The Sickness Route to Benefits

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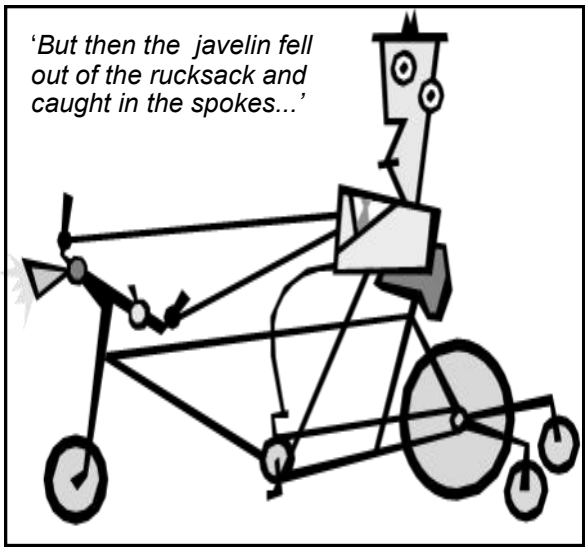
A little history:

Way back in 1948, the Government of the day introduced measures to ensure some sort of income for people who were too sick or disabled to work.

By the early 90s, Invalidity Benefit was costing around £6 billion a year. The Government of the day suggested that some people receiving the benefit were fit for work. "*Frankly, it beggars belief that so many more people have suddenly become invalids, especially when the health of the nation has improved,*" said John Major in 1993.

"*Too many people regard Invalidity Benefit as a readily available supplement to their occupational pensions when they take early retirement,*" said Peter Lilley… Secretary of State for Social Security "*There are well publicised cases of people on Invalidity Benefit .... enjoying cycling holidays and winning javelin contests...*"
So in 1995, Incapacity Benefit and the 'All Work Test' were introduced. It was planned that this



would save money (pilot studies showed that 50 per cent of people on the old Invalidity Benefit were effectively finding themselves fit for work through their own answers, saving the Department having to do so), provide a 'clearer' definition of incapacity and reduce the role of GPs in the process
The then Benefits Agency Medical Service staff had their numbers doubled. When Incapacity Benefit was introduced, BAMS doctors had undergone a two day training course on Incapacity Benefit, including a 30 minute video on interviewing people with mental health problems. A further five day course was available on a voluntary basis, including a half day on awareness of disability and mental health issues...

Many, many people who were too sick to work found themselves thrown off the sickness route to benefit and the All Work Test was derided by Labour in opposition as clearly not working...

The new Labour Government of 1997, then, pledged to rethink and reform Incapacity - to concentrate on what people could do, not on what they couldn't. All that actually happened though was that the infamous 'All Work Test' was renamed the 'Personal Capability Assessment', without *any* change to its format.

An organisation called 'SEMA' was awarded the contract for the medical service originally provided by BAMS and we were told that training had improved. Evidence suggested though that it remained far from good, especially in the field of mental health, where many bad decisions continued to be made. Tribunal after tribunal found in claimants' favour.

In February 2004 SEMA was bought up by Atos Origin, an international IT services company.

In an attempt to salvage the reputation of the doctors' reports, we saw the introduction of 'mouse driven' medicals, where, dependant on diagnosis/ treatment regime etc. a computer programme prompted the doctor to consider particular descriptors.

The stated aim was to remove some of the subjectivity from a much criticised process, but doctors continued to be told *not* to ask people *directly* about the mental health descriptors, the choice of which button to push was still open to interpretation and the process remained a subjective one.

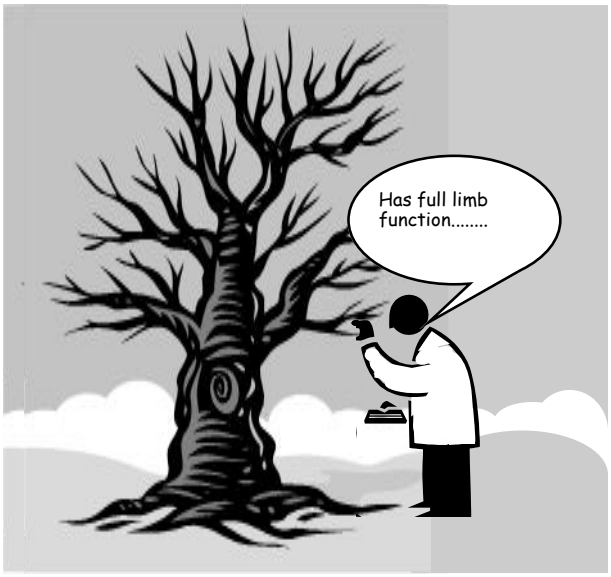
The resulting reports came—and continue to come - under fire for often being inconsistent and impersonal.

Plus ça change...

They say that history repeats itself and the Welfare Reform agenda of recent years has felt very like 1995 all over again…

Murmurings from government that many people on Incapacity Benefit *could* actually be working grew louder and louder - albeit that the message was now presented in terms of 'if only they were enabled to do so' rather than 'if only they would get on/ off their bike/ leave their javelin at home' - culminating in the introduction of Employment and Support Allowance in 2008.

The long term aim is to reduce the number of people on Sickness Route Benefits by 1 million.



Changes include:

- The expansion of the Jobcentre Plus-based 'Pathways to Work' system of work focused interviews, personal advisers etc. to cover the whole of the country
- 'Old' Pathways areas have seen the extension of a series of mandatory work-focused interviews to people who have been on the sickness route to benefit for less than three years and in some areas for all claimants.
- The introduction of Employment and Support Allowance for new sickness route claimants on October 27th 2008 with people with mental health problems singled out for particular attention…
- New work-focused conditionality attached to receipt of Employment and Support Allowance for the majority of claimants, with sanctions for claimant who fail to comply. These sanctions, when applied, can leave some people existing on Jobseekers' Allowance levels of benefit—potentially indefinitely.
- The loss of vital group exemptions which used to spare all people deemed to have severe mental health problems or severe learning disabilities from the assessment process.
- A radically reformed, much harder test for ESA—the Work Capability Assessment
- The creation of a 'two tier' system of sickness route benefit

'Employment and Support Allowance will only be for new claimants' said the Government back in 2005 and yet they have since announced plans to 'migrate' all existing claimants on both old Incapacity Benefit and/ or Income Support and Severe Disablement Allowance to ESA, starting in October of 2010, with completion by 2014.

'Nobody will be worse off under Employment and Support Allowance' pledged the Government back in 2005—and yet the detail of ESA has revealed a very different picture:

- The loss of amounts paid for an adult looking after the claimant's child(ren)
- The loss of 'age addition' amounts paid to people younger when they first became unwell—who were thus less able to build up financial security for their future
- The loss of a means-tested amount paid for some partners after a year of being on the sickness route plus the loss of a means -tested top-up element for many who are long term sick—and thus the associated route to passported Housing and Council Tax Benefits, the Social Fund and free prescriptions
- Massively more people (68 per cent at the time of updating for 2010) are failing the new test for ESA compared with the old one for Incapacity Benefit/ Income Support for sickness—and hence losing *all* entitlement to sickness route benefit.
- The promise of a new, even harder test to come in future...

