

Mental health problems, benefits and tackling discrimination

Alexander Galloway,¹ Billy Boland,² Gareth Williams³

BJPsych Bulletin (2018) 42, 200–205, doi:10.1192/bjb.2018.43

¹Specialty Doctor, Hertfordshire Partnership University National Health Service Foundation Trust, UK;

²Consultant Psychiatrist, Hertfordshire Partnership University National Health Service Foundation Trust, UK; ³Benefits Adviser, Mental Health Project, Money Advice Unit, Hertfordshire County Council, UK

Correspondence to Dr Alexander Galloway (alexander.galloway1@nhs.net)

First received 30 Jun 2017, final revision 6 Apr 2018, accepted 21 May 2018

© The Authors 2018. This is an Open Access article, distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives licence (<http://creativecommons.org/licenses/by-nc-nd/4.0/>), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is unaltered and is properly cited. The written permission of Cambridge University Press must be obtained for commercial re-use or in order to create a derivative work.

Summary Poverty is strongly associated with mental illness. Access to state benefits can be a lifeline for people with mental health problems in times of hardship and can assist them on their journey of recovery. However, benefit application processes can discriminate against those with mental illness and can result in individuals unjustly missing out on support. Clinical evidence from mental health professionals can ameliorate these challenges and ensure that people get access to financial help.

Declaration of interest Dr Billy Boland is on the advisory board of the Money and Mental Health Policy Institute.

The relationship between money and mental illness

There is a clear link between financial hardship and mental disorder.^{1–3} In 2009 the global financial crisis was estimated to be responsible for an additional 4884 suicides worldwide.⁴ In Britain, people with severe mental illness are three times more likely to be in debt than the general population.⁵ The aim of this article is to help clinicians understand Employment Support Allowance (ESA) and Personal Independence Payments (PIP) (Box 1), two key state benefits in England and Wales, as well as provide further advice on writing supporting clinical evidence for applications.

Box 1

'We can provide the best treatment in the world for our patients but if they can't afford accommodation, heating or food this will be ineffective. It's essential that clinicians know how to support their patients in applying for the benefits they are entitled to.'

Professor Wendy Burn, President, Royal College of Psychiatrists (personal communication, 2017)

The modern, post-war British welfare state was founded to eradicate what *The Beveridge Report* of 1942 identified as the five 'giant evils' in society: squalor, ignorance, want, idleness and disease.⁶ In 2011 the World Health Organization reported mental illnesses to be the leading cause of worldwide disability,⁷ with global costs estimated to exceed \$6 trillion by 2030.⁸ It is therefore no surprise that people with severe mental illnesses are the largest group (49%) claiming working age sickness benefits in the UK.⁹

Disadvantage and discrimination

However, in England and Wales the benefits system often does not work, especially for people with mental disorders, leaving some claimants 'fearful, demoralised, and further away from achieving their work-related goals'.¹⁰ In 2013 the Court of Appeal upheld a ruling that people with mental disorders, along with those with intellectual disabilities and autism, are specifically disadvantaged by the ESA application process.¹¹ Many benefits assessors do not have prior training or experience in mental health.¹² Award decisions are often inaccurate; 67% of ESA and 68% of PIP decisions are later overturned by appeal tribunals.^{13,14} In January 2018, the

Government announced a review of 1.6 million PIP claims following a High Court ruling in December 2017 that described recent changes to the mobility component as ‘blatantly discriminatory’ against people with mental health problems.¹⁵

The reliance on self-reported information in claims is a major obstacle, particularly for those with impaired insight.¹⁶ Submission deadlines are short and those who miss them (perhaps because they do not check their post or were in hospital) may be penalised for the very problems that led them to apply for benefits in the first place. Disturbingly, there is evidence that the assessment for ESA, known as the Work Capability Assessment (WCA; see below), is linked with harm as it is independently associated with an increase in suicides, self-reported mental health problems and prescribing of antidepressants.¹⁷ Clinical and academic experts have long argued that clinicians should have a good understanding of benefits to better care for patients.¹⁸ People using community mental health services frequently under-claim and, for these people, benefits advice can result in additional payment.¹⁹

ESA and PIP claims

ESA and PIP claims share much in common; both require assessment by an independent provider of the functional impact of a claimant’s condition based on a completed medical questionnaire, supporting clinical evidence and, potentially, face-to-face assessment. Nevertheless, there are notable differences: ESA provides a basic day-to-day income for a claimant unable to work full time due to illness, whereas PIP provides a supplement for the increased costs of living with disability. Claimants may receive either benefit, or both, if eligible.

