Rethink Mental Illness

A safer, fairer route to meaningful activity

The Participation Plan

Contents

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Executive Summary

Rethink Mental Illness proposes a Participation Plan to replace both the Work Capability Assessment (WCA) and the Universal Credit Claimant Commitment for people living with mental illness and other health conditions and disabilities. The Plan provides a structured, personalised way to agree what participation is realistic, appropriate and beneficial for an individual at a particular point in their life.

With the abolition of the WCA and the end of LCW and LCWRA status, government still requires a fair, consistent and personalised way of determining what people are expected to do. The Participation Plan would provide that mechanism. Rather than categorising people as fit or unfit for work, it assesses what participation is realistic, appropriate and beneficial for a person at a particular point in their life. The Plan becomes the mechanism through which expectations, support and any work-related requirements are agreed and reviewed. It is a personalised and recovery-oriented approach.

Today, work coaches set requirements and sanctions enforce them. The evidence, including DWP's own analysis, shows that sanctions do not help people with mental illness into good, lasting work.1 2 Across 94 international studies, sanctions moved people off benefit faster, but into lower-quality, less stable jobs, or out of the labour market altogether.3 In England, sanctions are associated with worse mental health.4

We do not believe the current sanctions system is effective for people living with mental illness or other health conditions and disabilities. However, successive governments have attached some form of reciprocity to income-replacement benefits. This proposal therefore sets out a safeguarded model of conditionality as a practical and politically deliverable alternative to the current approach.

Most people severely affected by mental illness want to work, learn or contribute. What holds them back is rarely motivation. It is fluctuating symptoms, unsuitable jobs, insecure housing, debt, and a system that too often feels like a threat rather than support.

The purpose of the Participation Plan is not to compel work but to support participation, recovery and progression while protecting people from inappropriate requirements and financial harm.

The Participation Plan rests on five pillars:

1. **Time**: how long the plan lasts and how much activity is reasonable.
2. **Health**: symptoms, treatment, recovery and fluctuation, built in from the start.
3. **Objectives**: the person's own goals, whether paid work, learning, volunteering or a mix.
4. **Labour market**: only genuinely suitable, available opportunities count, and local government creates them where none exist.

5. **Barriers**: the local service acts on housing, debt, poverty and other barriers outside the person's control.

Participation Plans would be developed jointly by the claimant and a trained participation adviser drawing on health, employment and local support expertise, with independent advocacy available where needed.

The Participation Plan is not intended to replicate the current claimant commitment model. Its purpose is to establish a shared understanding of a person's goals, strengths, barriers and support needs, and to coordinate access to appropriate support.

The plan keeps the principle that support and responsibility go together, but makes responsibility run both ways. If the state has not kept its side of the plan, the person cannot be penalised.

Where government keeps a sanctioning power, it should sit behind a **Safeguarding Gateway**. Under it, nobody who is unwell, unsupported or without a genuinely suitable option could ever be sanctioned.

We are asking government to:

1. **Make the Participation Plan the basis for any participation-related requirements for UC claimants with health conditions and disabilities when the Work Capability Assessment (WCA) is abolished.**
2. **Legislate for rights, safeguards and confidence to participate**, including a legal right to a Participation Plan, independent advocacy and appeal rights, putting the Safeguarding Gateway into law so that no sanction can be applied unless all ten safeguards are met, and strengthening the Right to Try by extending protections to all participation activity and providing a six-month protected period after entering participation activity.
3. **Protect people where sustained employment remains unrealistic.** Establish a Protected Participation Route for people who have meaningfully engaged with a Participation Plan but for whom sustained employment remains unrealistic after a period of participation and support. Participation, recovery and contribution should be recognised as successful outcomes in their own right, and people should not lose access to health-related financial support simply because participation has not resulted in sustained employment.

- **Fund local delivery and workforce capacity**, including local and combined authorities and NHS partners, to meet their labour market and barriers duties, and publish a workforce plan staff needed to deliver the model effectively.
- **Pilot and independently evaluate the model in at least three areas from 2027**, co-designed and governed with people with lived experience, and publish transparent data on participation, employment outcomes and sanctions. This should initially focus on younger people.

Why change is needed

The current system costs people their health and income without delivering the good, sustained work that government wants.

