (ORR, 2016).

However, Access for All fund for 2014-19, which funds access improvements to rail stations, has been cut from £102 million to £55 million, with the rest carried over to the next spending period, 2019-24.

Organisations campaigning for better accessibility say the Access for All fund had delivered much needed ring-fenced funding to improve the situation for disabled people. For example, most stations still do not have lifts, tactile paving, audio-visual information, induction loops and other equipment that enables disabled people to use them (Disability News Service, 2016). The Welsh National Transport Finance Plan (Welsh Government, 2015f) outlines a number of steps that need to be taken under the UK Access for All programme. This includes

improving station access and conducting feasibility studies into accessibility adjustments at other sites. However, the EHRC is concerned that a loss of funding will mean poorer access for a growing number of disabled rail users.

The industry needs to undertake further work to ensure that greater numbers of disabled passengers receive the assistance they need to travel. In 2014, approximately one in 10 disabled people in the UK had difficulties getting to a rail, bus or coach station or stop, and a similar proportion had difficulties getting on or off these forms of transport (DWP and ODI, 2015). Scottish Household Survey data for 2013-14 shows 83.1% of disabled people surveyed said they had not used a rail service in the last month, compared with 70.7% of the Scottish population (Scottish Government, 2015j).

Passenger Assist is a free service provided by train companies to assist disabled passengers and older people with any part of their train journey. In its 2014 review of this service, the independent transport user watchdog, Transport Focus, found that despite current good practice there are areas where the industry might usefully focus attention on improvements. These include a more consistent delivery of assistance and improved communication and staff training (Passenger Focus, 2014).

Buses and coaches

There is concern that cuts to bus routes across Britain have a detrimental impact on disabled people. According to the Campaign for Better Transport, since 2010, 70% of all local authorities in England have cut, altered or withdrawn 2,000 bus routes. In Wales, the budget for supported bus services has been relatively stable since 2010-11, but the Welsh Assembly has since reduced this and made cuts to the concessionary travel scheme for older people, resulting in 179 route withdrawals or alterations. In Scotland, press reports have suggested that the number of bus routes registered with the Traffic Commissioner for Scotland has fallen by 21% since 2006 (Picken, 2016).

The EHRC (2015b) carried out a formal assessment of the extent to which the Spending Review conducted by the UK Government in 2010 complied with the requirements of the former equality duties for race, gender and disability. One example of weaknesses in the decision-making process was that the potential impact on disabled people in England of the 20% reduction in the Bus Service Operators' Grant was not provided to HM Treasury Ministers.

Accessibility on buses is improving. The House of Commons Transport Committee (2013) called for 'a system of incentives for operators to bring forward investment in new accessible vehicles, together with a phasing in of audio-visual information as new buses are introduced over the next 10 years' (p.3).

In March 2016, 94% of buses in England had been issued with an accessibility certificate and the proportion of buses in England with an accessibility certificate has increased each year since 2004/05 (DfT, 2016).

In a telephone survey of over 3,000 Concessionary Bus Pass Scheme cardholders, commissioned by Transport for Scotland, 46% of respondents reported that they used the scheme 'for independence or freedom' with about one in five (22%) saying that this was the Scheme's most important aspect for them (Shaw and Hewitt, 2014). However, about one in 10 people in remote and inaccessible rural areas in Scotland do not have access to a bus service; these areas also have a higher proportion of older people and disabled people (Scottish Government, 2015a).

In February 2012, Mr Doug Paulley, a wheelchair-user, was not allowed to board a bus because a wheelchair space was occupied by a woman with a sleeping child in a pushchair, who refused to move. The driver also would not allow Mr Paulley to fold down his wheelchair and use an ordinary passenger seat, because the wheelchair could not be secured and was a safety hazard. Mr Paulley successfully sued FirstGroup at the County Court for unlawful discrimination and was awarded £5,500. The County Court decision that a non-wheelchair user in a wheelchair space should move from it if a wheelchair-user needed it was overturned on appeal. In June 2016, the EHRC took Mr Paulley's case to the Supreme Court to argue that the Court of Appeal's ruling undermines the effectiveness of the need to make reasonable adjustments by anticipating what changes may be needed even before a disabled person uses the service. In January 2017, the Supreme Court ruled that bus companies must end 'first come, first served' policies, and do more to give priority to wheelchair-users. This means that wheelchair-users should be given priority for wheelchair spaces on buses, and bus companies should have clear policies in place and give training to drivers to remove the barriers wheelchair-users face when using buses (EHRC, 2017).

Taxis and private hire vehicles

There is no national requirement to make a proportion of taxi or private hire vehicle fleets accessible. This is deferred to individual local licensing authorities and individual councils can require all or a proportion of vehicles licensed by that authority to be accessible. For example, in Edinburgh all taxis have been required to be wheelchair-accessible since 1 January 1997 and since 1 January 2000 every taxi operating in London has been required to take wheelchairs (HoC Library, 2016).

Section 165 of the Equality Act 2010, if fully brought into force, would make changes to the service that disabled passengers can expect from taxi drivers in England and Wales, (arrangements in Scotland are devolved and the powers to introduce regulations are contained in section 20 of the Civic Government (Scotland) Act 1982). Section 165 would also place duties on drivers who have an accessible vehicle to carry a passenger while in the wheelchair without an additional charge. The EHRC welcomes the UK Government's announcement in May 2016 to make taxis accept and assist wheelchair-users.

There are further concerns that need to be addressed:

- Almost two in three wheelchair-users report being charged more due to being a wheelchair-user (Extra Costs Commission, 2015).
- The proportion of taxis and, particularly, private hire vehicles that are accessible is relatively low. For example, an estimated 58% of all taxis in England were wheelchair-accessible (either purpose-built or converted) at August 2015. This proportion has been broadly unchanged over the past decade. Outside London, metropolitan areas in England had 84% wheelchair-accessible taxis with a substantial decline in the proportion of accessible taxis in other urban (36%) and rural areas (13%) (DfT, 2015).
- Questions of accessibility also relate to taking bookings, ensuring drivers are properly trained and treat disabled people equally, carrying guide dogs and not making extra charges (HoC Library, 2016).

Public services

GB

The figures reported here, on people who have difficulty accessing public services (health, benefits, tax, culture, sport and leisure), are from analysis specifically for this report using data from the Life Opportunities Survey. See online data table EF6.3.

There was an overall increase between 2009-11 and 2012-14 in the percentage of disabled and non-disabled adults in GB who reported having difficulty accessing services in the areas of health, benefits, tax, culture, sport and leisure. In 2012-14, disabled people (45.3%) were more likely to report having difficulty accessing services compared with non-disabled people (31.7%). For some groups the gap was large; for example, for those with a behavioural impairment (75.1%), a mental health condition (54.4%) or memory impairment (53.1%).