Being off sick whilst still with an employer:

Going off sick with the flu or a stomach bug is one thing. You know that it will fairly soon be over and your employer—although temporarily inconvenienced—is probably quite glad you're not spreading your germs around the entire workforce. Going sick when you have mental health problems feels very, very different.

Chances are that you will actually have been struggling with your symptoms for some time—in fact may already have had to take some days off sick because of them, even if you explained them to your employer as a migraine or virus.

Some people manage to carry on like this indefinitely— or even find that their symptoms improve. Others eventually reach some sort of breaking point and *have* to disclose to their employers—and sometimes to loved ones—that they are experiencing mental health problems.

*'I'd been having problems for months—but then just broke down one night—couldn't stop crying—and, what really frightened me—didn't **want** to stop crying… It felt as if some storm that had been gathering for a long, long time inside me was finally breaking…'*

There are many fears of course associated with taking this step—fears about 'going mad', fears about what other people will think, fears about whether you'll ever feel better again, and of course, fears about your finances…

Hopefully the information here will be useful in at least giving you some idea of what financial help might be available to you, both immediately and longer term, should you need it. In the meantime I also hope you find the other helping hands—and listening ears—you need at such a potentially difficult time.

Going sick—the practicalities.

Your employer probably has their own rules about notifying them of sickness geared towards their convenience. To get *Statutory* Sick Pay though, all you are actually *obliged* to do is to notify them within seven days. You may, of course, decide you want to meet the conditions laid down in your contract for the sake of goodwill— and to preserve any right to entitlement under more generous contractual schemes! Beyond seven days, you will need to provide them with a medical certificate—sick note/ line/doctor's paper etc.

From April 2010 the familiar sick note has been replaced by a 'Statement of Fitness for Work'. Contradictory as it sounds, it still serves the same purpose. It looks like this:

STATEMENT OF FITNESS FOR WORK
FOR SOCIAL SECURITY OR STATUTORY SICK PAY

Patient's name — Mr, Mrs, Miss, Ms

I assessed your case on — / /

And, because of the following condition(s)

I advise you that

☐ you are not fit for work
☐ you may be fit for work taking account of the following advice

If available, and with your employer's agreement, you may benefit from

☐ a phased return to work
☐ altered hours
☐ amended duties
☐ workplace adaptations

Comments, including functional effects of you condition(s):

This will be the case for

or from ____ to

I will/ will not need to assess your fitness for work again at the end of this period — / / / /

etc….

The first six months of being off sick from work:

If you earn less than £97 a week...

If you do not earn £97 a week then unfortunately your employer has no legal duty to pay you for time you are off sick, no matter how long you have been with them.

If this is the case, you should apply, straight away, for Employment and Support Allowance (ESA) - see the second part of this chapter.

You may well find that you don't have the National Insurance Contributions to qualify for the 'contributory' part of ESA - although this does depend on your employment history rather than your situation when you go off sick.

NOTE: *People who have been self-employed also need to claim ESA as soon as they go sick… and see below...*

You should still though apply for ESA, because even if you don't get the contributory part, you may be able to get means-tested help with the cost of living and, eventually, with any mortgage interest.

If you earn more than £97 a week…

In your situation, the basic legal minimum that your employer MUST pay you is something called Statutory Sick Pay. Most larger—and indeed many smaller - decent—employers have more generous schemes, but whoever your employer is, you will find that an element of the money you are paid during the first 28 weeks is made up of SSP.

SSP kicks in after you've been off sick for three days. Depending on your circumstances—other income/ savings etc.—you may also be eligible for Income Support on top of your SSP—but not if you have a partner who works more than 24 hours a week—see below

Beyond 28 weeks— i.e. as soon as your SSP ends— you should claim Employment and Support Allowance, even if you are still receiving pay from your employers. You will very likely qualify for contributory ESA, and perhaps some income related ESA.

In either situation:

If you have a partner, the 'income-related' part of ESA—or Income Support claimed on top of your Statutory Sick Pay—is only open to you as long as s/he doesn't work over 24 hours a week.

However if s/he works 16 hours or more, you may be able to get help through Working Tax Credit.

If you already get Working Tax Credit then you can carry on getting it for the first 28 weeks of sickness as long as you qualify for Statutory Sick Pay or either sort of ESA. If not—and beyond 28 weeks—you will stop qualifying for it unless a partner works sufficient hours and can take over the claim.

You *may* also benefit from asking for your award of Tax Credits to be re-assessed when you lose all or some of your wage, although check this out with an independent advice agency first as whether you'll be better or worse off after a re-assessment depends on what your circumstances were when your Tax Credits were last assessed.

Some people with partners working between 16 and 24 hours can claim both Working Tax Credit and income related ESA/ Income Support—however in this situation your Working Tax Credit is counted as income when your entitlement to income related ESA or Income Support is calculated.

You may also be eligible for:

- Child Tax Credit— on top of Child Benefit for any dependant children
- Housing Benefit —claimed through your local authority— to help with your rent
- Council Tax Benefit—also claimed through your local authority—to help with your Council Tax costs, whether or not you own your own home

And, after you have had health problems for three months:

- Disability Living Allowance—on top of any other benefits and not means tested in any way. Disability Living Allowance can be claimed whether or not you are off sick, and can increase entitlement to other in work and out of work benefits.

Claiming on the Sickness Route:

If you claimed before October 27th 2008:

At the moment you will probably be on:

- Incapacity Benefit—either after your Statutory Sick Pay ended or straight away if you weren't with an employer or
- Severe Disablement Allowance– now abolished for new claimants

or/ and

- Income Support on the sickness route—either because you didn't have the National Insurance Contributions to get Incapacity Benefit or as a means tested 'top up' on top of your other benefits.

You may also be eligible for:

- Child Tax Credit—for any dependant children
- Housing Benefit/ Council Tax Benefit
- Disability Living Allowance—on top of any other benefits

Government plans are to 'migrate' your claim to one for ESA between October 2010 and April 2014—see the 'survival guide' later in the chapter for further—hopefully helpful—information.