What people feel about the current approach

- fear of losing income and facing greater hardship when unwell
- distrust of the system
- fluctuating mental health not being seen
- being pushed before ready and getting stuck in the recovery trap, as described in our Rethinking PIP report
- wanting meaningful opportunities rather than monitoring

What the evidence tells us

Research with people claiming benefits finds that conditionality makes existing illness worse. The ESRC Welfare Conditionality Project singled out its impact on people with mental health needs as a particular concern.[5]

- **Sanctions do not move disabled people closer to work.** The ESRC Welfare Conditionality Project (2013–2018) found sanctions had "no tangible positive effects in moving disabled people closer to paid work".[6]
- **DWP's own analysis points the same way**. A DWP study completed in 2020 and published in April 2023 found that a sanction leads the average UC claimant to move into paid work more slowly and to earn less once they do. Sanctioned claimants earned on average £34 a month less over six months.[7]
- **The counter-argument does not change the picture.** The Institute for Fiscal Studies argued that DWP's study may mix up the effect of sanctions with existing differences between claimants, and that wider research finds sanctions raise employment.[8] A review of 94 international studies confirms that sanctions speed exits into work. It also found consistently worse job quality and stability over time, and more moves into economic inactivity.[9] Sanctions can move people off benefit faster, but not into the kind of work that supports recovery.
- **Sanctions are associated with worse mental health.** In England, every 10 extra sanctions were associated with about one more person receiving antidepressants.[10] The rollout of UC was associated with a 6.57 percentage point rise in psychological distress among unemployed claimants.[11] WCA reassessments in 2010–2013 were associated with 590 additional suicides and 279,000 additional cases of self-reported mental health problems in England.[12] Areas with higher sanction rates saw more food bank use.[13] These studies show associations rather than proof of cause, but they consistently point the same way.
- **Most sanctions are for missed appointments, and many do not stand up.** Between February 2024 and April 2025, 90.8% of UC sanctions were for missing or being late to an appointment. In a small casework sample, 86% of the sanctions that Public Law

Project and Central England Law Centre helped people challenge were decided in the claimant's favour.[14]

Why now

- **The WCA is being abolished.** Government still intends to abolish the WCA after the Timms Review of PIP reports, linking access to UC Health to PIP entitlement. The PIP assessment decides who receives PIP, which is an extra-cost benefit, not a means-tested employment-related benefit. The WCA currently decides who faces work-related requirements, so something must replace it.
- **Young people's health is critical.** The Milburn Review's interim report found that six in ten NEET young people have never had a job, and that health is central to who becomes and stays NEET. It said the system's first question should be "what can they do and how can it enable that to happen".[15]
- **People have told government what they need.** Responses to the Pathways to Work consultation warned that mandatory support conversations would undermine trust. Government is still considering its approach.[16]
- **Incomes are already tighter.** Since April 2026, the UC health element has been almost halved for most new claimants under the Universal Credit Act 2025, and the cost-of-living crisis has not lessened.
- **Other countries are changing course.** The Netherlands abolished compulsory unpaid "quid pro quo" activity for people on social assistance from 1 January 2026, with trust and the human dimension as core principles.[17] Germany's stricter 2026 reform is still meant to spare people with mental illness and requires a personal hearing before sanctions.[18] Australia paused payment reductions and cancellations after its Ombudsman found 964 unlawful automated cancellations.[19]

Our proposal: the Participation Plan

A Participation Plan is a personalised, time-limited plan agreed with the person. It sets out what they will do to take part in work, learning, volunteering or community life, and what the state will do to make that possible.

Principles

- **Recovery first.** The plan is built around personal recovery: connectedness, hope, identity, meaning and empowerment (the CHIME framework).[20] Living a satisfying life with ongoing symptoms is a valid goal.
- **Participation through support:** Participation Plans are intended to support people to engage in activities that reflect their goals, circumstances and capacity. People should be expected, where possible, to engage with the development, review and discussion of their Participation Plan. However, participation should be built through trust, support and meaningful opportunities rather than compliance with prescribed activities. Access to financial support should not depend on undertaking specific employment, training, treatment or community activities.
- **Made with the person.** The plan is developed through co-production. The person's goals, preferences and lived experience should carry significant weight in determining what participation is realistic and beneficial. Where the person wishes, family members, carers, independent advocates, trusted professionals and others involved in their support may participate in developing, reviewing, and agreeing the plan. For people with complex or co-occurring needs, with consent, the planning process should bring together relevant members of their support network to ensure the plan reflects the full range of circumstances affecting participation. Where disagreement arises, it should be resolved through independent review rather than unilateral decision-making.
- **Responsibility both ways.** The plan records duties on the person and on the state. If the state does not meet its duties, the person cannot be penalised.
- **Safe.** Health comes first. Activity is never put above recovery or safety.
- **Good participation.** Success means sustained, suitable work or meaningful participation, not any job at any cost.

The Participation Plan differs from the current claimant commitment because it focuses on engagement rather than compliance. People are expected, where possible, to engage with planning, reviews and discussions about support. However, participation is not defined as completing prescribed activities. Decisions about work, training, treatment or community participation are reached through co-production and informed choice. The aim is to encourage participation through trusted relationships and meaningful opportunities rather than through the threat of financial penalties.

Who it is for

The plan is for UC claimants whose health condition or disability affects their capacity to work, including mental illness. It should recognise that many people experience multiple and intersecting needs that can include mental and physical health conditions, caring responsibilities, language barriers, poverty, and discrimination. Plans should always consider the combined impact of these factors in order to provide the appropriate support.