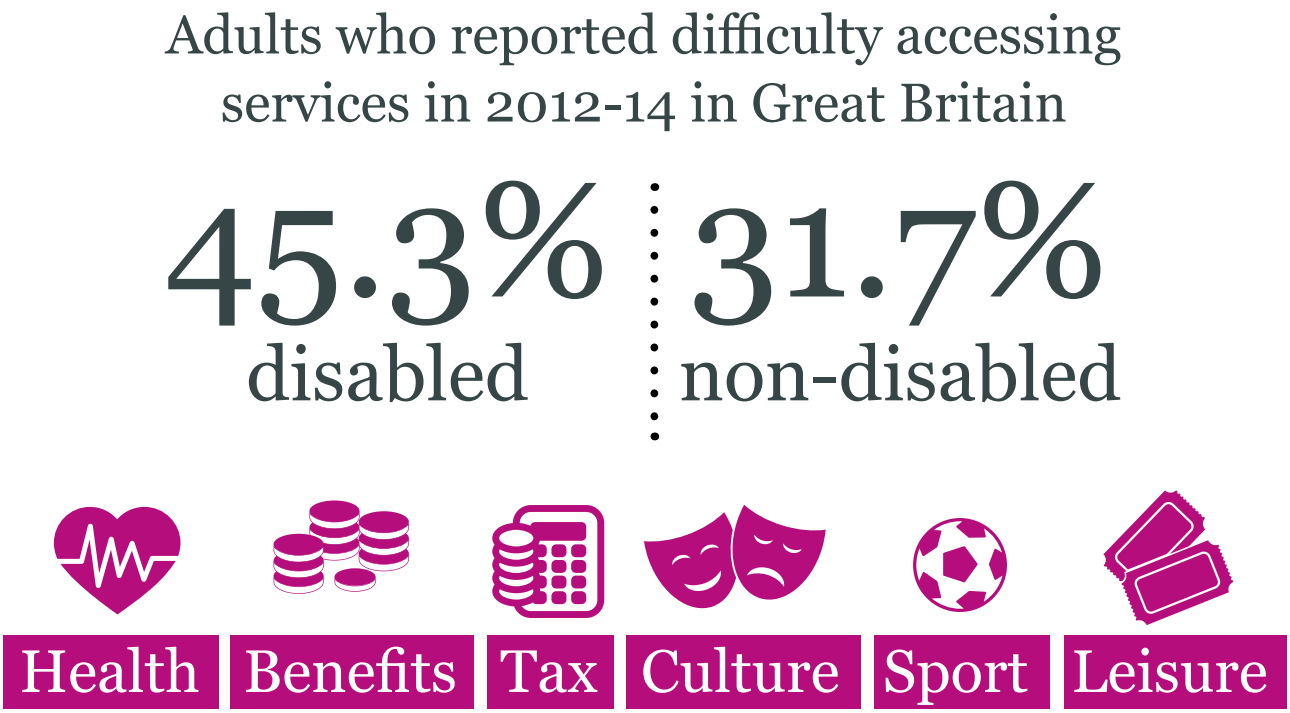
Allowing for the combined effects of age, disability, gender, and access to a car, a higher percentage of people without access to a car have difficulty accessing these services. By age, difficulty accessing services is greater for non-disabled people in the 25-34, 35-44 and 45-54 age groups compared with 16-24-year-olds, and lower for the over-75s. In every age group, more disabled than non-disabled people have difficulty accessing services, but this effect decreases with age.

Leisure

GB

Poor access to leisure can affect the community and social life of disabled people, creating a barrier to independence and their enjoyment of leisure activities.

The figures reported here, on people who say they are limited in leisure activities because of: a health condition, illness or impairment; a disability; lack of help



or assistance; lack of special aids or equipment; badly designed buildings; or attitudes of others, are from analysis specifically for this report using data from the Life Opportunities Survey. See online data table EF6.2.

In 2012-14, disabled adults were much more likely to report being limited in leisure activities (27.9%) than non-disabled people (2.8%), with a similarly wide gap in 2009-11. High percentages of the following impairment groups reported limitations in leisure activities: 47.1% of those with mobility impairments, 48.6% of those with dexterity impairments, 51.4% of those with social or behavioural impairments and 44.7% of those with other impairments.

Allowing for the combined effects of age, disability, gender, access to a car, and size of household, limitations in leisure activities were higher for people without use of a car and for disabled people in one- or two-person households. By age, restrictions were higher from age 35 upwards for disabled people.

In other research, participants who had physical and/or sensory impairments reported that the places and spaces they wished to visit were often inaccessible to them. Participants felt that issues of inaccessibility contributed to feeling isolated, as it often seemed easier to stay at home rather than attempt a trip out. Over a third (35%) of disabled respondents said they found leisure a challenging area of life, with general health or condition (74%) cited as the main barrier among those who identified this as a main or secondary challenge. Barriers to accessing appropriate and specialist leisure activities include a lack of specialist activities and not having the support required to participate in leisure facilities (Copestake *et al.*, 2014).

The EHRC has highlighted the difficulties faced by disabled people in accessing stadiums. Football clubs are legally obliged under the Equality Act to ensure disabled fans are not disadvantaged. In England, all Premier League clubs pledged to improve their stadium facilities for disabled supporters and increase the numbers of wheelchair user spaces by August 2017. However, the Premier League has acknowledged that many will miss the deadline. Seven Premier League clubs will not have adequate facilities for disabled fans by August 2017. We have warned that clubs could now face legal action (EHRC, 2016d).

The State of Access Report (Attitude is Everything, 2016)67 provides a biannual snapshot of the live music industry in Britain when it comes to accessibility and inclusion for deaf and disabled people. Although there is a significant body of best practice within the industry, deaf and disabled people still face significant barriers at all stages of attending live music events. Findings show that one-third of venue and festival websites and two-thirds of independent venues provide no access information. Less than one-fifth of websites surveyed provide ‘good’ access information.

Hynt, a national access scheme for theatres and arts centres in Wales, ensures that there is a consistent offer available for disabled visitors and their carers or personal assistants. Since the scheme was introduced, the number of theatres and arts centres with access policies increased from 22 in 2013/14 to 34 by March 2015 (Arts Council of Wales, 2016).

The Scottish Household Survey shows that in 2014 an estimated 48% of all adults visited the outdoors one or more times per week for leisure or recreation compared with only 36% of adults with

a ‘long-term health condition or illness’ (Scottish Government, 2016i). Research commissioned by Sport Scotland found that in Scotland disabled people are less active, have poorer experiences of physical education in school, and are less likely to participate in sport as adults. Disabled people are also less likely to use leisure facilities. However, when disabled people do take part in sport and exercise, they are almost as likely as others to take part frequently (on 15 or more days per month). Barriers to disabled people’s participation in sports can include: negative attitudes and stereotypes, physical accessibility and inclusion, pathways into sport, under-representation and wider issues of socio-economic disadvantage (Sport Scotland, 2016).

Digital accessibility

The Equality Act 2010 covers digital accessibility. It places a requirement on public and private providers of goods and services to anticipate barriers and think in advance about what disabled people with a range of impairments might reasonably need. An organisation is required to put in place reasonable adjustments such as alternative means of communication where it is not possible for disabled consumers to overcome access barriers. However, the law leaves a degree of interpretation for service providers about how far they are required to go to increase digital accessibility and there is as yet no UK case law precedent on web accessibility to clarify the position (Barton *et al.,* 2015).

The UK Government’s ‘Digital inclusion strategy’ (Cabinet Office and Government Digital Service, 2014) has enlisted the voluntary and private sectors to play a part in this process and encourage disability organisations to refer disabled people where necessary to appropriate services, for example, AbilityNet and Barclays Digital Eagles. Another key issue is the accessibility of online content. The actions in the strategy do not address accessibility directly, nor does the strategy identify clear accountability for improving digital accessibility.