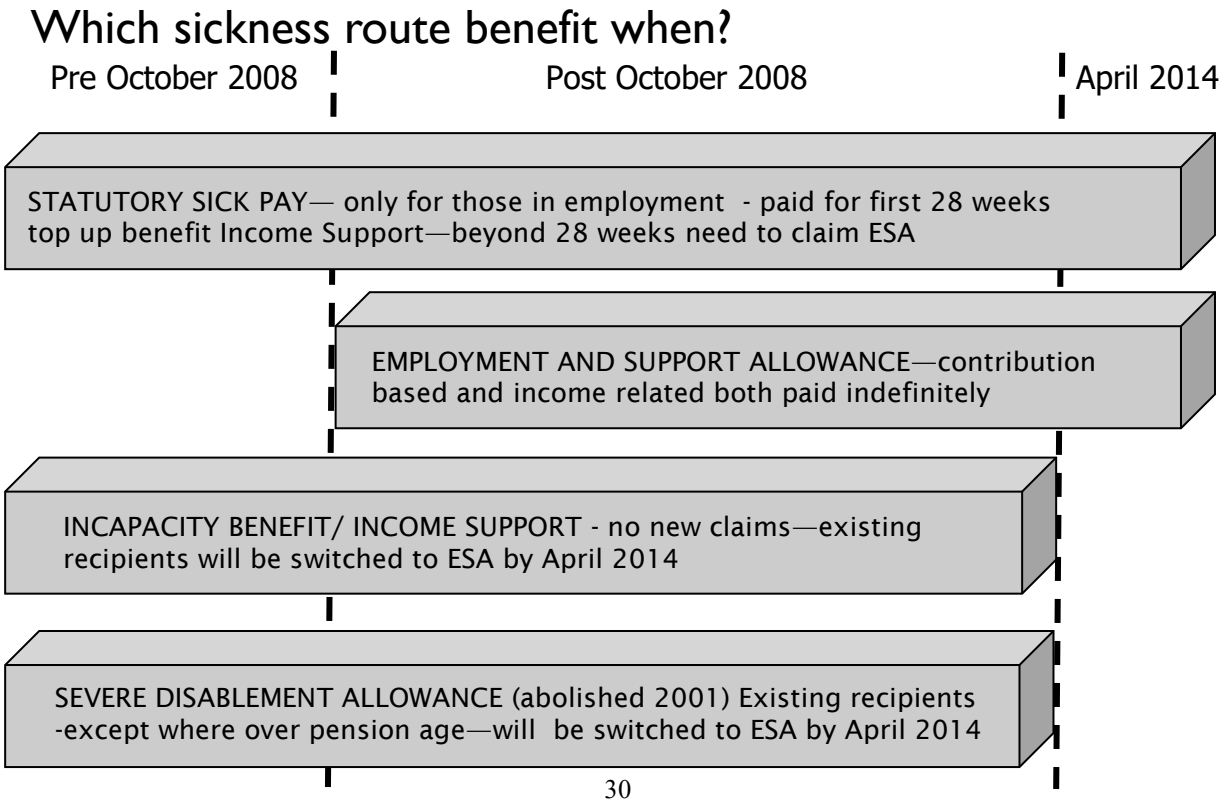
If you claimed/ claim after October 27th 2008:

The benefit you claim either at once—or, if still on an employer's books, when your Statutory Sick Pay stops after 28 weeks is:

- Employment and Support Allowance

You may also be able to get

- Child Tax Credit—for any dependant children
- Housing Benefit/ Council Tax Benefit
- Disability Living Allowance—on top of your ESA



How the rest of this chapter works:

The next seven pages look at the DWP contact involved in claiming sickness route benefits.

Immediately after there are sections on:

- The medical tests for getting Incapacity Benefit or Income Support through the sickness route, plus a guide to surviving the 'conversion' process to come.
- The medical tests for getting Employment and Support Allowance

Immediately following those you will find information common to both systems on:

- Medical interviews
- What you can do if you are found fit for work

Goodbye 'Pathways to Work'

Pathways to Work—part of the Government's big hope for 'enabling' tens of thousands of people off the sickness route to benefit back into work through the use of Personal Advisers, Work Focused Interviews and a raft of practical and financial support measures —has been running for some years now. Since April 2008 it covered all of the country.

Many people claiming sickness route benefits then — and all those claiming for the first time — now face a 'Work Focused Interview' conducted by the DWP at the Jobcentre in connection with receipt of their benefits. New claimants potentially face a series of them—either with the DWP or, after the initial interview, with a company or organisation contracted to deliver Pathways —e.g. A4E, The Shaw Trust..

If people do *not* attend interviews, or turn up but fail to 'participate', then their benefit can be 'sanctioned' - i.e. reduced.

Initial Pathways pilots suggested that more people got back to work, faster when supported by Pathways. However research published in October 2009 showed that once Pathways expanded to cover further areas, it made no difference to 'job entries'.

The Government announced in March 2010 then plans to end Pathways to Work but 'learn from its successes' and 'better focus' support offered...

I can't say I'm surprised by the findings. My own experience of supporting people through the claims process suggests that for many, an intensive focus on work in the very early days of sickness can actually *add* to the stressors they are experiencing and—in doing so - make a return to work *less* likely. Many people have struggled against the odds to remain within work as long as possible and are forced into seeking medical help only when matters come to a head in some sort of crisis. The early stages of a claim for sickness route benefits, then, are often also the weeks when someone is struggling to come to terms with major life changes, compounded by symptoms of mental health problems.

I'm pleased to report then that this seems to have been acknowledged, and that greater freedom is to be given to Personal Advisers to very the timing and frequency of Work Focused Interviews. The changes are intended for April 2011—election results allowing...

Problems will remain though. The majority of claimants will still be required to attend WFIs—there will just be greater flexibility about when. Those 'well' and assertive enough – or those with support – might be able to argue for postponement of the interviews. Others though may go through hell and high water to get there, and potentially manage to sustain the best possible front for the interview only to find themselves steered towards ventures unsuitable for them at that time. Embarking on such a venture and then failing to sustain it because of underlying mental health problems could of course compound feelings of uselessness, doubts regarding self-worth etc.

Other people will simply be unable to attend, and may well not try to communicate a reason unless or until financial crisis forces them to. That some will also fall through the safety net of 'good cause' for non attendance seems inevitable.

Surviving as a Sickness Route Claimant:

Making a claim:

So, what are you likely to face when you claim ESA?

The DWP want your ESA claim contact with them —wherever possible—to be by telephone - which is fine as long as you :

- have access to a phone where you can't be overheard,
- are well enough - either physically or mentally - to make the call and
- can take in, respond to and remember the things that you are told during that telephone interview.

Having to have telephone contact raises real issues for some people whose reasons for being unable to work are very personal or upsetting - e.g. because of mental distress following an attack or abuse, recent bereavement, paranoid thoughts etc. Although the DWP don't need detailed information regarding the nature of your unwellness at this stage, you may then still want to consider asking someone else to be there with you when you telephone if you might find explaining your situation to a complete stranger distressing.

Although there seems no way round actually having to telephone to *start* your claim going, YOU STILL HAVE A RIGHT TO MAKE A PAPER-BASED CLAIM IF YOU WISH TO DO SO *with or without* 'health grounds' - i.e. you don't have to give any special reason.

You can either ask yourself—or ask someone to ask on your behalf—for claim forms for what the DWP call a 'clerical claim', i.e. an old fashioned, paper-based application for benefit. If they refuse, ask to speak to a supervisor. If *they* refuse ask for their name and get advice.