ESA

ESA is awarded instead of Jobseeker’s Allowance when a claimant is determined by the Department for Work and Pensions’ (DWP) WCA to have limited capability for work due to illness or disability. ‘Limited’ does not imply *no* capability and claimants are assessed in terms of whether they can sustain full-time work (16 h per week or more).

ESA applications, once separate, are now being integrated into Universal Credit claims as the programme rolls out nationwide. As the assessment process remains the same, this article will use the term ESA to refer to either route of application.

To establish limited capability for work, a claimant initially needs only to provide a medical certificate from their doctor. At this point, their claim is processed and provisional payment is issued (if applicable). The claimant is then placed in the ‘assessment phase’, which lasts for 13 weeks, or until the DWP completes the WCA, whichever is longer. If this phase lasts longer than 13 weeks, successful claims will have any additional payment due as a result of passing the assessment backdated to the 13th week.

Following the WCA there are three possible outcomes:

(1) The claimant is found to be fit for work and is redirected to claim Jobseeker’s Allowance (or their Universal Credit claim is adjusted accordingly).

(2, 3) The claimant is found to have limited capability for work and is awarded ESA. Within this cohort are two subdivisions:

- The ‘limited capability for work group’, typically shortened to the ‘work group’. In this group, a claimant can be mandated to attend work-focused interviews at their local Jobcentre (or by phone if necessary) and perform ‘work-related activity’, for example skills or CV training. Failure to participate can result in financial sanctions, although a claimant in the work group cannot be asked to apply for or take paid employment.
- The claimant is found to have ‘limited capability for work-related activity’. In this case, they are placed in the ‘support group’ (technically the ‘limited capability for work-related activity group’), which has no attached requirements. Claimants may still choose to do part-time or voluntary work, or other forms of work-related activity if they wish.

PIP

PIP has replaced the Disability Living Allowance for new claims for 16–64 year olds. Both are based on the presumption that functional impairments incur additional living costs. Unlike ESA, PIP is not means tested and eligibility is unaffected by savings, income, household or work status. Award duration varies from 1 to 10 years (an ‘ongoing award’) and successful claimants may still appeal the award length.²⁰

The PIP assessment separates functional difficulties into two components: daily living and mobility. Support for either or both components may be awarded, with payments at a standard (requiring 8 points) or enhanced rate (12 points).

The assessment process

For both ESA and PIP assessments, points are scored for key functional tasks known as ‘descriptors’, according to the claimant’s assessed level of difficulty. For PIP there are ten daily living descriptors (such as preparing food, dressing and budgeting) and two for mobility. ESA assessments are split between ten descriptors for physical disabilities and seven for mental, cognitive and intellectual function (see [Box 2](#)). Scoring 15 points or more anywhere in the ESA assessment qualifies a claimant for the work group. There are also specific descriptors that, if awarded, will further qualify a claimant for the support group.

ESA contains ‘substantial risk’ rules that may allow claimants with insufficient scores (including zero) to qualify for either the work or support group if ‘there would be a substantial risk to the mental or physical health of any person if the claimant were found not to have limited capability for work/work-related activity.’²³ As well as obvious risks, such as self-harm or hospital admission, substantial risks may also include that of causing increased distress (e.g. if forced to travel by public transport) or the possibility that medication will need to be changed as a direct consequence.²³ Reportedly up to 23% of ESA claims are awarded by this route.²⁴

There is some degree of overlap in the descriptors for ESA and PIP, as well as notable differences; the activities relevant to mental, cognitive and intellectual functioning