The new Digital Inclusion Charter, which the Welsh Government has implemented to get people online, promotes digital inclusion through participating organisations. There are no specific principles that relate to disability; however, participating organisations may include this in their specific charters (Digital Communities Wales, 2016).

There is a strong need to support disabled people to develop digital skills. The figures reported here, on people aged 16 and over who have used the internet (for any purpose), are from analysis specifically for the ‘Is Britain Fairer?’ review. See online data table EE4.1.

In GB, disabled people were less likely than non-disabled people to have accessed the internet in 2013 (63.6% compared with 89.5%). Compared with 2008, the percentage of disabled people accessing the internet has increased by 24.6 percentage points, a larger increase than the 11.7 percentage points seen for non-disabled people.

In England, Wales and Scotland in 2013, disabled people were less likely to have accessed the internet compared with non-disabled people: England 65.1% compared with 89.8%; Wales 47.1% compared with 85.7%; Scotland 61.5% compared with 88.2%. England and Scotland have seen large increases in the percentage of disabled people accessing the internet, resulting in the gap between disabled and non-disabled people becoming smaller.

Statistics from the Office for National Statistics (ONS, 2015) suggest the wide gap in internet usage between disabled and non-disabled people has persisted and is particularly the case for older disabled people. In 2015, 27% of disabled adults had still never used the internet compared with 11% of non-disabled adults, which translates to over three million people.

A report by the Extra Costs Commission (2015) states there are a number of factors that may restrict the digital inclusion of disabled people. Some disabled people lack the training and skills to understand and use the internet.

Financial accessibility

Control over personal finances and choice about how to spend one's own money is important to living independently. Disabled people have less wealth and fewer assets than their non-disabled peers. The longer someone experiences disability the greater the wealth and asset gap. This is because disabled people earn less than non-disabled people and face extra costs, referred to as 'the disability penalty' (McKnight, 2014).

Almost all disabled people report high extra transport costs. Most report difficulties affording insurance and many pay more for housing, fuel and energy (Extra Costs Commission, 2015). Disabled people are less likely to be able to cope with financial shocks and more likely to have to turn to 'payday loans' to help with everyday living (Brawn, 2014). Research indicates that as many as three million disabled people feel that they are either charged too much for insurance or denied cover. Disabled people are over-represented among those on standard tariffs who pay more for their energy (Extra Costs Commission, 2015).

The financial penalty an individual faces affects their standard of living and can limit their family life, opportunities to learn, work, and participate in society. This can be exacerbated by poor access to finance and financial products and digital exclusion.

Ipsos MORI (2013) research on disabled people and internet access, including finance and banking services, found that many disabled people receive professional financial advice from their banks, yet a significant minority of disabled people cannot access their bank at all. Almost half (48%) of disabled people said they would prefer to receive advice in person, rather than over the telephone or by email. Another 20% said they would prefer someone to come to their home, or meet at a local venue. Four in 10 disabled people (38%) get their financial advice from managers or advisers at their bank or building society – this is the second most commonly used form of advice after independent financial advisers (IFAs) (mentioned by 42%). Yet one in eight disabled people (12%) had found it difficult to physically access their bank or building society in the last 12 months.

The Financial Services Vulnerability Taskforce produced a report (British Banking Association, 2016) criticising access to banks and their services and highlighting avoidable debt issues and vulnerability to fraud. The Taskforce cited examples where technology can have a significant role to play in relation to vulnerability by breaking down communication barriers for those with accessibility issues and recommended better publicising of services for disabled customers. It highlighted the importance of ongoing evaluation and monitoring, especially as firms do not often explore whether there is a different course of

action that would be more helpful to the customer, and there is a danger that customer processes may become inflexible. The Taskforce agreed that feedback on outcomes from customers in high-risk circumstances was critical to enable firms to examine the impact of their policies and procedures.

People with a learning disability have reported specific problems around access to financial products. Proof of identity documents, such as passport, driving licence or child benefit books, are often not held by people with a learning disability and this means they may have to apply for a passport to achieve this proof. They do, however, often have other forms of documentation related to the benefits they receive, or health and social care support services they access. Furthermore, people with a learning disability often have little or no credit history as they may have never had any loans, mortgages or credit cards (Dosh, 2014).

The Financial Inclusion Commission (2015) heard evidence that, of those who want to buy insurance, some disabled people may face unfair exclusion or disproportionately high costs. It recommended to the Financial Conduct Authority that risk profiles, premiums and refusals of cover in the personal insurance market are based on accurate information. Evidence provided to the Commission showed that six in 10 disabled people turned down for insurance said that it was because of their impairment or condition. One in five disabled people feel they pay more for insurance because of their impairment. The Commission recommended, if a person is either refused insurance or offered it at a prohibitively high cost, insurers should direct them to other more specialised insurers or an effective brokerage service (Financial Conduct Authority, 2015).

8.3. Discrimination, abuse, attitudes and stigma

Legal and policy framework

GB

The law contains protections against harassment in the Equality Act 2010, the Protection from Harassment Act 1997 and the Communications Act 2003. The scope of protection under each of these acts is different.

England

In England, several changes have been made to the legal and policy framework relating to emotional and financial abuse in recent years. In March 2013, a new definition of financial and emotional abuse was recognised and implemented as part of the wider redefinition of domestic abuse agreed across Government for England (Home Office, 2013). The Serious Crime Act 2015 made 'coercive and controlling behaviour in an intimate or family relationship' a criminal offence (s.76); this section came into force on 29 December 2015. The previous UK Government stated that the Act would outlaw 'sustained patterns of behaviour that stop short of serious physical violence, but amount to extreme psychological and emotional abuse' (Home Office, 2014). The Act provides that it is a defence for a perpetrator of domestic abuse to show that they believed themselves to be acting in the victim's 'best interests' and that the behaviour was, in all the circumstances, reasonable. This was intended to cover partners caring for a spouse, who, by virtue of their medical condition, has to be kept at home or compelled to take medication for their own protection or in their own best interests (House of Lords, 2015, p.5). This defence provision of the Act has been criticised by Women's Aid, which argues

that it could exclude women with disabilities from protection (McVeigh, 2015).

Providing support and protection for adults who are at risk of abuse is a key responsibility of local authorities in England, Scotland and Wales (known as 'safeguarding' in England and Wales). In England, the Care Act 2014 has introduced a general duty on local authorities to promote individual wellbeing, which includes protection from abuse and neglect. The Act also places a more specific duty on authorities to: make enquiries where they have 'reasonable cause' to suspect abuse or risk of abuse; to set up multi-agency safeguarding adult boards; and to arrange for case reviews to take place where there has been a serious incident. The Department of Health (2014b) has updated its adult safeguarding guidance to accompany the new legislation.

Wales

In Wales, guidance for local authorities is currently available in the form of the 'Wales interim policy and procedures for the protection of vulnerable adults from abuse', which was updated in 2013. The guidance defines abuse as 'a violation of an individual's human and civil rights by another person which results in significant harm', and includes negligence or ignorance and acts of omission (failing to act). It covers emotional and psychological abuse and states that abuse may involve a vulnerable adult being persuaded or forced to enter into a financial arrangement (Adult Protection Fora, 2013).