Although when first introduced an initial call to claim benefit used to be followed by a 'ring back' to take the detail of the claim, in this area at least it can now all being done on the initial call. If you *do* decide to make your claim by telephone, you might choose to have company with you for this—the script-led interviews only cope well with people who fit neatly into boxes!

As a result of this interview, a mostly pre-completed claim print-out will be sent to you to check (important—they do make mistakes!) and sign. Also check where it has to be returned to—different areas seem to be operating different systems at the moment. If you return your form to your local Jobcentre it MAY be necessary for you to also contact the benefits processing centre to register it and ensure payment is properly backdated.

You also need to provide the DWP with a doctor's sick note ('paper'/ 'line') when you return the form.

Once your claim has been processed, you should begin to receive payment—usually within a couple of weeks—if it's longer, ring them and ask them what's happening.

Around 8 weeks after you claim—planned to become 13 weeks in the future - you will usually be called into the Jobcentre for a 'Work Focused Interview. At the time of writing no-one is automatically exempted from attending, but it's planned in the future to delay the first WFI until after your claim has been medically assessed. When this change happens people on the Support Component will not have to attend. You (or someone else acting on your behalf) can ask for the interview to be deferred (i.e. postponed to a later date) or even waived (i.e. abandoned) on very limited grounds—see the table on the next page.

Beyond this initial interview, most people will also have to go through a series of 5 other subsequent interviews—again see next page.

TACTICAL TIP:

If you think you might be eligible for the 'Support Component' (see later in this chapter) it *might* be worth you also enclosing copies of any other supporting medical evidence you can get with your initial claim form.
Doing so MAY help the DWP make the right decision and save you having to attend future interviews/ medicals.

Deferrals and Waivers— who doesn't have to attend Work Focused Interviews?

Incapacity Benefit/ SDA/ Income Support	Employment and Support Allowance
A White Paper published in December 2008 suggests that when assessed under ESA, all existing claimants will be expected to attend one Work Focused Interview. Existing claimants aged 50 or under will be expected to attend a minimum of 3 Work Focused Interviews. You will be able to ask for these interviews to be waived or deferred under the rules opposite. More recent Government documents have simply talked about people 'coming under ESA rules on transfer'. It seems likely that meanwhile, whilst you are on 'the old system' the 'old rules' will apply to any WFIs you may face —i.e. WAIVER: The 'grounds' suggested to staff in guidance for waiver are when the interview would not be: • of assistance to the person concerned OR • appropriate in the circumstances If your interview is 'waived' then the DWP treat you as if you had taken part in it and process the rest of your claim. DEFERRAL: Guidance suggests some situations where deferral may be appropriate: • the person is emotionally distresses because, for example, a close relative has died or a relationship has broken up • the person is too ill to attend an interview - for example recovering from a serious illness or operation • the person is likely to claim benefit for only a short period because, for example, they are a homeless person in short-stay accommodation. This is NOT an exhaustive list! If you think your situation applies, say so!	**FIRST INTERVIEW** At the time of writing, no exemption, but you—or someone acting on your behalf—can ask for it to be 'waived' - i.e. put off altogether - or 'deferred' - i.e. put off to a later date.The decision to allow deferral or waiver is NOT appealable but may be changed by negotiation, getting someone to ring/ write on your behalf etc. Plans announced in March 2010 will at some point see the first interview postponed until after medical determination on the claim—those on the Support Component will not have to attend. WAIVER: The only 'ground' for a waiver within Employment and Support Allowance is that you are about to enter employment. DEFERRAL: The 'grounds' suggested to staff in guidance for deferral are when the interview would not be: • of assistance to the person concerned OR • appropriate in the circumstances This is not a mistake in writing the book—the grounds for both waiver and deferral have got considerably 'tougher' under ESA. . NOTE: Arrangements for 16-17 year olds are slightly different under ESA—get specific advice.
SUBSEQUENT INTERVIEWS: Under IB rules, people exempted from the Personal Capability Assessment (see the section on Incapacity Benefit) were exempted from attending these. I *trust* this remains true until people are actually 'migrated' to ESA.	**SUBSEQUENT INTERVIEWS:** No group exemptions. Those eligible for the Support Component of ESA will not be *required* to attend subsequent interviews but may be *invited* to do so. Otherwise you can continue to request Deferrals as above.

Work Focused Interview(s)

At the time of going to print, most people (but see table on previous page) will be expected to attend 6 work focused interviews during the first eight months of their claim. News emerging however suggests that there will be more flexibility about this in the future… see 'Stop Press!' pages later in this chapter.

The 'reasoning' behind this concentration is that statistically, people who have been on the sick for a certain length of time are more likely to stay on the sick indefinitely, so emphasis is being put on getting people back into the workplace early on.

Beyond the initial series there are also occasional follow-up interview at certain 'trigger points' - again, if for some reason you feel you cannot attend, you, or someone acting on your behalf, can ask for a 'deferral'
If it is agreed to defer an interview, a new date is theoretically set for it there and then—although you may just be told e.g. 'three months' or 'six months'. Until the date of the new interview you will be treated as having taken part in one and your claim will be processed. It's hard to know how reasonable a length of deferment is. How long, for example, is it 'reasonable' to expect someone to be emotionally distressed because they are grieving for a close relative?

TACTICAL TIP:
The DWP seem far more likely to agree to deferring interviews if your request is backed up by a 'professional' of some sort—either by telephone or by letter.

You can also ask for the interview to be conducted at your home. Guidance suggests this should be allowed when 'it would be unreasonable to expect the person to attend elsewhere' because their personal circumstances are such that doing so would:

- cause undue inconvenience or
- endanger health (although if this is the case then perhaps you would be better off asking for deferral...)

As with requests for deferral, the DWP are much more likely to agree to an interview at home if your request is backed up by a 'professional'.

If you don't turn up for your Work Focused Interview at all, or if you turn up but they decide you didn't 'participate' then they *can* reduce your benefit—see the table on the next page. The government say though that benefit sanctions are meant to be a 'last resort' and that care will be taken to ensure that vulnerable people don't have their money wrongly reduced.

Certainly having seen the Pathways scheme in operation locally for a while most people I've worked with have seemed to get through it without sanctions—but often helped by a combination of deferral and then exemption because they fell within one of the groups of people exempted from the Personal Capability Assessment under the 'old' system.

At the Work Focused Interview:

The 'point' of the Work Focused Interview is to:

- assess your chances of staying in or getting work and help and encourage you to do so
- identify 'activities, training, educational or rehabilitation opportunities' to make either of the above more likely
- Identify current or future work opportunities 'relevant to your needs and abilities'

You may also be offered information about in-work benefits and a calculation of how much better off you might be in work… read on...

What happens if I don't attend a Work Focused Interview or it's decided I didn't participate?