Box 2. ESA and PIP assessment criteria

ESA descriptors concerning mental, cognitive and intellectual impairment:

- learning tasks
- awareness of everyday hazards
- initiating and completing personal action
- coping with change
- getting about
- coping with social engagement
- appropriateness of behaviour with other people
- conveying food or drink to the mouth/chewing or swallowing food or drink (if due to severe disorder of mood or behaviour)

Adapted from *A Guide to Employment and Support Allowance – The Work Capability Assessment*.²¹

PIP criteria:

- Daily living activities:
 - Activity 1 – preparing food
 - Activity 2 – taking nutrition
 - Activity 3 – managing therapy or monitoring a health condition
 - Activity 4 – washing and bathing
 - Activity 5 – managing toilet needs or incontinence
 - Activity 6 – dressing and undressing
 - Activity 7 – communicating verbally
 - Activity 8 – reading and understanding signs, symbols and words
 - Activity 9 – engaging with other people face to face
 - Activity 10 – making budgeting decisions
- Mobility activities:
 - Activity 11 – planning and following journeys
 - Activity 12 – moving around

Taken from *PIP Assessment Guide Part Two: The Assessment Criteria*.²²

can be found in [Box 2](#). For further information on specific criteria and how they are judged, please see the Royal College of Psychiatrist's guidance to clinicians on the ESA WCA²⁵ (see [Box 3](#) for a summary). Similar College guidance on the PIP assessment is in development.

In addition to ensuring accurate award decisions, supporting clinical evidence can also provide assistance and safeguards throughout the application process itself. Given the disadvantages claimants with mental health problems face,¹¹ there are numerous areas where problems can arise.

Completing the questionnaire and initial review

Once a valid claim for ESA or PIP has been made, the case is referred to an independent medical assessment provider. The claimant is sent a Limited Capability for Work

Box 3. Advice on writing supporting clinical evidence

The general structure for supporting letters advised by the Royal College of Psychiatrists²⁵ is as follows:

- (1) Basic clinical details: diagnosis, medication, side effects, length of service contact, current contact, variability of condition (e.g. diurnally, between episodes and during the most severe peaks of illness), impact of stress and overall symptoms.
- (2) How this affects level of functioning in regards to the specific descriptors. If unaware whether a specific criteria applies, a clinician can still state they believe it is likely it does on the balance of probabilities.

Information about difficulties a claimant may have travelling to an assessment centre or completing paperwork should be clearly stated.

questionnaire (ESA50/UC50) or How Your Disability Affects You form (PIP2), covering their condition and its impact, and it is to be completed by them, or on their behalf. This is submitted along with any supporting clinical evidence. Once received, the assessor – who may be an occupational therapist, nurse, physiotherapist, paramedic or doctor – conducts an 'initial review' of the file. They may request a face-to-face interview or decide there is sufficient evidence to make an immediate determination. Supporting clinical evidence can therefore make the process far more straightforward for the claimant.

Notably, supporting clinical evidence is not mandatory at any stage of the process. An independent review of the WCA for the Government concluded: 'it is essential that all relevant medical and allied evidence about the claimant is available to the DWP Decision Maker at the earliest possible stage in the assessment process.'²⁶ Following a more recent independent review of the PIP assessment,²⁷ the Government accepted the DWP should make clear that the responsibility to provide further evidence 'lies primarily with the claimant and they should not assume the Department will contact health care professionals.' The same problems exist with ESA applications.¹¹

Questionnaire problems

Claimants can face numerous difficulties when completing the initial questionnaire. In 2013 the High Court¹¹ identified 11 reasons why people with mental health problems may struggle with self-reporting at this stage, including: failure due to lack of insight, inability due to difficulties with social interaction or confusion and unwillingness because of shame or fear of discrimination. Failure to return the questionnaire may result in termination of the benefit. There are some safeguards against this for ESA, as the WCA Handbook²⁸ states:

'Where a claimant has a mental function problem an assessment will be carried out even if the [medical questionnaire] is not returned.'