The wider definition of abuse has been afforded devolved legislative status in Wales. The Social Services and Wellbeing (Wales) Act 2014, which was mostly brought into force in April 2016, defines abuse as 'physical, sexual, psychological, emotional or financial abuse', and includes abuse taking place in any setting, whether in a private dwelling, an institution or any other place (s.197). 'Financial abuse' is further described as including having money or other property stolen, being defrauded, being put under pressure in relation to money or other property, and having money or other property misused.

The Social Services and Wellbeing (Wales) Act 2014 strengthened procedures for safeguarding and protection of adults at risk of abuse and brought them more in line with protections in Scotland. In both England and Scotland, there is a new duty to report and enquire into suspected cases of abuse, and in Scotland, an 'authorised officer' will be able to obtain an order from the magistrates' court that entitles them to speak in private with a person suspected of being at risk.

Scotland

In Scotland, policing and justice are devolved, meaning that domestic abuse falls within the competence of the Scottish Parliament. Police Scotland includes in its definition of domestic abuse, emotional abuse 'which might amount to criminal conduct and which takes place in the context of a relationship', and the Scottish Government includes 'mental and emotional abuse' within its definition of domestic abuse. Unlike in England and Wales, there is currently no specific offence of emotional abuse under criminal law in Scotland, which means that perpetrators of this form of abuse cannot be prosecuted for that particular crime. In some cases, non-violent but threatening or abusive behaviour that 'would be likely to cause a reasonable person to feel fear or alarm' may be prosecuted under the Criminal Justice and Licensing (Scotland) Act 2010 (Scottish Government, 2015i, Part

1). The Scottish Government is currently consulting on a proposal to create a specific domestic abuse offence that would make it easier to prosecute ongoing emotional or psychological abuse (Scottish Government, 2015i).

The Adult Support and Protection (Scotland) Act 2007 put a duty on councils in Scotland to make enquiries into, and investigate, cases of suspected abuse of adults at risk, for example, those affected by 'disability, mental disorder, illness or physical or mental infirmity who are more susceptible to being harmed'. The Act contains a range of protection orders and facilitates local multi-agency adult protection committees across Scotland, and requires specific organisations to cooperate with councils and each other within investigations. A council can also ask a sheriff to allow them to speak in private to a person suspected of being abused, or for them to be examined by a medical professional; the person is not obliged to comply and can leave the conversation or examination at any time. A key principle of the Act is that public authorities take the least restrictive course of action in deciding how best to support an adult at risk of harm (s.1).

The Adults with Incapacity (Scotland) Act 2000 aims to protect adults who lack capacity to act or make some or all decisions for themselves, and to support their involvement in making decisions about their own lives as far as they are able to do so. It also supports carers and others to manage and safeguard the welfare and finances of the person. It covers people whose incapacity is caused by a 'mental disorder', for example, severe dementia, a learning disability or a severe mental health condition, and those who are unable to communicate due to a physical condition such as a stroke or severe sensory impairment. Anyone who is authorised to make decisions must apply the principles contained in the legislation: any decision must benefit the individual; it must be the least restrictive option; it must take account of the individual's own wishes; people relevant to any decision must be consulted; and the individual's own skills and abilities must be supported and developed. The Public Guardian (Scotland) oversees and supervises people appointed by the courts to make financial decisions.

Outcomes

Reliable estimates for the extent to which disabled people in Britain enjoy freedom from stigma and negative stereotyping continue to be elusive or incomplete.

Unless otherwise stated, the figures reported here, on people who say they have been treated unfairly by a service because of a health condition or disability, are from analysis specifically for this report using GB data from the Life Opportunities survey See online data table EF5.1.

GB

Very few people[68] who are not disabled say they have been treated unfairly by a service because of a health condition or disability and the percentage is also low for disabled people, decreasing from 5.3% in 2009-11 to 1.8% in 2012-14. Allowing for the combined effects of age, disability, gender, access to a car, and size of household, being treated unfairly by a service because of a health condition or disability is reported more often by people without access to a car and people living alone.

Measures of disability prejudice have focused largely on disability as a general category. There is a lack of evidence on how people's attitudes towards disability differ by disability type. There is some evidence that different impairment groups may suffer different levels and forms

of discrimination compared with others (Abrams, Swift and Mahmood, 2016).

Disability prejudice can be expressed in subtle forms, being usually (but not always) patronising rather than overtly hostile. There are also barriers to social inclusion, especially for people with mental health conditions because they are particularly likely to be stigmatised (Abrams, Swift and Mahmood, 2016). A series of research projects commissioned by disability charity Scope showed that negative attitudes towards disabled people remain quite common in Britain (Aiden and McCarthy, 2014):

- A substantial proportion (38%) of respondents reported believing that disabled people are less productive and 13% viewed them as 'getting in the way' some or most of the time.
- The majority of respondents thought that disabled people needed to be cared for (76%), supporting the notion that prejudiced attitudes are based on benevolent or patronising stereotypes of disabled people.
- Only 33% of respondents said that they would feel comfortable talking to a disabled person and many worried that they might say the wrong thing or patronise the person.
- In particular, younger respondents (ages 18-34) reported avoiding talking to a disabled person because they were unsure how to communicate with them.

Experiences of discrimination among disabled people can relate to misconceptions or a lack of understanding by others who do not believe they are disabled. Other types of discrimination are described as patronising, or take the form of refusals to make adjustments in public places to accommodate the needs of disabled people. A lack of understanding of individuals' needs seems particularly evident for those with a mental health condition, learning disability and/or memory impairment (Aiden and McCarthy, 2014). In 2012 disability charities reported an increase in the number of people contacting them to say they had been taunted on the street for 'supposedly faking their disability', an increase that according to *The Guardian* (Walker, 2012), can be attributed to a narrative of benefit scroungers or fakers that is perpetuated by the UK Government and the media.

Fear of stigmatisation is an important issue for mental health. Both mental health service users and carers reported that their lives were affected by fear of, or perceived, stigma and discrimination (Corry, 2008). In addition, frontline staff from local authorities reported that disabled victims often lacked access to advocacy and consequently did not receive necessary support in dealing with and reporting discrimination and hate crime (Hoong-Sin *et al.,* 2011).

The EHRC's (2011) inquiry into disability-related harassment found that it is a widespread but under-reported problem that has a significant impact on the day-to-day lives of disabled people. However, the extent of harassment remains largely hidden, with its seriousness rarely acknowledged, and its link to the victim's disability not investigated. The inquiry recommended actions to improve reporting, recognition and recording of the crime. These included better identification of disability hate crime, making it easier to report, more effective victim support, and prosecution of the crime.

A higher proportion of disabled people than non-disabled people reported feeling discriminated against in the workplace.

In 2013, research showed that 15% of disabled people (compared with 7% of non-disabled people) in Britain felt that discrimination was the reason they had been turned down for a job (Coleman, Sykes and Groom, 2013). British Social Attitudes Survey data revealed that 22% of respondents thought that disabled people would be less effective at work than non-disabled people. Highlighting the possibly normative, rather than personal, basis for such views, 90% of respondents said they would not mind personally if a suitably qualified disabled person was appointed as their boss, but only 77% believed that their colleagues would not mind (Coleman, Sykes and Groom, 2013). This may also reflect social desirability concerns not to appear prejudiced in the workplace.