Incapacity Benefit/ SDA and/ or Income Support	Employment and Support Allowance
Under 'Pathways to Work' Work Focused Interviews, your benefit may be reduced by up to 20% of the over 25 adult personal allowance within Income Support. Once people are actually 'migrated' from the old system to ESA then the sanctions as listed right for ESA will apply.	You may find yourself facing a sanction which means that the Work Related Activity Component of your ESA may be reduced in two chunks—effectively taking you back to Jobseeker's Allowance levels. Half will be lost after 4 weeks of non-compliance. The other half will be lost after a further 4 weeks. Failure to attend an interview at the start of a claim can lead to the claim not being processed further.
Compliance will lead to immediate re-instatement (but no backdating). You can also try to get the decision changed informally by demonstrating you had good cause for not attending (see below) or formally by appealing. The latter could take some time.	
Benefit, or Income Support on top of Severe Disablement Allowance, then they will take any deduction from the Income Support first and then the other benefit —but they must not leave you with less than 10p Income Support a week.	Support Allowance on top of Contributory ESA then they will take any deduction from the Income related ESA first and then the other benefit —but they must not leave you with less than 10p Income related ESA a week.

'Good Cause' for not attending a Work Focused Interview

You have five days (potentially extendible to a month—get advice) to show that you had 'good cause' for not taking part. Circumstances amounting to 'good cause' suggested by guidance are:

- there was a misunderstanding about the requirement to take part because of learning, language or literacy difficulties or the DWP gave you misleading information
- you yourself had a medical or dental appointment OR you were accompanying someone you care for to an appointment AND it would have been unreasonable to change the appointment
- you had problems with your normal method of transport and other transport wasn't available
- your established religious customs and practices prevented you from attending
- you were at a job interview or 'pursuing opportunities for work as a self-employed earner'
- you, a dependant or someone you care for suffered an accident, sudden illness or relapse of a chronic condition
- you were attending the funeral of a relative or close friend on that day
- your disability made it impractical to attend at the time fixed

but this is NOT AN EXHAUSTIVE LIST—basically if you had a reason, let them know as soon as possible.

If offered a Tax Credit calculation, remember that it's *not* reliable if it only looks at how much 'better off' you might be during the first year in work. Many people find that come the second—and even the third -year of employment, their Tax Credit drops off quite sharply. You should also ask whether their calculation assumes that you will keep any DLA you are currently getting, and ask them if they can guarantee you will keep it (they can't).

ESA regulations say that to 'participate' in the WFI you must answer, if asked, about your:

- qualifications/ vocational training
- work history/ aspirations for future work
- work-related skills/ abilities
- paid or unpaid employment being undertaken
- any caring or childcare responsibilities

You must also be willing to discuss:

- any past, present or future activity you're willing to undertake which might make you likely to stay in or get a job
- any progress you've made towards staying in/ getting a job
- a work focused health assessment you may have had (but probably won't have had if it's your first interview)
- your opinion about the extent to which staying in or getting work is affected by your health.

There are certainly issues here regarding people being able to - and feeling comfortable about - providing information about their mental health problems to a complete stranger. Will it be enough to say that you have mental health problems, or will those conducting the interviews want more detail? May you need a private space within which to talk?

The information you give your Personal Adviser will be used to draw up an 'Action Plan' which will be:

- A record of the Work Focused Interview
- A record of any activity you're willing to undertake which will make it more likely that you'll stay in work, or get a job.
- 'any other information considered appropriate'

AT THE TIME OF WRITING attending the interviews and participating as above is all they can INSIST that you do. You don't HAVE to agree to any activities you don't feel ready for or actually go to them if you have agreed to but then feel unable to. The Government however have indicated that in future they will extend the 'conditionality' to actual participation in 'work related activity' 'as resources allow'.

Work Related Activity

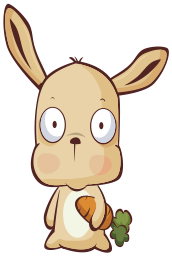
At the moment the Government have said that 'claimants will not be forced to undertake a *particular* activity' although undertaking *some* work related activity will at some point in the future be required of those receiving the Work Related Activity Component.

Examples given of work related activity include:

- Work trials
- Voluntary work
- Permitted work
- Preparation for self employment
- Condition Management Programmes
- Progress to Work Programme
- NHS Expert Patient's Programme
- Basic Skills Programmes
- Other training
- New Deal Scheme
- Assessing childcare options
- Managing financial situation
- Stabilising housing situation
- 'Activities to stabilise health conditions'

At the moment, given that participation is theoretically 'voluntary' there is little conflict here. I can imagine problems arising amongst host agencies though if, for example, people felt they 'had to' attend their local drop-in to get their benefit. And how voluntary can *conditional* voluntary work ever be?

Additional 'help'



It's not all stick—there are some carrots attached to Pathways, including routes to training and support and an 'Advisor Discretionary Fund' which can be used for one-off payments to help people return to work.

Feedback suggests that different Advisers use this fund to a greater or lesser extent… e.g. some have used it to pay for new clothes for interviews or to pay for driving lessons, whereas others are reported to hardly use it at all… If you think you might benefit, ask! The most measurable carrot though is the 'Return to Work Credit' which is a payment of £40 a week for up to a year for those who start work and earn less than £15000 p.a.

Condition Management Programmes

One option open to claimants is participation in 'Condition Management Programmes' These programmes—run in partnership with the NHS— do not aim to 'treat' your medical condition but to help you learn to live (and presumably work) with it. In an evaluation study published in December 2004, one Personal Adviser was recorded as having been put off using the Condition Management Programmes… She had thought that they were there to help people learn to manage their health problems as a step along the road to re-entering work, but records her concerns that 'the first sessions were based around job goals which she felt would frighten her customers off, particularly those who lacked confidence'.

Other Concerns raised by Personal Advisers

Another interesting concern to come out of the evaluation study mentioned above was the lack of confidence many Personal Advisers—including those with 'years of experience' - felt about working with people with mental health problems. In particular they mentioned people who were suicidal or severely depressed, along with those diagnosed as having schizophrenia.

One adviser spoke of his or her concern and feelings of responsibility towards people who were 'verging on suicide' - and the fear that should that person be found lying in a river the following morning, that perhaps there was something they could have done. Advisers also flagged up the effect listening to other people's experiences was having on their own emotional wellbeing, with the quote addended that '*a lot of the days you're just stopping them from crying*'.

Whilst both feeling for the Advisers and experiencing relief that they have this sense of responsibility towards people, I also feel that having people who are actively suicidal or permanently on the verge of tears being drawn into the programme in the first place poses a big question about the effectiveness of exemption criteria, and of the suitability of Work Focused Interviews for some of the people with whom they are trying to engage.

Some of them also said they saw a conflict in their role—i.e. trying to build a trusting working relationship—sometimes with vulnerable individuals—alongside the knowledge that at the end of the day, they also had the power to cut their money if they failed to participate.