Who delivers it

- **A Local Participation Service**, jointly commissioned by local or combined authorities and NHS integrated care boards.
- **A multidisciplinary team** led by an appropriately trained primary case worker, and made up of employment specialists, clinical support, peer support workers, welfare rights and debt advisers, and housing link workers. Successful delivery depends on having enough relevant staff. Government should publish a workforce strategy before national rollout.
- **DWP** funds the service, sets national standards and pays benefit. It does not write the plan or deliver it.
- **Work coaches** continue to support people without a plan and act as the link with DWP.

How it works

1. **Referral.** Through a GP, mental health team, Jobcentre or local service, or by self-referral.
2. **Getting to know you.** Up to (three min. 30-minute, max. 1-hour) sessions with the primary caseworker to build trust and rapport. Where requested, the person may involve an independent advocate, family member, carer, interpreter, or other trusted professional. For people with complex needs, additional meetings may bring together relevant members of a person's support network to help co-develop a holistic plan.
3. **Co-designing and agreeing to the plan.** A plain-language plan, signed by the person and the primary caseworker, with a plan length and review dates.

- People should be expected, where possible, to engage with the development and review of their Plan. Co-production should mean more than consultation. The person's views, aspirations, and preferences must be actively reflected in the final plan. Plans should not be based on standardised templates; they must demonstrate how the whole person has been considered and included in the decision-making process.

4. **Resolving disagreements**
    a. Any unresolved disputes should be subject to independent review. Disagreement about a specific activity should not in itself be treated as non-compliance.
5. **Support begins.** Employment support, training, volunteering placements and help with barriers and symptoms start straight away.
6. **Regular reviews.** At agreed intervals, and whenever health or circumstances change.

7. **Next steps.** The plan ends when the person is in sustained work, is renewed with new goals, or pauses for recovery. Where a person has engaged with their Participation Plan over a sustained period but sustained employment remains unrealistic, they may move onto a Protected Participation Route with ongoing support and financial protection. This may be because important barriers remain unresolved, or because their health continues to significantly limit their ability to work despite appropriate support being in place.

Delivering participation plans locally

Participation Plans should be delivered through locally integrated services that bring together employment, health, social care and community support around a single personalised plan. While national government should establish the framework and safeguards, local areas should have flexibility in how services are organised and delivered.

A locally led approach recognises that opportunities, labour markets, public services and community assets vary across the country. It also aligns with the Government's wider direction of travel towards greater local responsibility for employment, health and economic growth.

Local participation services

Participation Plans should be developed and overseen by multidisciplinary Local Participation Services.

The services should act as a single front door for people living with mental illness and other health conditions and disabilities whose circumstances affect their ability to participate in work or other meaningful activities. They should bring together professionals with expertise in employment, health, social care and community support, including occupational therapists, employment specialists, peer support workers and other relevant practitioners. Government should therefore publish a workforce plan and investment strategy setting out how the necessary staff will be recruited, trained and retained to support delivery.

Rather than requiring people to navigate multiple services independently, the Local Participation Service should coordinate support, identify barriers, and ensure people can access appropriate opportunities.

Aligning with local priorities

Participation Plans should be integrated with wider local strategies and partnerships, including:

- Get Britain Working plans
- Mayoral Combined Authority employment and skills strategies
- Local Growth Plans and industrial strategies
- NHS mental health and community health services/Integrated Care Systems
- Local authority wellbeing, housing and inclusion services

- Voluntary and community sector provision

This would help ensure that participation opportunities reflect local labour market needs, community assets and available support rather than being driven solely by centrally defined requirements.

Creating meaningful opportunities

Participation Plans can only succeed if suitable opportunities exist.

Local areas should therefore be expected to work with employers, education providers, community organisations and public services to identify, develop and broker opportunities that meet a range of needs and aspirations.

For some people this may mean supported employment, apprenticeships or paid work. For others it may involve volunteering, education, training, creative activity, peer support roles, community participation or other meaningful forms of contribution.

Where appropriate opportunities do not currently exist, local partners should have the flexibility and resources to develop them.

Workforce and implementation

Successful delivery will depend on sufficient workforce capacity.

Government should publish a national implementation and workforce strategy before rollout, developed jointly with local government, the NHS, Royal Colleges, people with lived experience and the voluntary sector – following the joint interviews with Fonagy and Milburn, and in line with recommendation 6 of the Fonagy Review.

This should include plans to increase the availability of occupational therapists, employment specialists, peer support workers and other professionals required to deliver Participation Plans effectively.

Participation Plans should be introduced gradually, with local areas supported to build capacity and test delivery models before full national implementation.

National oversight

While delivery should be local, national government should retain responsibility for setting minimum standards, funding arrangements, claimant protections and appeal rights.

This approach combines consistent national safeguards with local flexibility, ensuring that support remains person-centred while reflecting the realities of different communities and labour markets.