However for PIP claims, failure to return the questionnaire can be more problematic. Regarding customers with additional support needs, the PIP assessment guide²² states:

'1.12.2 Some may have an Appointee ... or support from a family member, carer, Community Psychiatric Nurse or other person who will usually ensure that the claimant is supported throughout the process. In those circumstances, the claimant would not be classified as requiring additional support from the DWP. These people already have support.'

This assumption effectively means less protection for PIP than ESA applicants and makes early termination of claims more likely. In this event, supporting clinicians can write to the DWP to provide evidence as to how the claimant's condition has adversely affected their ability to fulfil their requirements, ask for good cause to be accepted and for the claim reinstated.

Arranging the assessment

A determination is not usually made on initial review of paper evidence. The assessor may attempt to contact professionals named in the questionnaire for additional information or, more commonly, refer the claimant for a face-to-face assessment (as with 72% of ESA assessments in 2013).²⁹ If a claimant cannot reasonably be expected to travel to an assessment centre they can request a home visit, but this will almost certainly require specific supporting clinical evidence.

Assessment problems

If a face-to-face assessment for ESA or PIP is missed, the case file is returned to the DWP to decide whether to accept good cause or to terminate the claim. Both ESA and PIP legislation require that the decision maker consider the claimant's state of health and the nature of their disability in making this determination.^{30,31} As such, these decisions can be challenged using clinical evidence to justify why the claimant was unable to attend.

Assessment providers will typically refuse to conduct a home visit if there is a history of violence or aggression, which may lead to an impasse if the claimant cannot attend the assessment centre. In such cases, it is advisable to write directly to the assessment providers, explaining why the individual cannot travel and offering to provide further evidence. This may allow a paper-only assessment to be conducted.

The face-to face assessment

The face-to-face assessment can be extremely stressful for claimants, although they can be accompanied by a person of their choice who may also provide evidence. The assessor should have read all available information beforehand, although further clinical evidence can be provided on the day. The claimant's overall presentation at the interview can form a large part of the assessment, which may be problematic for those who lack insight, have a fluctuating condition, under-report or have become adept at masking their difficulties. This further highlights the importance of supporting clinical evidence to provide the full context.

Following the assessment, the health professional completes a report including recommendations to the DWP, who make the final decision.

Challenging decisions

The two initial stages of challenging an outcome are mandatory reconsideration and formal appeal. To challenge a decision, claimants must first request a mandatory reconsideration by the DWP, the legal term being 'any grounds revision'. Mandatory Reconsideration requests must be submitted within 1 month of the original decision, however this can be extended by up to 13 months if there is good cause.³² This 1-month rule applies not only to final award decisions but to any decisions made by the DWP, which carry right of appeal. For example, claimants could challenge the termination of their claim for failing to attend a face-to-face interview. In the real world, such situations are likely and mental health services may only discover essential information long after the designated 1-month limit. In these cases, clinical evidence should support both the original challenge and also why a late application for revision should be accepted. Even if application for a late revision is denied, a recent Upper Tribunal case³³ ruled that a claimant still has a statutory right of appeal if a late request is not considered.

If the Mandatory Reconsideration outcome is unfavourable, the claimant can then submit (within a month) an appeal to the independent Courts and Tribunals Service. Further clinical evidence can be provided. It is important to ensure claimants are aware that reconsideration or appeal of one aspect of a decision could lead to a potentially disadvantageous revision of the whole decision. For example, challenging a decision about PIP mobility could theoretically lead to an existing daily living award being revoked. Appeals can be withdrawn at any point prior to the hearing.

Supporting clinical evidence

Reports can be sent directly to the assessment centre or, preferably, given to the patient to submit with their completed questionnaire. Additional evidence can be provided at any point, however early submission ensures its use throughout all subsequent stages and may allow for a quicker decision. Most supporting evidence will be requested to establish whether a claimant meets the qualifying descriptors (Box 2), however it might also be necessary to provide evidence in response to, or in anticipation of, specific problems outlined above. For example, if a patient reports their ESA has stopped, it may be due to insufficient points scored during their WCA or because they failed to attend it at all. The clinical evidence should address the issue in question.