They also flagged up worries that although they were not, at the moment, subject to personal targets for getting people back into work, they are based within offices which DO have such targets… they feared that they would feel under pressure to help meet the office target and that given Jobcentre Plus 'ethos and culture', it was probably only a matter of time before a target-driven focus was introduced for them.

2010 Update:

A new report; *'Employment and Support Allowance: Early implementation experiences of customers and staff'* also makes interesting reading. One clear theme is concern amongst Personal Advisers about the number of people being found fit for work—and the impact on people's mental health when this happens.

'Staff… believed that large numbers of customers who were not well enough to go onto JSA were being found fit for work at the WCA. While this was viewed as distressing for most customers, advisers believed that it could be particularly damaging for customers with mental health conditions, and carried a high risk of worsening their symptoms.

'Some JCP advisers thought the WCA was especially poor at identifying mental health conditions...'

Still receiving Incapacity Benefit or Income Support (sickness):

All change…

It's with sadness that the Big Book carries these pages probably for the last time, for barring U-turns, all existing recipients of Incapacity Benefit/ Income Support for sickness will face ESA tests when due re-assessment after February 2011…

However apart from a small ESA migration 'pilot', from October 2010, I *assume* that the DWP intend to continue to assess people whose benefit falls due for renewal until then using the PCA...

The Personal Capability Assessment (PCA):

Until your entitlement to benefit is reassessed using the new ESA rules, the test you need to continue to pass to receive Incapacity Benefit or Income Support on the sickness route is the Personal Capability Assessment—unless you are 'exempted' from or 'treated as' having passed it—see below and the next page.

Group Exemptions from the PCA:

- Those on DLA Higher Care
- Those deemed to have a ***'severe mental health problem'*** in the DWP's eyes. Their definition is not exact - '*an illness which severely and adversely affects someone's mood or behaviour and which severely restricts their social functioning or awareness of their immediate environment*'. In making the decision to exempt someone on these grounds, the DWP will seek medical evidence - usually from your GP - about diagnosis, history of hospitalisation, current treatment and level of care and support needs
- People who are terminally ill (i.e. whose death would not be unexpected if it were to happen in the next six months)
- People who are registered blind
- People who are in a persistent vegetative state, or who have dementia, tetraplegia, paraplegia (including uncontrollable involuntary movements or ataxia which render them functionally paraplegic)
- Some people getting benefits linked to industrial injury or war disablement
- People with severe learning disabilities
- People with a severe and progressive neurological or muscle wasting disease
- People with active and progressive inflammatory polyarthritis
- People with progressive impairment of cardio-respiratory function which severely and persistently limits effort tolerance
- People paralysed down one side (including arm, trunk and leg)
- People with 'severe irreversible motor sensory and intellectual deficits' due to impairment of functioning of the brain or nervous system'
- People with a severe and progressive immune deficiency state with severe constitutional disease, opportunistic infections or tumour formation.

Group Exemptions from the PCA (continued)

If then, for example, you get DLA Higher Care and you receive an IB50 form which marks the start of the Personal Capability Assessment DO NOT FILL IT IN.

Contact the issuing office and tell them about your DLA entitlement (they can check on this very easily and it could save you a lot of worry). As long as they confirm your entitlement you need do no more.

IF however you receive an IB50 don't just ignore it because you get DLA Higher Care. You shouldn't have received it in the first place—their systems have broken down somewhere and you NEED to contact them.

If you think you might fit into the definition of having a severe mental health problem and can get your doctor or psychiatrist to put this in writing in the timescale you have then it's worth trying that too. Although the DWP will approach—usually your GP—for information on this your psychiatrist might know your limitations better.

The Personal Capability Assessment:

Anyone who is not exempted has to 'pass' the Personal Capability Assessment to stay on the sickness route to Benefits.

'Treated as passing' the PCA:

Some people are 'treated as' passing the Personal Capability Assessment. They are:

- Hospital inpatients
- People receiving chemotherapy, radiotherapy, regular weekly dialysis or total parenteral nutrition treatment—but only on the days of treatment
- People with certain notifiable diseases
- Pregnant women for whom there would be a serious risk to their health or the baby's health if working
- A mother or expectant mother at times immediately before and after the birth of a child—roughly six weeks before and a fortnight after

You can also be treated as having *passed* the PCA if there would be 'substantial risk to the mental or physical health of any person if you were found capable of work' - but this decision is usually made by the doctor conducting the interview once you've actually filled in the IB50 form which usually kicks off the PCA process… read on...

How the Personal Capability Assessment 'works'...

The Personal Capability Assessment's medical test is made up of two sets of "descriptors" covering physical and mental health (see overleaf).

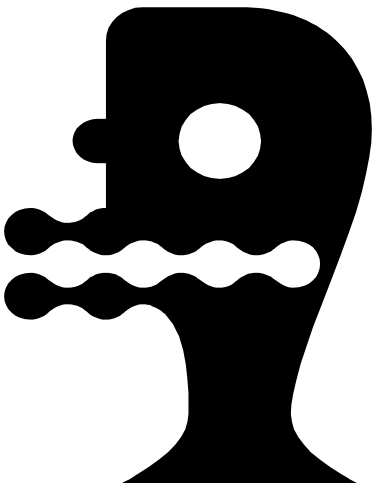
- People with purely physical or sensory problems have to 'score' 15 points or more to be found incapable of work.
- People with purely mental health problems have to score 10 points or more.

HOWEVER

- People who score between 6 and 9 points on the mental health descriptors are counted as having scored 9 and then have this figure added to any points they score on physical and sensory grounds.

HOWEVER

- They now have to reach the 15 point score to be found incapable of work...



Walking on level ground ***(with a stick or other walking aids)***

Cannot walk at all 15

Cannot walk, without stopping or feeling severe discomfort, more than:

- a few steps 15
- more than 50 m. 15
- more than 200 m. 7
- more than 400 m. 3
- more than 800 m. 0

OR

Walking up & down stairs

Cannot walk up and down:

- 1 stair 15
- a flight of 12 stairs 15

Cannot walk up and down 12 stairs:

- without a rest and holding on 7
- without holding on 3
- without going sideways, one step at a time 3

Sitting in an upright chair ***(with a back, but no arms)***

Cannot sit comfortably 15

Cannot sit comfortably, without having to move for more than:

- 10 minutes 15
- 30 minutes 7
- 1 hour 3
- 2 hours 0

Standing - ***without support from another person or aid (except stick)***

Cannot stand unassisted 15

Cannot stand, without needing to sit down, for more than:

- 1 minute 15
- 10 minutes 15
- 30 minutes 7

Cannot stand without needing to move around, for more than:

- 10 minutes 7
- 30 minutes 3

Rising from sitting unaided ***(from an upright chair- no arms)***

Cannot rise from sitting 15

Cannot rise without holding on to something :

- All the time 7
- Sometimes 3

Bending and kneeling

Cannot bend to touch the knees and straighten up 15

Cannot bend or kneel as if to pick a piece of paper from the floor and straighten up:

- All the time 15
- sometimes 3

Manual Dexterity

Cannot with **either** hand:

- turn the pages of a book 15
- turn a tap or cooker knobs 15
- pick up a coin less than 1 inch wide 15
- Cannot use a pen or pencil 15
- Cannot tie a bow in laces/string 10

Cannot with **one** hand:

- turn a tap or cooker knob 6
- pick up a coin less than 1 inch wide 6

Lifting and Carrying by use of upper body/ arms

Cannot pick up with **either** hand:

- a paperback book 15
- and carry a 1 pt milk carton 15
- and pour a full 3 pt kettle 15
- and carry a 6 lb. bag of potatoes 8

Cannot pick up and carry with **one** hand:

- a 1 pt milk carton 6
- a 6 lb bag of potatoes 0

Reaching

Cannot raise **either** arm as if to:

- put something in the top pocket of a coat/jacket 15
- put on a hat 15
- to reach above the head 15

Cannot put hands behind back as if to put on a coat or jacket 15

Cannot raise **one** arm arm to:

- to put on a hat 6
- reach above the head 0

Speech

Cannot speak 15

Speech cannot be understood by:

- family or friends 15
- Strangers 15

Strangers understand speech:

- with great difficulty 10
- with some difficulty 8

Hearing
(with an aid if worn)

Cannot hear at all 15

Cannot hear to follow TV with volume turned up 15

Cannot understand someone talking in a:

- *loud* voice in a quiet room 15
- *normal* voice in a quiet room 10
- normal voice on a busy street 8

Vision
(in normal daylight or bright indoor light with aids)

Cannot see well enough to:

- tell light from dark 15
- see the shape of furniture 15
- read 16 pt. print at 20 cm.+ 15
- recognise friend in same room 12
- recognise friend across the street 8

Continence

No voluntary control of:

- bowels 15
- bladder 15

Loses control of bowels:

- at least once a week 15
- at least once a month 15
- occasionally 9

Loses control of bladder:

- at least once a month 3
- occasionally 0

Remaining conscious

Has an involuntary episode of lost or altered consciousness at least

- once a day 15
- once a week 15
- once a month 15
- twice in the last 6 months 12
- once in the last 6 months 8
- once in the last 3 years 0

PERSONAL CAPABILITY ASSESSMENT—IB and IS (physical)

Add together the highest score from each box, noting that 'walking on level ground' and 'walking up and down stairs' count as one box.

15 points are needed to be found incapable of work on physical grounds...

Personal Capability Assessment - Mental 'Disabilities' - for IB and IS

Completion of tasks		**Coping with pressure**	
Person cannot answer the phone and reliably take a message	2	Frequently feels scared or panicky for no apparent reason	2
Often sits for hours doing nothing	2	Mental stress was a factor in stopping work	2
Cannot concentrate to read a magazine article or follow a radio or TV programme	1	Avoids routine activities as convinced they will be too tiring or stressful	1
Cannot find a number in a phone book etc.	1	Cannot cope with changes in daily routine	1
Mental condition prevents person from doing leisure activities previously enjoyed	1	Frequently finds there is so much to do that gives up due to fatigue, apathy or disinterest	1
Overlooks/forgets risks posed by domestic appliances or other common hazards	1	Is scared or anxious that work would bring back or worsen illness	1
Agitation, confusion or forgetfulness has led to a mishap or accident in the last 3 months	1		
		Interaction with other people	
Concentration can only be sustained by prompting	1	Mental problems impair ability to communicate with others	2
Daily Living		Cannot look after self without help from others	2
Does not care about appearance or living conditions	1	Gets upset by ordinary events and it results in disruptive behavioural problems	2
Needs encouragement to get up and dress	2	Is too frightened to go out alone	1
Needs alcohol before midday	2	Prefers to be left alone for 6 hours+ a day	1
Is frequently distressed at some time of the day, due to mood fluctuations	1	Gets irritated by things that would not have bothered claimant before s/he became ill	1
Sleep problems interfere with daytime activities	1		

Any - or all - points can be combined to give a 'mental health' score,
NOT just the highest from each section!

10 points are needed to be found incapable of work on grounds of 'mental disability' alone.

If you score between 6 and 9 on this test, the DSS treat you as having scored 9 and then add on any 'Physical' points you score. To be found incapable of work with a mixture of mental health and physical points you must 'score' 15 points.

Completing the IB50 Form

- Are you exempt because you get DLA Higher Care? If so, DO NOT complete the IB50 form. Ring them and tell them about your award.
- Might you be exempt because of a 'severe' mental health problem or some other condition? Get advice! Many of the forms on which exemptions are based are never returned by GPs.
- Might you be able to get some supporting evidence to go with the form? See the section at the end of this chapter on 'Supporting Evidence'.
- Take time to list ALL the problems you have, looking at physical AND mental health issues. It can help to keep these in front of you as you work through the form - e.g.. someone who loses control of their bladder during epileptic fits should complete the section for fits AND for incontinence.
- Where the form asks for the name of your doctor, you could insert that of your psychiatrist if you feel they know more about you than your GP does.
- Do a quick 'score' using a list of descriptors. If it all adds up to less than 10/15 points, then think again! Have you underestimated any of the problems?
- When answering, consider whether something can be completed safely, reliably and repeatedly. Consider activities in an 'in work' context, where a reasonable employer might expect you to e.g. go up and down stairs several times a day.
- Think of all the reasons you might be unable to do something - e.g. your ability to bend may be limited by giddiness as well as a bad back.
- Tick the HIGHEST SCORING box appropriate for each activity, qualifying your response if needs be. - e.g. while you might be able walk for 400 metres once, you might not be able to do so repeatedly, regularly and without pain. Might the 50 metre box be more appropriate?
- Use the blank box to put any limitations you experience into words and to describe any pain, distress or tiredness felt when trying to accomplish a task. If something could not be done reliably or repeatedly, say so.
- Use the (small!) box on page 16 of the form to address any mental health issues. Add pages if needs be! Do this with a list of the mental health descriptors in front of you, and try to make points relevant to them - e.g.. "Because of my anxiety and depression, I often sit for a long time not doing anything much. Perhaps the telly will be on but I won't really be watching it because I can't concentrate...". Seek or provide supporting evidence and enclose it with the form if possible.
- Remember to include any examples of jobs that you have lost or have had to give up because of health problems. In the context of the mental health 'descriptors', caselaw says that if you have to give up *unpaid* work - e.g. - looking after your children, or caring for someone - because of your mental health, then that counts too.
- If appropriate, explain how any permitted work is made manageable for you - e.g. *'They know at the office that I've not been well so I don't have to answer the phone or do things that are too much for me. They understand that there will be mornings when I can't get there on time and are great about it'...*

About you - continued

N.B.
IB50s actually allow much less space for writing than shown below—add in your own extra page/s or continue the information on page 18 of the form

Information about anxiety, depression and other mental health problems

Have you been treated for anxiety, depression or mental illness? Or do you think you have a mental health problem?