The five pillars of the Participation Plan

Each pillar poses and answers questions about a person's life and circumstances that are essential to supporting participation that is fair, safe and recovery oriented.



TIME: how long, and how much?

- **What it covers:** The length of the plan is personalised but a general standard could be 6 to 12 months with light-touch check-ins at least every three months. It also covers how many hours a week the person can reasonably manage, how activity steps up or down, and time for rest and recovery.
- **Why it matters: Symptoms of** mental illness fluctuate, and the system having capacity to grade activity up and down is essential. The Right to Try Guarantee, in force since spring 2026, means that starting work or volunteering does not in itself trigger a reassessment. But the Social Security Advisory Committee warned that the law still allows reassessment at any time, and recommended six months' protection after someone starts work.[21]
- **What changes:** Today, reduced hours depend on a work coach's discretion. Under the plan, agreed hours are an entitlement. They change only at a review, and only with the person's agreement.

HEALTH: what does the person's health mean for what they can do?

- **What it covers:** Symptoms and their impact, the treatment and recovery plan, medication side effects, good days and bad days, capacity, and a crisis plan.
- **Why it matters:** Mental illness can make it hard to open post, take calls or attend appointments, which are exactly the things most sanctions punish.[22] In addition, many people are not receiving treatment for their mental illness due to waiting lists, so this pillar keeps that in mind and avoiding setting them up for failure.
- **What changes:** The plan works alongside the person's treatment plan/start, with their consent. Capacity is judged on a typical day and a bad day, not a good day. Changes in health pause requirements automatically (see Built-in protections).

OBJECTIVES: what does the person want to achieve?

- **What it covers:** Paid work (part-time, full-time or flexible), volunteering, learning and training, peer support, creative and community activity, or a mix. It builds on the person's strengths, skills, interests and long-term goals.
- **Why it matters:** People keep going with goals they choose for themselves. Motivation driven by threat is weaker and shorter-lived.[23] The capabilities approach judges policy by what people are actually able to do and be.[24] This aligns with the Milburn Review's stated aim to start with what people can do.[25]
- **What changes:** Today, the default is job search. Under the plan, the person's goals set the direction. Paid work could be the long-term aim for many, but equally learning, volunteering and recovery activities should count as real steps towards it or enough for the time-being.

LABOUR MARKET: is there a suitable opportunity?

- **What it covers:** Whether suitable opportunities genuinely exist locally (or digitally if appropriate), matching the person's health, skills, fair wage, hours, travel, support that the employer is able to offer, and goals. Where suitable opportunities do not exist, the local service should work with local authorities, employers and partners to identify, broker or create opportunities, including through supported employment, subsidised employment, apprenticeships and other locally determined approaches.
- **Why it matters:** In Marienthal, Austria, a voluntary job guarantee sharply reduced long-term unemployment, with no harm to other jobs, and improved participants' wellbeing.[26] The evidence government relies on says work is good for health when it is good work and poor-quality work can be worse for mental health than unemployment.[27]
- **What changes:** A *suitable opportunity test*. Nobody can be required to apply for work that fails it. Where nothing suitable exists, the local government has a duty to create or broker an opportunity, and the person is protected while it does.

BARRIERS: what is in the way?

- **What it covers:** Insecure housing, debt, low income and the cost of living, food insecurity, digital exclusion, transport, caring responsibilities, and discrimination.
- **Why it matters:** Nobody can focus on work or recovery while facing eviction, debt collection, an ability to afford basics including transport or their ability to provide vital care to loved ones being compromised.
- **What changes:** The local service has a duty to assess barriers and act on them within set timescales. Barrier support is written into the plan. While a barrier the service committed to tackle remains unresolved, any requirement it affects is paused.

Built-in protections

Fourteen protections make the plan safe to rely on and hard to misuse. They close the gaps in a plan-based approach and respond to risks that are commonly experienced.

Protection	What it means in practice	Why it matters
Separate roles	The primary case worker and the claimant co-produce the plan. The caseworker never recommends sanctions, that is the DWP's decision-maker's role.	People need to be honest about their health without fearing it will be used against them. Pathways to Work Consultation responses warned that mandatory conversations undermine trust.[28]
Independent advocacy and right to involve supporters	A right to an independent advocate when the plan is set, at reviews and in any dispute, modelled on the Care Act 2014[29]. The person can also involve carers, interpreters, and trusted professionals in planning, reviews, disputes, and safeguarding processes.	Many people with complex health conditions, disabilities, or communication needs cannot participate fully without support from others they trust.
Appeal the plan itself	The person can challenge an unreasonable plan before anything goes wrong. Where there is disagreement about the content of a plan, an independent process is available before any enforcement action can be considered. Benefit continues in full during the challenge.	Wrong decisions should be caught early. It protects co-production and prevents professional disagreement becoming claimant non-compliance.
Automatic pauses	Requirements pause automatically on set triggers: crisis team contact, hospital admission, detention under the Mental Health Act, a medication change, bereavement, a domestic abuse disclosure, or a clinician's notice. Evidence burden falls on the system rather than person.	Losing contact is often a symptom of illness, not a choice.
Consent and data	Health information is shared only with explicit consent that can be withdrawn, and only for the plan. It never goes to DWP compliance or benefit assessments.	Trust is the foundation of the plan.