It is important that supporting letters are objective, link functional problems to health issues, expand on common clinical concepts (e.g. negative symptoms of schizophrenia) and state obvious clinical inferences explicitly (e.g. negative symptoms persist even during periods of remission). It should be remembered that DWP decision makers are not medical professionals and they may have a limited understanding of terminology or mental health problems.

Care plans can be valuable evidence if they demonstrate that a claimant cannot manage relevant domains of functioning, such as their own self-care. However, there is a danger of care plans inadvertently giving a positively skewed

impression of functioning if they are too simplistic. One example is preparing meals: PIP defines a 'simple meal' as 'a cooked one-course meal for one using fresh ingredients'. Therefore, a care plan that refers to independent cooking but does not clarify that this extends only to the use of a microwave could adversely affect the outcome.

The DWP's overall definition of capability is more narrow than it might first appear and requires some measure of consistency; the claimant must be able to perform the given tasks reliably (defined as 'safely, repeatedly, to an acceptable standard and as often as is reasonable to require'²⁸) on a majority of days. In addition, judgments about qualifying for a particular descriptor need not be unequivocal and may be accepted on a balance of probabilities.

Finally, when providing clinical evidence, it is always worth bearing in mind that you must demonstrate not only whether a claimant is affected by their condition, but also whether they are affected in the specific legal ways that qualify them for the benefit. The best evidence will therefore directly address the descriptors and, as such, a working knowledge of the criteria is vital in ensuring that claimants have the best possible support throughout the process.²⁵

Conclusions

With some basic knowledge, mental health professionals can play a key role in redressing the discrimination against people with mental health problems and ensuring accurate award decisions by providing relevant, well-written clinical evidence for benefits assessors. Clinicians should be vigilant in demonstrating individuals' needs eloquently, accurately and in a timely way. Through an appreciation of the additional stresses on patients applying for benefits, mental health services can provide better support and signpost appropriately to agencies such as Citizens Advice. Welfare expertise is outside the experience of many mental health clinicians, but a patient's access to (eligible) benefits is an important part of recovery. Clinicians should work towards forging closer links with the benefits system and supporting services such as benefits and welfare advice to enable better outcomes for patients. Professionals need to understand the subtleties and potential for discrimination in the system to best support people.

About the authors

Alexander Galloway is a specialty doctor at Hertfordshire Partnership University National Health Service Foundation Trust, UK; **Billy Boland** is a consultant psychiatrist at Hertfordshire Partnership University National Health Service Foundation Trust, UK; **Gareth Williams** is a benefits adviser at the Mental Health Project, Money Advice Unit, Hertfordshire County Council, UK.

References

1 Sturm R, Gresenz CR. Relations of income inequality and family income to chronic medical conditions and mental health disorders: national survey. *BMJ* 2002; **324**: 20.