England and Wales

A survey of over 2,000 disabled people carried out in 2013 on behalf of Scope found that, in the previous 12 months: 4% of disabled people reported being physically attacked; 16% experienced someone acting in an aggressive or hostile way; and 17% experienced being called names when dealing with members of the public; and 35% experienced being talked to in a patronising way (Aiden and McCarthy, 2014).

Another quantitative survey of 2,045 disabled adults found that when respondents were asked how a particular area of challenge they faced (such as health and wellbeing, money and benefits) could be changed for the better, around one in five (19%) said 'other people's attitudes or behaviours'. The majority of the sample (59%) identified 'health and wellbeing' as a main or secondary challenge, and the report notes that the experiences of participants in the qualitative research were often marred by stigma and discrimination, with professionals treating disabled people like children, not taking them seriously and confusing mental health conditions for learning disabilities (Copestake *et al.,* 2014, p.21). The survey findings suggest that other people's attitudes or behaviour are more of a barrier for people with a learning disability (51%) or a mental health condition (42%) than for disabled people in general (20%).

Public awareness campaigns are also strategies used to tackle the issue of stigma and discrimination. For example, Time to Change, a major campaign currently running across England and Wales, aims to tackle mental health discrimination and stigma. Evidence from a study carried out by Mind and Rethink Mental Illness as part of the Time for Change programme suggests that many young people experience mental health-related stigma from family, friends, teachers and medical professionals, and that many have missed school because of prejudice on the part of others (Time to Change, 2012).

One study (Beckett and Buckner, 2012) found that few English state-funded primary schools surveyed (38%) had a disability equality scheme in place under the previous public sector disability equality duty (now replaced by a general public sector equality duty) and fewer still (30%) included a plan to promote positive attitudes towards disabled people. However, more than half felt that they could do more to promote such attitudes (57%). This could be explained by schools' prioritisation of issues; 56% of schools reported prioritising race equality over gender or disability equality. The Time to Change campaign found that parents tended to prioritise dealing with discriminatory language regarding race, gender or sexual orientation more commonly than discriminatory language

in relation to mental health. In a survey of teachers, 76% indicated that they were not receiving guidance on dealing with mental health stigma (Time to Change, 2012).

Scotland

Scotland has a national, long-running mental health campaign called See Me, which is aimed at tackling stigma and discrimination. This is joint funded by Comic Relief and the Scottish Government as part of its Mental Health Strategy for 2012-15. The campaign has been running for a number of years and an evaluation of the programme in 2009 found that it had made progress on its key objective to tackle stigma and discrimination by raising public awareness (Myers *et al.,* 2009). Disability Agenda Scotland launched a pledge for the Scottish Parliament 2016-21, asking parliamentarians to work with them on a number of issues, including to ensure that disabled people in Scotland are less likely to face stigma and discrimination (DAS, 2016).

The figures reported here, on the percentage of people experiencing domestic abuse (emotional or financial) in the last 12 months, are based on: (a) the perpetrator being a partner or ex-partner; (b) the perpetrator being another family member, not a partner; and (c) all perpetrators, are from analysis specifically for the 'Is Britain Fairer?' review. See online data tables: EH2.1a, EH2.1b EH2.1c.

England and Wales

In 2008-09 and 2012/13, disabled respondents (4.3% and 3.7%) were about twice as likely as non-disabled respondents (2.1% and 1.8%) to report that they had experienced emotional or financial abuse in the last 12 months, of which their partner or ex-partner was the perpetrator.

In 2008-9 and 2012/13, disabled people (2.0% and 1.8%) were more likely to have experienced emotional or financial abuse by other family members (not a partner) in the last 12 months than non-disabled people (1.1% and 0.8%).

In 2008-09 and 2013/14 disabled people (5.5% and 4.7%) were twice as likely as non-disabled people (2.8% and 2.4%) to report emotional or financial abuse by family and/or partners or ex-partners (all perpetrators).

Data gaps

There is a lack of disability data on our elected representatives at a national level: Members of Parliament, Members of the Scottish Parliament and Welsh Assembly Members.

There is also a lack of data about members of the House of Lords. Surveys of local councillors are carried out, but only every few years.

There are no reliable statistics on the media representation of disabled people.

Measures of disability prejudice have focused largely on disability as a general category. There is a lack of evidence on how people's attitudes towards disability differ by disability type.

Endnotes

1. The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, and International Convention for the Protection of All Persons from Enforced Disappearance are not signed or ratified by the UK.
2. The Equality Act 2010 provides a legislative framework to tackle discrimination and advance equality across Britain, and places an equality duty (the Public Sector Equality Duty) on public authorities.
3. The Human Rights Act 1998 incorporates the ECHR into UK law and applies to the whole of the UK.
4. Following the Children and Families Act 2014, the ability of children and young people and their parents to be involved in discussions and decisions about their individual support and local provision has been strengthened. The creation of a more coordinated assessment process for those with SEN and/or a disability was seen with the provision of a new 0-25 Education, Health and Care plan for those with more complex needs. Education, Heath and Care plans replace Statements of SEN and the earlier Learning Difficulty Assessments.
5. Any child or young person who, for whatever reason, requires additional support for learning. The Scottish Government defines the following reasons for ASN: learning disability; dyslexia; other specific learning difficulty (for example, numeric); other moderate learning difficulty; visual impairment; hearing impairment; deafblind; physical or motor impairment; language or speech disorder; autistic spectrum disorder; social, emotional and behavioural difficulty; physical health problem; mental health problem; interrupted learning; English as an additional language; looked after; more able pupil.
6. Measured by exclusions per 1,000 pupils, where more than one exclusion may be recorded for the same pupil.
7. The intersectional analysis differs in taking probability of one or more exclusion as the measure.
8. Measured as the number of fixed-period and permanent exclusions per 1,000 pupils.
9. Note that these comparisons include the effect of adding pupil referral units to the data in 2014/15.
10. Measured as the number of permanent and temporary exclusions per 1,000 pupils. In Scotland temporary exclusions are counted in half-days. Any change in the length of time for which pupils were excluded would also affect the number of exclusions counted.
11. Note that the samples of disabled respondents numbered only 103 in 2010/11 and 118 in 2015/16. Hence the estimates of being NEET for the disabled group have high variability and any difference or changes over time would need to be large to be detected by the analysis.

12. Note that the samples of disabled respondents numbered only 136 in 2010/11 and 110 in 2015/16. Hence the estimates of being NEET for the disabled group have high variability and any difference or changes over time would need to be large to be detected by the analysis.

13. A shorthand term for a number of schemes aimed at assisting Jobseeker's Allowance claimants to find work.

14. The report uses the term 'customers' and defines this as disabled recipients or users of Access to Work support.

15. The Two Ticks symbol has been awarded to 8,387 organisations by the Department for Work and Pensions' Jobcentre Plus since its launch in 1990.

16. The reporting of average spend was based on a small self-selecting sample of 70 organisations, and it has been noted by the British Association for Supported Employment (2014) that this could under-represent a picture of significant disinvestment, based on its experience of a number of services disappearing and many more having faced substantial cutbacks.