Protection	What it means in practice	Why it matters
Expand Right to Try	Nothing done within a plan can be used as evidence of capability in PIP, UC health element or any successor assessment. Right to Try is extended to all plan activities, with six months' protection after starting work.	Fear of losing benefits stops people trying.
Protected Participation Route	Where a person has meaningfully engaged with their Participation Plan over a sustained period but sustained employment remains unrealistic, they move onto a Protected Participation Route. This may be because barriers to work remain unresolved despite reasonable efforts by the person and the service, or because the person's health continues to significantly limit their ability to work despite appropriate support being in place. People on this route continue to receive health-related financial support that recognises the impact of ongoing illness and barriers to employment.	The purpose of the Participation Plan is to support recovery, participation and inclusion, not simply move people into work. Some people will continue to face barriers that are outside their control. Others will receive appropriate support but remain too unwell to work. Neither group should be financially penalised because sustained employment remains unrealistic. Participation and recovery should be recognised as successful outcomes in their own right.
National standards, local delivery	A national entitlement with minimum standards and regular IPS fidelity checks, delivered locally.	This avoids a postcode lottery.
Fair funding	Services are funded on capacity and quality, not paid per 'participation' (i.e., job) start. Success is measured by sustained participation at intervals, quality of participation, wellbeing, and recovery.	Payment per 'participation' start rewards helping the easiest cases and parking the rest.
A workforce plan	DHSC and NHS England plan for workforce.	Appropriately trained primary case workers, and the multidisciplinary team would

Protection	What it means in practice	Why it matters
		require having adequate resource in national and local scale.
Lived experience in charge	People with lived experience co-design the model and sit on its governance.	Nothing about us without us.
Offline routes	Every requirement can be met in person, by phone or on paper.	Digital access problems have contributed to sanctions.[30]
In-work requirements	No in-work progression requirements for people with a plan, *unless* they choose them.	Keeping a job is itself a recovery goal.
Equality monitoring	Outcomes and any sanctions are published by set of conditions, ethnicity, sex, age and area, with independent oversight.	Sanction rates differ between groups, and data on disabled people is poor.[31]

Sanctions: a safeguarded last resort

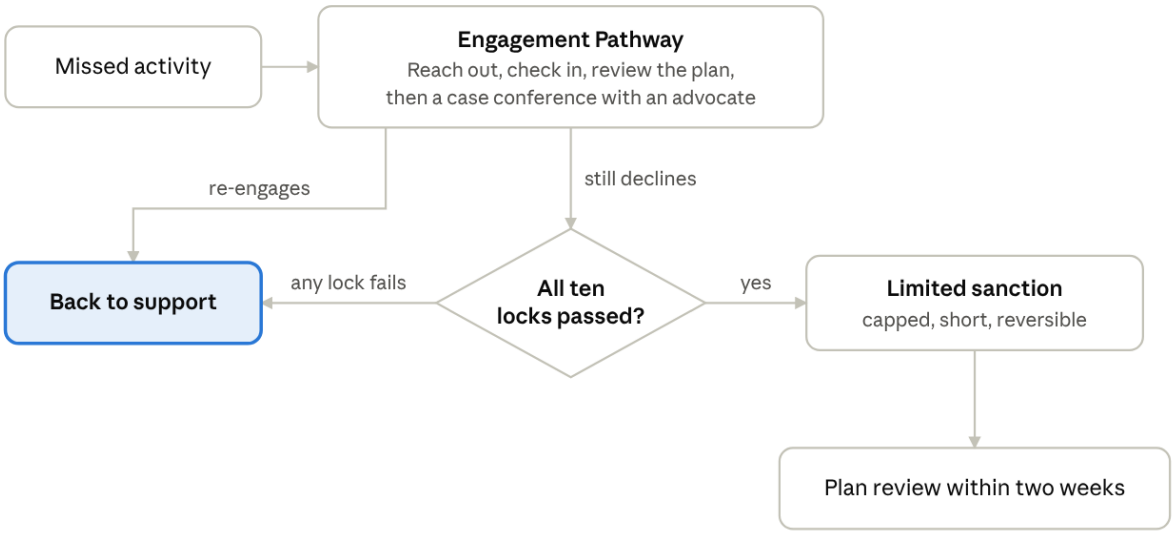
Financial sanctions should not be applied to people severely affected by mental illness or other conditions or disabilities that significantly affect people's lives. Where government keeps a sanction power, it should only ever be used through a **Safeguarding Gateway** so strict that nobody who is unwell, unsupported or without a genuinely suitable option could be sanctioned.