- 2 Jenkins R, Bhugra D, Bebbington P, Brugha T, Farrell M, Coid J, et al. Debt, income and mental disorder in the general population. *Psychol Med* 2008; **38**: 1485-93.
- 3 Parsonage M. *Welfare Advice for People Who Use Mental Health Services*. Centre for Mental Health, 2013.
- 4 Chang S-S, Stuckler D, Yip P, Gunnell D. 2008 Impact of global economic crisis on suicide: time trend study in 54 countries. *BMJ* 2013; **347**: f5239.
- 5 Fitch C, Chaplin R, Trend C. Debt and mental health: the role of psychiatrists. *Adv Psychiatr Treat* 2007; **13**: 194-202.
- 6 Abel-Smith B. The Beveridge report: Its origins and outcomes. *Int Soc Secur Rev* 1992; **45**: 5-16.
- 7 World Health Organization (WHO). *Global Status Report on Non-Communicable Diseases 2010*. WHO, 2011.
- 8 Bloom D, Cafiero E, Jané-Llopis E, Abrahams-Gessel S, Bloom L, Fathima S, et al. *The Global Economic Burden of Non-communicable Diseases*. World Economic Forum, 2011.
- 9 Emmerson C, Joyce R, Sturrock D. *Working-Age Incapacity and Disability Benefits*. Institute for Fiscal Studies, 2017.
- 10 Hale C. *Fulfilling Potential? ESA and the Fate of the Work-Related Activity Group*. Mind, 2014.
- 11 *Regina (MM and others) v Secretary of State for Work and Pensions (Mind and others intervening)* [2013] EWCA Civ 1565, [2013] MHLO 132.
- 12 Health Assessment Advisory Service. *Assessments/Frequently Asked Questions*. Health Assessment Advisory Service, 2017. Available at <https://www.chdauk.co.uk/frequently-asked-questions> (accessed 25 December 2017).
- 13 Ministry of Justice. *Tribunals and Gender Recognition Statistics Quarterly - July to September 2017 (Provisional)*. Ministry of Justice, 2017.
- 14 Citizens Advice Bureau. *Right first time? An indicative study of the accuracy of ESA work capability assessment reports*. Citizens Advice Bureau, 2012.
- 15 *RF v Secretary of State for Work and Pensions* [2017] EWHC 3375, 2017.
- 16 Twamley EW, Anderson H, Halpern B, Patterson TL, Harvey PD, Bowie CR. Self-assessment of functional status in schizophrenia. *J Psychiatr Res* 2007; **41**: 1012-8.
- 17 Barr B, Taylor-Robinson D, Stuckler D, Loopstra R, Reeves A, Whitehead M. 'First, do no harm': are disability assessments associated with adverse trends in mental health? A longitudinal ecological study. *J Epidemiol Community Health* 2016; **70**: 339-45.
- 18 Slade M, McCrone P, Thornicroft G. Uptake of welfare benefits by psychiatric patients. *Psychiatr Bull* 1995; **19**: 411-3.
- 19 Frost-Gaskin M, O'Kelly R, Henderson CM, Pacitti R. A welfare benefits outreach project to users of community mental health services. *Int J Soc Psychiatry* 2003; **49**: 251-63.
- 20 *RS v Secretary of State for Work and Pensions* [2016] UKUT 0085 (AAC).
- 21 Department for Work and Pensions. *A guide to Employment and Support Allowance - The Work Capability Assessment (ESA214)*. Department for Work and Pensions, 2016.
- 22 Department for Work and Pensions. *Personal Independence Payment (PIP) assessment guide for assessment providers: Guidance for health professionals carrying out PIP assessment activity and for those responsible for the quality of PIP assessments*. Department for Work and Pensions, 2017.
- 23 Department for Work and Pensions; Decision Making and Appeals (DMA) Leeds. *Memo DMG 17/15 ESA: Work related activity and substantial risk*. DMA Leeds, 2015.
- 24 Department for Work and Pensions. *ESA: outcomes of Work Capability Assessments including mandatory reconsiderations and appeals: March 2017*. Department for Work and Pensions, 2017.
- 25 Royal College of Psychiatrists. *Guidance for Mental Health Clinicians providing Clinical Evidence for the Work Capability Assessment (WCA)*. Royal College of Psychiatrists, 2014.

- 26 Harrington M. *An Independent Review of the Work Capability Assessment - Year 3*. The Stationary Office, 2012.
- 27 Department for Work and Pensions. Personal Independence Payment (PIP) assessment second independent review: government response. Department for Work and Pensions, 2017.
- 28 Department for Work and Pensions. Work Capability Assessment handbook: for healthcare professionals. Department for Work and Pensions, 2017.
- 29 Department for Work and Pensions. Work Capability Assessment fifth independent review: statistics. Department for Work and Pensions, 2014.
- 30 Department for Work and Pensions; Decision Making and Appeals (DMA) Leeds. Memo ADM 3/14 ESA: Good Cause. DMA Leeds, 2014.
- 31 Department for Work and Pensions. Advice for decision making: staff guide P6: Good Reason. Department for Work and Pensions, 2013.
- 32 Regulation 4, *The Social Security and Child Support (Decisions and Appeals) Regulations, 1999*.
- 33 *R (CJ) and SG v Secretary of State for Work and Pensions (ESA)* [2017] UKUT 0324 (AAC).