17. If entitled to Employment and Support Allowance a person is placed in one of two groups: a support group or a work-related activity group (the latter is a where a disability or health condition limits a person's ability to work, but where there are things that can be done to improve this).

18. Employment rates include those who are either employees or self-employed as a proportion of the working-age population.

19. Among the economically active population over the age of 16.

20. In October 2016 this was £3.40 an hour.

21. The apprenticeship levy is a UK Government employment tax that is due to come into force in April 2017. It will be collected across the whole of the UK. All employers (public, private, charities and voluntary organisations) with a pay bill of more than £3 million each year will pay the levy. The levy rate is 0.5% of pay bill; there is an allowance of £15,000 per year. The levy is paid to HM Revenue and Customs through the PAYE process.

22. Section 1(2) of the 1998 Act provides that a person qualifies for the National Minimum Wage if they are an individual who: (a) is a worker; (b) is working, or ordinarily works, in the UK under their contract; and (c) has ceased to be of compulsory school age.

23. The current National Minimum Wage (NMW) for those under the age of 25 still applies. The NMW rates came into force on 1 October 2016: £7.20 per hour (age 25 and over); £6.95 per hour (age 21-24); £5.55 per hour (age 18-20); £4 per hour (age 16-17); £3.40 for apprentices (aged under 19, or 19 or over who are in the first year of apprenticeship). The rate will change every April starting in 2017.

24. Where employment is carried out within Britain or where there is a sufficiently close link between the employment relationship and the UK.

25. Occupational segregation can be 'horizontal', when those with certain protected characteristics are clustered into specific job types, or 'vertical', when they are clustered into specific positions within organisations and may be largely absent from senior management and executive positions.

26. Some disability benefits and payments have not been frozen. These include Attendance Allowance, Carer's Allowance, Disability Living Allowance, Personal Independence Payment, and the disabled and severely disabled elements of Working Tax Credit.

27. Contractors are used by the DWP to carry out disability and health assessments to inform benefit decisions.

28. In *R (MM & DM) v Secretary of State for Work and Pensions [2013]*, the Court of Appeal agreed that the DWP has to make adjustments for persons with a mental health condition undergoing the assessment, for example, by obtaining further medical evidence if there is evidence that the applicant has had suicidal thoughts.

29. There are currently two forms of Employment and Support Allowance, contributory for those with sufficient National Insurance contributions, and income-related which is means-tested. Income-related Employment and Support Allowance will be replaced by Universal Credit. Following a Work Capability Assessment, a claimant is either found fit for work in which case they may apply for Jobseeker's Allowance or Universal Credit, or they are placed in the 'Work-Related Activity Group', or they are placed in the 'Support Group'. Only the latter group is not required to undertake any work-related activity.

30. Based on Wave 1 and 3 results from the Life Opportunities Survey, a large-scale longitudinal survey of disability in Britain.

31. Based on Wave 1 and 3 results from the Life Opportunities Survey, a large-scale longitudinal survey of disability in Britain.

32. See *R (on the application of Carmichael and Rourke) (formerly known as MA and others) (Appellants) v Secretary of State for Work and Pensions (Respondent) and R (on the application of Rutherford and another) (Respondents) v Secretary of State for Work and Pensions (Appellant) [2016]* UKSC 58.

33. The number of households accepted as homeless by the local authority.

34. Based on Wave 1 and 3 results from the Life Opportunities Survey, a large-scale longitudinal survey of disability in Britain.

35. Visitability in the report is defined as properties that have at least four key accessibility features: level access; a flush threshold; door width and circulation space compliant with Part M of Building Regulations; and a toilet on the entrance-level floor.

36. House of Commons Library calculations based on data provided by DWP Stat-Xplore. In August 2015, of the 449,159 claimants subject to the deduction in their housing benefit, 211,624 were in receipt of income-related Employment and Support Allowance.

37. Disabled Facilities Grants are available in England and Wales to fund home adaptations for older people, or those who have a disability, to improve access into and around the home.

38. Very sheltered housing will usually have special bathroom facilities, a greater level of care and support through the service of extra wardens, full-time carers or domiciliary assistance, and the provision of meals.

39. A review of Joint Strategic Needs Assessments in England found that there was a reduction between 2013 and 2014 in the proportion of assessments that mentioned people with a learning disability (from 82% to 72%) (Baines and Hatton, 2014). Moreover, three out of four Joint Strategic Needs Assessments included no information on the number of children with learning disabilities in their area, and 19 out of 20 gave no indication of future prevalence. According to the review, analysis of the type of information contained within Joint Strategic Needs Assessments suggested that it was unlikely to be of value in planning future services.

40. Use of ampersand between two years indicates that two years' data were combined to improve the precision of the estimates of the change over time analysis.

41. See Table B4 in Appendix B for information on these groups.

42. Analysis of impairment data is not available for later years.

43. Five of the 14 health boards met the target by December 2014, with 13% of people having to wait between three and six months to access services; 11% waited more than six months, and 4% waited over a year. This compares to England where 61% of people access services within 28 days. See Scottish Association for Mental Health (SAMH) (2016).

44. Note that the samples of disabled respondents numbered only 76 in 2009 and 2010, and 54 in 2012 and 2014. Hence the estimates of poor mental health for the disabled group have high variability and any difference or changes over time would need to be large to be detected by the analysis.

45. Scoring 45 or less in the mental health domain of the SF36 questionnaire.

46. Note that the samples of disabled respondents numbered only 72 in 2009 and 2010, and 100 in 2013 and 2014. Hence the estimates of poor mental health for the disabled group have high variability and any difference or changes over time would need to be large to be detected by the analysis.

47. Deprivation of Liberty Safeguards aim to protect people in care homes or hospitals in England or Wales from being deprived of their liberty unless it is in their best interests to protect them from harm, or to provide treatment, and there is no other less restrictive alternative.

48. *(P (By His Litigation Friend The Official Solicitor) (Appellant) V Cheshire West And Chester Council And Another (Respondents); P And Q (By Their Litigation Friend, The Official Solicitor) (Appellants) V Surrey County Council (Respondent) [2014] UKSC 19 On Appeal From [2011] EWCA Civ 1257; [2011] EWCA Civ 190).*

49. Under Part 5, Adults with Incapacity (Scotland) Act 2000

50. *R (Tracey) v Cambridge University Hospitals NHS Foundation Trust and Secretary of State for Health [2014].*

51. People may, for instance, be unable to phone to make appointments unaided, be unable to read appointment letters and other correspondence, have difficulties with patient call systems, be unable to read or understand standard advice leaflets, and sometimes not trust doctors or other clinicians they have not met before.

52. Directed enhanced services are primary medical services other than essential services, additional services or out-of-hours services that are commissioned by the NHS.

53. The report notes the possibility of under-reporting, checks being performed under arrangements other than direct enhanced services, people with a learning disability or their carers not wishing to receive annual checks, or general practices not wanting to participate in the scheme.

54. The sample for the data in this report was 557 prisoners who died in prison custody between 2012 and 2014 and whose deaths were investigated by the PPO.

55. Section 297 is the power to remove a ‘mentally disordered’ person from a public place to a place of safety by the police.