Our position

- When someone with mental illness loses contact or misses an activity, the most likely reason is that they are unwell, overwhelmed or unsupported, not that they are unwilling.
- So, the default response to a missed activity must be support, not penalty. Non-engagement should prompt a review of barriers rather than a compliance response. Where a person is unable or unwilling to engage, services should seek to understand the reasons for non-engagement and offer additional support where appropriate. Responses may include outreach, advocacy, reasonable adjustments, review of support needs, or revision of the Participation Plan. Non-engagement should be understood as a potential indicator of unmet need, deteriorating health, unsuitable support, or wider barriers in a person's life.
- We recognise that government sees reciprocity as a core principle. If a person who is well, fully supported and offered something genuinely suitable repeatedly chooses not to take part, government will want a consequence. Below we set out the strictest conditions under which that could happen.

- No design can remove all risk. That is why we expect the Gateway to be used very rarely, and why its use must be published, reviewed, and allowed to lapse if it causes harm.

Support is the default; a sanction needs all ten locks



Step 1: The Engagement Pathway

When a person misses an agreed activity, the service follows four stages. A missed appointment can never by itself lead to a sanction.

1. **Reach out:** Within two working days, contact the person by their preferred method and at least two others. Assume a health reason first.
2. **Check in:** With the person's consent, contact their care team or GP, and offer a safe and well visit.
3. **Review the plan:** Ask whether the plan is still right, and reduce, pause or change it. A plan that was wrong is the service's learning, not the person's fault.
4. **Hold a case conference:** Meet with the person, their advocate and, with consent, their care team to agree a way forward.

The Gateway can be considered only if all four stages are complete and the person still clearly and repeatedly declines to take part.

Step 2: The Safeguarding Gateway

Every one of the ten locks must be passed. If any lock fails, there is no sanction and the person goes back to support. Caps and time limits below are proposals for discussion.

Lock	The test
1. Right reason	Only sustained and deliberate refusal to engage with the Participation Plan process itself after all stages of support, outreach, advocacy have been exhausted. Refusal to undertake a specific employment, education, volunteering, treatment or

Lock	The test
	participation activity cannot by itself trigger a sanction. Never for a missed or late appointment, digital problems, not finding work, turning down work that fails the suitable opportunity test, or anything during a pause.
2. Fair plan	The activity is within the person's agreed hours, has been health-checked, and a suitable opportunity exists. The service has delivered all the barrier support it committed to and that the claimant advocated for. If the state has not kept its side, there is no sanction.
3. Health first	A legal presumption that non-engagement by someone with a mental illness is linked to their health, which can only be rebutted with written clinical input. Sanctions are barred during a crisis, admission or detention, within 12 weeks of discharge or a medication change, or where the person lacks capacity under the Mental Capacity Act 2005.
4. Real contact	All four Engagement Pathway stages are complete, including a face-to-face meeting such as a home visit and a personal hearing before any decision.
5. Advocacy	An independent advocate, if not already supporting the claimant, has been offered and given at least 14 days to engage before any decision.
6. Independent human decision	An independent panel decides. It includes a clinician and a person with lived experience, gives written reasons in an accessible format, and never relies on automated decisions.
7. Safeguarding check	A safeguarding assessment of the person and anyone in their household, including children. Any risk means no sanction and a safeguarding referral.
8. Limited and proportionate	Capped at 20% of the standard allowance. It never touches housing, child, carer or health elements. It lasts at most four weeks and ends the day the person re-engages. Hardship payments are automatic and never repaid. No sanction can leave a household destitute.
9. Opportunity to challenge	No reduction for 14 days after the decision, or while an independent review or appeal is pending, with a fast-track tribunal route.
10. Learning and oversight	Every sanction triggers a plan review within two weeks. Any death or serious harm within 12 months of a sanction triggers an independent, published review. Data is published quarterly and overseen by an independent body. The power lapses after three years unless evidence shows it improves sustained outcomes without causing harm.

- **For people with lived experience:** if you are unwell, in crisis, waiting for support the service promised, or have not been offered anything suitable, you cannot be sanctioned. You cannot be sanctioned for missing an appointment.
- **For DWP:** the Gateway turns the department's commitment that sanctions are a last resort into a guarantee. It keeps reciprocity in the system while protecting DWP from wrongful decisions, legal challenge and serious harm.

Imagined Case Study

Katherine is 24 and lives alone in a one-bedroom rented flat in Middlesbrough. She is estranged from her family and lives with recurrent depression, anxiety and chronic back pain following a car accident two years ago. Before her health deteriorated, she worked as an administrator for a small company with limited resources and enjoyed the routine and social contact that work provided. Her fixed-term contract was not renewed after repeated periods of sickness absence. She has never been told why, but worries her health played a role. The uncertainty has badly damaged her confidence. She used to love arts and crafts but lost interest as her depression worsened and has experienced frequent suicidal thoughts. Today, severe panic attacks make it difficult to meet new people and, when her back pain flares up, she can spend days unable to leave her bed, disrupting all aspects of her life.

Today, Katherine receives £862.64 a month through a combination of Universal Credit (£338.58), the new lower-tier UC health element (£217.26), and standard daily living PIP (£306.80). However, this does not cover her basic living costs. She worries constantly about money and often avoids putting the heating on, even when the cold makes her pain and mental health worse.

Katherine wants to work again, but not yet. Some weeks she can manage appointments and short walks. Other weeks, pain and depression leave her exhausted and isolated. She has also been waiting months for NHS treatment.

When Katherine is referred for a Participation Plan through her local youth participation service, she is deeply worried. Previous experiences with assessments and the Jobcentre have left her anxious and distrustful of services. She is offered an independent advocate and introduced to the primary caseworker who will remain her main point of contact throughout the life of the plan. Her friend is allowed to join her in the meetings to provide emotional support and help her through the meetings.

Rather than being assessed in a single snapshot appointment, Katherine meets with her caseworker several times over several weeks, even with home visits if that was most feasible. The early conversations are focused on building trust and understanding her situation. For the first time in years, Katherine feels able to talk openly about her panic attacks, suicidal thoughts, financial worries and fears about returning to work without worrying that what she says could be used against her.

Together, they develop a six-month Participation Plan with support from a multidisciplinary team. Rather than starting with compliance checks or job applications, the conversation focuses on Katherine's goals, health and the barriers preventing her from moving forward. Katherine's long-term goal is paid work, but her immediate priorities are reducing financial stress, rebuilding confidence and improving her physical and mental health.

The tailored Participation Plan follows the five pillars:

- **Health**: The plan recognises Katherine's fluctuating depression, anxiety and chronic pain. It includes a crisis plan and can be adjusted if her symptoms worsen.
- **Objectives**: Katherine's long-term goal is paid work, but her immediate priorities are rebuilding confidence, improving her wellbeing and reducing isolation.
- **Barriers**: The team identifies debt, financial insecurity, transport costs and long waits for treatment. A debt adviser helps with arrears, and the service supports Katherine to access local welfare and travel support.

- **Labour market**: An employment specialist works with Katherine to explore what kind of jobs and workplace adjustments might suit her when she feels ready.
- **Time**: The plan starts slowly, with attendance at a local arts and wellbeing group once a week and regular reviews to ensure expectations remain realistic.

The plan also records what the service must do. It commits to arranging support, tackling agreed barriers, coordinating local services and covering agreed travel costs. If those commitments are not met, Katherine cannot be penalised.

Three months later, Katherine's back pain flares up and she stops attending the group. Under the current system, a missed appointment or period of non-engagement could be treated as non-compliance. Under the Participation Plan, her primary caseworker already knows Katherine well enough to recognise that withdrawing from activities is often a sign that her health has deteriorated. Rather than treating the situation as a failure, the caseworker contacts Katherine to understand what has changed and arranges a home visit. Katherine explains that she has barely left her bed for two weeks because of pain and worsening depression. Together, they review the plan, temporarily scale back activity, and shift the focus towards pain management and maintaining social contact through phone-based support. Because the relationship is already established, Katherine engages with the review rather than withdrawing completely.

By the end of the year, Katherine is attending the group regularly, volunteering two hours a week helping with administration at a local charity, and beginning to explore part-time home-based work. Her employment specialist is helping identify opportunities that fit around her health and provide the support she needs to succeed.

The Participation Plan recognises that Katherine's biggest barriers are not motivation or willingness to work. They are poor mental health, chronic pain, financial insecurity and a lack of timely support. Progress is achieved not through the threat of sanctions, but through a trusted relationship with a named professional who understands Katherine's circumstances and can adapt support when things go wrong. Rather than asking why Katherine is not meeting requirements, the system asks what is preventing her from moving forward and what support, flexibility and opportunity are needed to help her do so.

If, after a sustained period of participation and support, Katherine's health continued to prevent her from moving into sustained employment, she would move onto the Protected Participation Route. She would continue to receive financial protection (i.e., UC, UCHE, PIP) and access support, without being treated as though she had failed. Her recovery, contribution and participation would continue to be recognised as valuable outcomes in their own right.

What the Participation Plan means for you, and for DWP

The Participation Plan offers people safety and choice, and offers government better, longer-lasting results.

If you live with mental illness

- You help write your plan, and your goals come first.

- You agree how many hours you can manage. That only changes if you agree.
- Your health and treatment are part of your plan. If you become unwell, things pause automatically.
- You won't be asked to apply for jobs that aren't right for you or don't exist near you.
- The service has to help with things like housing, debt and getting online.
- You can have an advocate with you, and you can challenge your plan.
- Trying meaningful activities won't be used against you in a benefit assessment like PIP.
- You can't be sanctioned for missing an appointment.