56. In the context of the Mental Capacity Act 2005. *Hillingdon London Borough Council v Neary [2012].*

57. This judgment contrasts with judgments in Scotland where the review and appeal mechanisms were found to be sufficient for the purposes of complying with Article 5(4) *(Black v Mental Health Tribunal for Scotland [2011]).*

58. See *P v Cheshire West and Chester; P & Q Surrey County Council Supreme Court [2014].*

59. Based on Wave 1 and 3 results from the Life Opportunities Survey, a large-scale longitudinal survey of disability in Britain.

60. The estimates have a coefficient of variation of 20% or greater.

61. For a more detailed overview of hate crime legislation see our report by Walters, M.A., Brown, R. and Wiedlitzka, S. (2016) ‘Causes and motivations of hate crime’.

62. The Criminal Justice Act 2003 section 146 imposes a duty on courts to increase sentences for crimes motivated by hostility based on disability.

63. A sentence uplift will apply in any hate crime prosecution where the evidence of hostility has been accepted by the court and the defendant pleads, or is found, guilty. See CPS (2016) 'Hate crime report 2014/15 and 2015/16', p.4.

64. The Speaker's Conference was convened on 12 November 2008 to consider the disparity between the representation of women, ethnic minorities and disabled people in the House of Commons and their representation in the UK population at large. It worked through 2009 collecting evidence and published its final report in January 2010.

65. Practical changes include making available and advertising British Sign Language interpretation, induction loop systems and accessible meeting rooms for local council meetings.

66. Based on Wave 1 and 3 results from the Life Opportunities Survey, a large-scale longitudinal survey of disability in Britain.

67. The findings and conclusions of the 2016 edition are based on 280 mystery shopping reports by deaf and disabled people, bespoke research including a survey of 386 venue and festival websites, and a set of case studies drawn from the hundreds of venues and festivals Attitude is Everything works with.

68. Based on Wave 1 and 3 results from the Life Opportunities Survey, a large-scale longitudinal survey of disability in Britain.

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Abbreviations and acronyms

AEO Fund	Access to Elected Office Fund
ASN	Additional Support Needs
A&E	Accident and emergency
BSL	British Sign Language
BIS	Department for Business, Innovation and Skills
CAAPC	Commission on Acute Adult Psychiatric Care
CAMHS	Child and adolescent mental health services
CQC	Care Quality Commission
CRPD	Convention on the Rights of Persons with Disabilities
DH	Department of Health
DNAR	Do not attempt resuscitation
DfE	Department for Education
DWP	Department for Work and Pensions
ECHR	European Convention on Human Rights
EHRC	Equality and Human Rights Commission
EU	European Union
GCSE	General Certificate of Secondary Education
GB	Great Britain
GP	General practitioner
HMI	Her Majesty's Inspectorate [of]
HMIP	Her Majesty's Inspectorate of Prisons for England and Wales
HRA	Human Rights Act 1998
HMIC	Her Majesty's Inspectorate of Constabulary
LASPO	Legal Aid, Sentencing and Punishment of Offenders Act 2012

LGBT	Lesbian, gay, bisexual and transgender
MP	Member of Parliament
MSP	Member of the Scottish Parliament
NEET	Not in education, employment or training
NGO	Non-governmental organisation
NHS	National Health Service
OECD	Organisation for Economic Co-operation and Development
ONS	Office for National Statistics
SEN	Special Educational Needs
SEND	Special Educational Needs and Disability
SQCF	Scottish Credit and Qualifications Framework
TUC	Trades Union Conference
UK	United Kingdom
UN	United Nations

Appendix A

Survey data tables

Table number and measure	Source
CE1.5 Percentage of children achieving at least five A*-C GCSEs including English and mathematics	Department for Education Scottish Government Welsh Government
CE2.10 Percentage of children who have been excluded from school (either for a fixed period or permanently)	Department for Education Scottish Government Welsh Government
CE1.7 The proportion of 16-18-year-olds who are not in education, employment or training (NEET)	Annual Population Survey
EE2.1 The percentage of people aged 25-64 with no qualifications	Annual Population Survey
EE2.2 The percentage of people aged 25-64 with degree-level qualifications	Annual Population Survey
EG1.1 The percentage of working-age adults in employment	Annual Population Survey
EG1.2 The percentage of the economically active population (16+) who are unemployed	Annual Population Survey
EG2.2 Pay gap in median hourly earnings of employees	Annual Population Survey
EF2.1 Percentage of individuals living in households below 60% of contemporary median income after housing costs (relative poverty)	Households Below Average Income and Family Resources Survey for 'Is Britain Fairer?'
EF2.2 The mean deprivation score among those above the income poverty threshold – working-age people	Households Below Average Income and Family Resources Survey for 'Is Britain Fairer?'
EF2.4 People who live in households that have difficulty in making ends meet	Life Opportunities Survey
EH1.1 Percentage of people meeting with relatives or friends at least once a week	Life Opportunities Survey

EF3.1 Percentage who say they are limited in one or more area, because of poor services, lack of help or assistance, or lack of special aids or equipment	Life Opportunities Survey
EF1.3 Housing tenure	Life Opportunities Survey
EB2.1 The percentage of adults who report current health status as bad or very bad	Health Surveys: England, Wales, Scotland
EB4.1e The percentage of adults who are overweight or obese	Health Surveys: England, Wales, Scotland
CB4.3 The percentage of children and young people who are overweight or obese	Health Surveys: England, Wales, Scotland
EB1.2 The percentage of adults with a GHQ12 score of 4 or more	Health Surveys: England, Scotland
EB1.2 The percentage of adults who scored 45 or less in the mental health domain of the SF36 questionnaire	Health Survey: Wales
CB1.2 The percentage of children and young people with a GHQ12 score of 4 or more	Health Surveys: England, Scotland
CB1.2 The percentage of children and young people who report poor mental health and wellbeing using Strength and Difficulty Questionnaire (score >=20)	Health Survey: Wales
EC5.1 Experience of different types of crime	Life Opportunities Survey
EC4.1 Percentage who feel very unsafe or unsafe when walking outside in the daytime (for Scotland: disabled/non-disabled only, no impairment breakdowns)	Crime Survey for England and Wales Scottish Crime and Justice Survey
EC4.2 Percentage who feel very worried/ worried about physical attack and acquisitive crime (for Scotland: disabled/non-disabled only, no impairment breakdowns)	Crime Survey for England and Wales Scottish Crime and Justice Survey

ED2.2 Percentage who agree that the criminal justice system: a) gives victims and witnesses the support they need b) treats those who have been accused of a crime as 'innocent until proven guilty' (for Scotland: disabled/non-disabled only, no impairment breakdowns)	Crime Survey for England and Wales Scottish Crime and Justice Survey
EJ1.1 Percentage who voted in most recent general election	British Election Study for 'Is Britain Fairer?'
EF6.1 People who say they are limited using transport because of: a health condition, illness or impairment; a disability; lack of help or assistance; lack of special aids or equipment; badly designed buildings; attitudes of others	Life Opportunities Survey
EF6.2 People who say they are limited in leisure activities because of: a health condition, illness or impairment; a disability; lack of help or assistance; lack of special aids or equipment; badly designed buildings; attitudes of others	Life Opportunities Survey
EF6.3 Percentage of people who have difficulty accessing services in the areas of health, benefits, tax, culture, sport and leisure	Life Opportunities Survey
EE4.1 People aged 16 and over who have used the internet (for any purpose)	ONS Opinions and Lifestyle Survey for 'Is Britain Fairer?'
EF5.1 People who say they have been treated unfairly by a service because of a health condition or disability	Life Opportunities Survey
EH2.1a EH2.1b EH2.1c Percentage experiencing domestic abuse (emotional or financial) in the last 12 months: a) perpetrator partner or ex-partner b) perpetrator other family members, not partner c) all perpetrators	British Crime Survey /Crime Survey for England and Wales for 'Is Britain Fairer?'