For DWP and government

- **It delivers on Get Britain Working.** The plan supports the long-term ambition of an 80% employment rate by focusing on sustained, good work rather than quick exits from benefit that end in inactivity.
- **It fills the gap the WCA leaves.** Abolishing the WCA removes the current basis for deciding who faces work-related requirements. The plan provides an evidence-based replacement.
- **It keeps reciprocity, lawfully.** The Safeguarding Gateway keeps a sanction power that is proportionate and defensible.
- **It saves money where it matters.** In DWP's own trials, health gains from integrated employment support were worth more to society and the Exchequer than the employment gains. Fewer wrongful sanctions also mean fewer reconsiderations and appeals.
- **It rebuilds trust.** It responds directly to what people told government in the Pathways to Work consultation.
- **It helps meet international obligations.** In 2016, the UN CRPD Committee found grave or systematic violations of disabled people's rights linked to UK welfare reform.

Why this approach leads to better outcomes

The objective of the Participation Plan is not simply employment, as it is more ambitiously and humanely planning for participation, recovery and inclusion.

For some people living with mental illness, employment may be the most appropriate outcome. For others, meaningful participation may include volunteering, education, training, caring responsibilities, creative activity or community contribution. Some people will participate meaningfully and still be unable to move into work. This may be because barriers such as housing, caring responsibilities or access to support remain unresolved. It may also be because, despite receiving appropriate support, their health continues to significantly limit their ability to work. A successful system should recognise these as legitimate outcomes rather than failures.

By matching expectations to a person's circumstances and removing barriers rather than imposing penalties, the Participation Plan creates better conditions for:

- sustained employment where work is possible
- improved health and wellbeing
- increased social participation
- stronger community connections, and

- progression towards future opportunities.

People are more likely to engage constructively with support when they feel trusted, respected and understood rather than threatened with financial loss.

How the Plan compares with today

The Participation Plan changes who decides on what evidence and against what test of fairness.

Feature	UC Claimant Commitment today	Participation Plan
Who sets it	A work coach/DWP controls expectations, with some claimant involvement but not equal decision-making power	The primary case worker and claimant co-produce it, with equal decision-making power.
Basis	Conditionality group set by the WCA	The five pillars, assessed with the person
Time	Hours can be reduced at the work coach's discretion	Agreed hours are an entitlement and change only at a review, with agreement
Health	Fit notes and easements, depending on disclosure. Health is considered as an adjustment.	Treatment plan built in, with automatic pauses. Health forms the basis of the plan.
Goals	Job search or work preparation	The person's goals: work, learning, volunteering or a mix
Labour market	Suitable work not formally tested. State obligations are largely discretionary in creating opportunities.	Suitable opportunity test is required, with a local duty to create opportunities. State obligations become enforceable.
Barriers	Easements for some circumstances	A named local duty to act on barriers
Enforcement	Sanctions, mostly for missed appointments	Engagement Pathway first; a sanction only through the ten-lock Gateway
Decision-maker	A DWP decision-maker, on a work coach's referral	An independent panel including a clinician and a person with lived experience
Challenge	Mandatory reconsideration, then tribunal, while the sanction applies	The plan itself can be appealed, and no reduction applies while a review is pending

Recommendations

Rethink Mental Illness calls on government to make the Participation Plan the basis for participation-related requirements for people with health conditions and disabilities, starting with these steps.

1. **Adopt the plan when the WCA goes.** DWP should make the Participation Plan the basis for any participation-related requirements for people with health conditions and disabilities when the WCA is abolished.
2. **Legislate for rights, safeguards and confidence to participate.** Government should create a legal entitlement to a Participation Plan, independent advocacy and appeal rights. It should also put the Safeguarding Gateway into law so that no sanction can be applied unless all ten safeguards are met. In addition, it should strengthen the Right to Try by extending it to all participation activity and providing a six-month protected period after starting participation.
3. **Protect people who participate but cannot move into sustained employment.** Government should establish a Protected Participation Route for people who have meaningfully engaged with a Participation Plan but for whom sustained employment remains unrealistic after a period of participation and support. This may be because significant barriers remain unresolved, or because their health continues to substantially limit their ability to work despite appropriate support. Participation, recovery and contribution should be recognised as successful outcomes in their own right, and should not lose access to health-related financial support simply because participation has not resulted in sustained employment.
4. **Fund local delivery and workforce capacity.** Government should fund local participation services, working through local and combined authorities and NHS partners, to deliver the labour market and barriers duties set out in Participation Plans. Funding should support capacity and quality rather than job starts alone. DHSC and NHS England should publish a workforce plan for the staff needed to deliver the model effectively.

- **Pilot, evaluate and publish outcomes.** Government should pilot the model in at least three areas from 2027, co-designed and governed with people with lived experience, commission an independent evaluation against a comparison group, and publish quarterly data on participation, employment outcomes and sanctions by condition, ethnicity, sex, age and area. This pilot could initially focus on a younger cohort to enable longitudinal monitoring of the success of the model

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