Appendix B

Impairment type categories

Wherever possible, the data tables include disaggregation of disabled people by impairment type and the preferred classification for this is the Government Statistical Service (GSS) harmonised question for impairment. This classifies all people with a long-lasting physical or mental health conditions or illnesses into one or more of the following categories (see right-hand column in the table below). Note that multiple responses are usually possible.

Table B1 Harmonised impairment categories mapped to labels used in the data tables

Data table category label	Harmonised impairment categories
Vision	1. Vision (for example, blindness or partial sight)
Hearing	2. Hearing (for example, deafness or partial hearing)
Mobility	3. Mobility (for example, walking short distances or climbing stairs)
Dexterity	4. Dexterity (for example, lifting and carrying objects, using a keyboard)
Learning, understanding or concentrating	5. Learning or understanding or concentrating
Memory	6. Memory
Mental health	7. Mental health
Stamina or breathing or fatigue	8. Stamina or breathing or fatigue
Social or behavioural	9. Socially or behaviourally (for example, associated with autism, attention deficit disorder or Asperger syndrome)
Other	10. Other (please specify)
None of the above	11. None of the above

Further information on GSS harmonised principles relating to disability and impairment can be found in ONS (2015).

Not all surveys include the harmonised question, however other classifications are available in some surveys. Where an alternative classification is available, the categories have as far as possible been mapped onto categories similar to those in the harmonised question. The following tables show these mappings.

Table B2 Life Opportunities Survey (LOS) impairment categories mapped to labels used in the data tables

Data table category label	LOS impairment categories
Vision	Whether has vision impairment
Hearing	Whether has hearing impairment
Mobility	Whether has mobility impairment
Dexterity	Whether has dexterity impairment
Learning or intellectual	Whether has learning impairment Whether has intellectual impairment
Memory	Whether has memory impairment
Mental health condition	Whether has mental impairment
Breathing	Whether has breathing impairment
Behavioural	Whether has behavioural impairment
Other impairment	Whether has communication/speech impairment Whether has limiting pain condition Whether has impairment not previously mentioned

Table B3 Annual Population Survey (APS) categories mapped to labels used in the data tables

Data table category label	APS categories
Progressive health conditions	Progressive illness not included elsewhere (e.g. cancer not included elsewhere, multiple sclerosis, symptomatic HIV, Parkinson's disease, muscular dystrophy)
Vision	Difficulty in seeing (while wearing spectacles or contact lenses)
Hearing	Difficulty in hearing
Physical disabilities	Problems or disabilities (including arthritis or rheumatism) connected with the arms or hands, legs or feet, back or neck
Learning difficulties or disabilities	Severe or specific learning difficulties
Mental health conditions	Depression, bad nerves or anxiety Mental illness or suffer from phobias, panics or other nervous disorders
Other health conditions	Chest or breathing problems, asthma, bronchitis A speech impediment, severe disfigurements, skin conditions, allergies Heart, blood pressure or blood circulation problems Diabetes Epilepsy Other health problems or disabilities

Table B4 Categories based on the International Classification of Diseases (ICD-10), as used in British health surveys, mapped to labels used in the data tables

Data table category label	Health survey categories, based on ICD-10
Cancer and benign growths	Cancer (neoplasm) including lumps, masses, tumours and growths and benign (non-malignant) lumps and cysts
Vision	Cataract/poor eyesight/blindness
Hearing	Poor hearing/deafness
Physical disabilities	Arthritis/rheumatism/fibrositis Back problems/slipped disc/spine/neck Other problems of bones/joints/muscles
Learning disabilities	Mental handicap (learning disability)
Mental health conditions and learning difficulties	Mental illness/anxiety/depression/nerves (nes) autism/Asperger syndrome/dyslexia
Other health conditions	All other conditions (see list below).

Other health conditions include:

- Bronchitis/emphysema, asthma, other respiratory complaints
- Other eye complaints
- Stroke/cerebral haemorrhage/cerebral thrombosis
- Heart attack/angina, hypertension/high blood pressure/blood pressure (nes), other heart conditions
- Diabetes, other endocrine/metabolic
- Epilepsy/fits, migraine/headache, other problems of nervous system
- Piles/haemorrhoids including varicose veins in anus, varicose veins/phlebitis in lower extremities, other blood vessels/ embolic
- Skin complaints, hayfever
- Other complaints
- Stomach ulcer/ulcer (nes)/abdominal hernia/rupture, other digestive complaints (stomach, liver, pancreas, bile ducts, small intestine - duodenum, jejunum and ileum)
- Complaints of bowel/colon (large intestine, caecum, bowel, colon, rectum)
- Complaints of teeth/mouth/tongue
- Kidney complaints, urinary tract infection, other bladder problems/incontinence
- Reproductive system disorders
- Infectious and parasitic disease
- Disorders of blood and blood forming organs and immunity disorders
- Tinnitus/noises in the ear, Ménière's disease/ear complaints causing balance problems, other ear complaints.

Appendix C

Intersectional analysis methodology

The intersectional analysis draws on the most recent year's data and uses disability and other characteristics to investigate how disability interacts with other factors when predicting outcomes.

The other characteristics used are based on six of the other eight protected characteristics listed by the Equality Act 2010: age, race or ethnicity, religion or belief, marital status, sex and sexual orientation. In addition, other variables that may have been of interest for a particular outcome were also included such as region or socio-economic status.

A list of explanatory variables to be considered for inclusion was drawn up for each outcome. Those that were unavailable for a particular survey, or had a high percentage of missing cases (more than 5%), were dropped from the analysis.

Logistic regression was used when the outcome variable was binary (for example, whether someone is overweight/obese or not). Linear regression was used when the outcome was an amount or value (for example, the median pay gap).

For binary outcomes, the output from the model is in the form of odds ratios. An odds ratio is a measure of association between a factor or characteristic, such as disability, and an outcome. The odds ratio represents the odds that an outcome will occur given a particular factor or characteristic, compared to the odds of the outcome occurring in the absence of that factor. For each characteristic in the model there is a 'reference group' (for example, people aged 16-24) which always has an odds ratio of one. If another group (such as people aged 55-59 years) has an odds ratio higher than one, this means that people in this group are more likely to experience the outcome than those in the reference group.

For continuous outcomes, the output from the model is in the form of coefficients which indicate the marginal effect of each factor or characteristics on the outcome holding all other factors at their means. For each outcome measure, two models were analysed:

- A basic regression model, including the equality characteristics of age, gender and disability as explanatory variables, plus other characteristics of interest (added to the model in a step-wise manner, with only the resulting model shown).
- A final model including interaction terms between disability and each of the other characteristics, for example, between disability and age.

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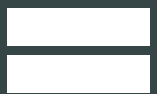

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