No ☐

Yes ☑

Please tell us about this

How often do you receive treatment? Please give dates

Counsellor - every fortnight
Psychiatrist - every three months

Please tell us the name of the person we should contact for more information about your condition.

Counsellor - every fortnight
Psychiatrist - every three months

Please tell us who they are. For example your GP, hospital consultant, community psychiatric nurse

Counsellor - every fortnight
Psychiatrist - every three months

When was your last appointment?

23 / 6 / 03

Use the space below to tell us about any problems you have with your nerves or any mental health condition and the type of treatment you receive. Include things like problems you have with normal day-to-day activities because of your mental health condition and problems you have dealing with other people.

My mental health problems began six years ago when I started experiencing panic attacks at work. Eventually I was finished because of these, and my self confidence just went.
Most of my time now I just spend sitting around at home - or lying on the settee, because sitting is so uncomfortable for me. I'll have the TV on but I won't be watching it - I just can't concentrate on things any more. I can't seem to motivate myself to start things or see them through. I don't want to see people any more - it's even gone that my stomach turns over when the phone rings and I often won't answer it at all. I used to enjoy going out to darts with my friends, but have had to stop it.
I also spend a lot of time crying - I used to be a cheerful person, but now tiny little things upset me - things I wouldn't even have noticed before. When I go to bed at night I can't sleep and in the mornings I don't want to get out of bed - I feel tired and 'low' all the time. I have recently been awarded DLA at the middle rate of the Care Component because of the help I need from other people with my personal care.
I also get the Mobility part of DLA at the lower rate because I need someone with me when I am outdoors because of my anxiety/ panic attacks. I worry a lot that I should be working, but don't feel able to. My Counsellor says to try to forget about work for the moment...

16

Surviving the switch to the new ESA system...

We've known for some time now that the pre-May 2010 Government intended going back on their original assurance that existing claimants would be unaffected by the introduction of Employment and Support Allowance.

The plan is that by April 2014, EVERYONE on 'old' sickness route benefits—whether they receive Incapacity Benefit, Income Support for sickness, Severe Disablement Allowance or NI credits only for sickness will have had their entitlement re-assessed under ESA tests and rules. And although at the time of writing a General Election is due, I see no reason to assume that a change of Government would lead to a change of plan.

Whether the rate of conversion they are proposing—10.000 claims a week—will be practical remains to be seen.

'Migration' plans for existing claimants:

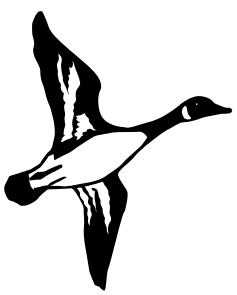
At the time of updating, the Government's plans for transferring people to ESA were stated as follows:

'*Migration will start gradually from October 2010, with full national implementation from February 2011, with a planned completion date by the end of March 2014'*

It is intended to 'convert customers' to ESA in the following order:

- A 'small trial' to test that the migration process 'works' from October 2010
- People on Incapacity Benefit/ Income Support from February 2011 onwards
- People on Severe Disablement Allowance once IB and IS claims have been completed

People who get National Insurance credits only will be transferred to ESA 'credits only' after the above are completed.



So when will my entitlement be re-assessed?

We don't know as yet who will be involved in the 'small trial' to run from October 2010. What the Government have said though is that from February 2010, all people receiving Incapacity Benefit/ Income Support for sickness will be re-assessed under the ESA rules when they would normally fall due to be medically re-assessed. You may know when this is already—if not then the DWP should be able to tell you.

The Government add though that: 'It may be necessary to adjust the dates to ensure that these are spread evenly over the conversion period.'

Will I have to make a new claim?

No. The Government plan that claims will automatically transfer from the old benefit to the new.

Will I have to fill in a form?

Yes—or get help from someone else to do so! Under the old system, many people were exempted from having to pass the medical tests either because they had a 'serious mental health problem' or because they got the Higher rate of DLA Care. ESA does not have these exemptions. Almost everyone then gets an ESA50 form sent to them when they are being medically assessed for benefit. You'll find a guide to filling it in later on in this chapter

And what then?

For the vast majority of people, the next step will be a medical interview. These are carried out by ATOS—the same firm who carried out 'old' sickness route medicals. The person interviewing you may or may not be a doctor—but will be medically qualified; under ESA, interviews CAN be carried out by a Nurse, Occupational Therapist etc. You are allowed to take company.

The report from this medical assessment will be sent to a DWP decision maker who will decide:

- whether you are entitled to Employment and Support Allowance at all and
- If you are, which rate—or 'component' you are entitled to

read on...

Will the decision take effect straight away?

No—the Government say that it will take effect 'no less than two but not more than four weeks' after the decision.

What if I am found fit for work?

Inevitably because the test for getting ESA is harder than the old tests, not as many people will qualify for it. However some of the decisions finding people fit for work will be wrongs ones, which can be overturned at Appeal. If you are found fit for work, both see the advice later in this chapter and try to find independent advice and representation in your own area.

If I'm awarded ESA, will my money remain the same?

Initially yes—and a small proportion of people will end up qualifying for more money under ESA. If this is the case, then they will pay you the extra amount immediately. If however you got more in your 'old' sickness route benefits than you would normally get under ESA, you will initially continue to get the difference between the two made up. However as time goes on, the value of that additional amount will disappear, being eroded away until amounts within ESA catch up. Anyone left with an additional amount in 2020 will lose it altogether.

If you get Housing Benefit and Council Tax Benefit, these might also have to be re-calculated. Those who gain under ESA will get the increase at once, whereas those who would lose out will initially get some additional amounts to prevent their awards reducing.

I get amounts for my children in my benefit—will I get them under ESA?

Not within your ESA payment, because ESA has no amounts for children. If you get the amounts for children within Income Support, you will have these switched over to Child Tax Credit. If this happens, depending on your household circumstances, you MIGHT come off a 'passporting' benefit altogether. If you do, you will also need to make a fresh claim for any Housing Benefit/ Council Tax Benefit. If you get extra amounts within Incapacity Benefit, then these will not transfer to Child Tax Credit but extra ESA will be paid as described above to compensate.

How much ESA will I get once the transitional extra amounts end?

Basically the amount of ESA you qualify for as an individual is determined by how unwell the Government think you are. At the moment, a minority of people on ESA qualify for the 'Support Component' rather than the 'Work Related Activity Component'. The Support Component is worth roughly £5 more than the Work Related Activity Component—see later in this chapter for the current rates.

Depending on your financial circumstances, you may also qualify for more ESA because of having a partner, because of being on certain rates of DLA or because of there being a carer or an older person covered by your claim.

What other differences will I notice?

If it's decided that you get the Work Related Activity Component, then you will have to do certain things to keep receiving it—e.g. participate in Work Focused Interviews at the Jobcentre, undertake 'Work Related Activity' in the future.

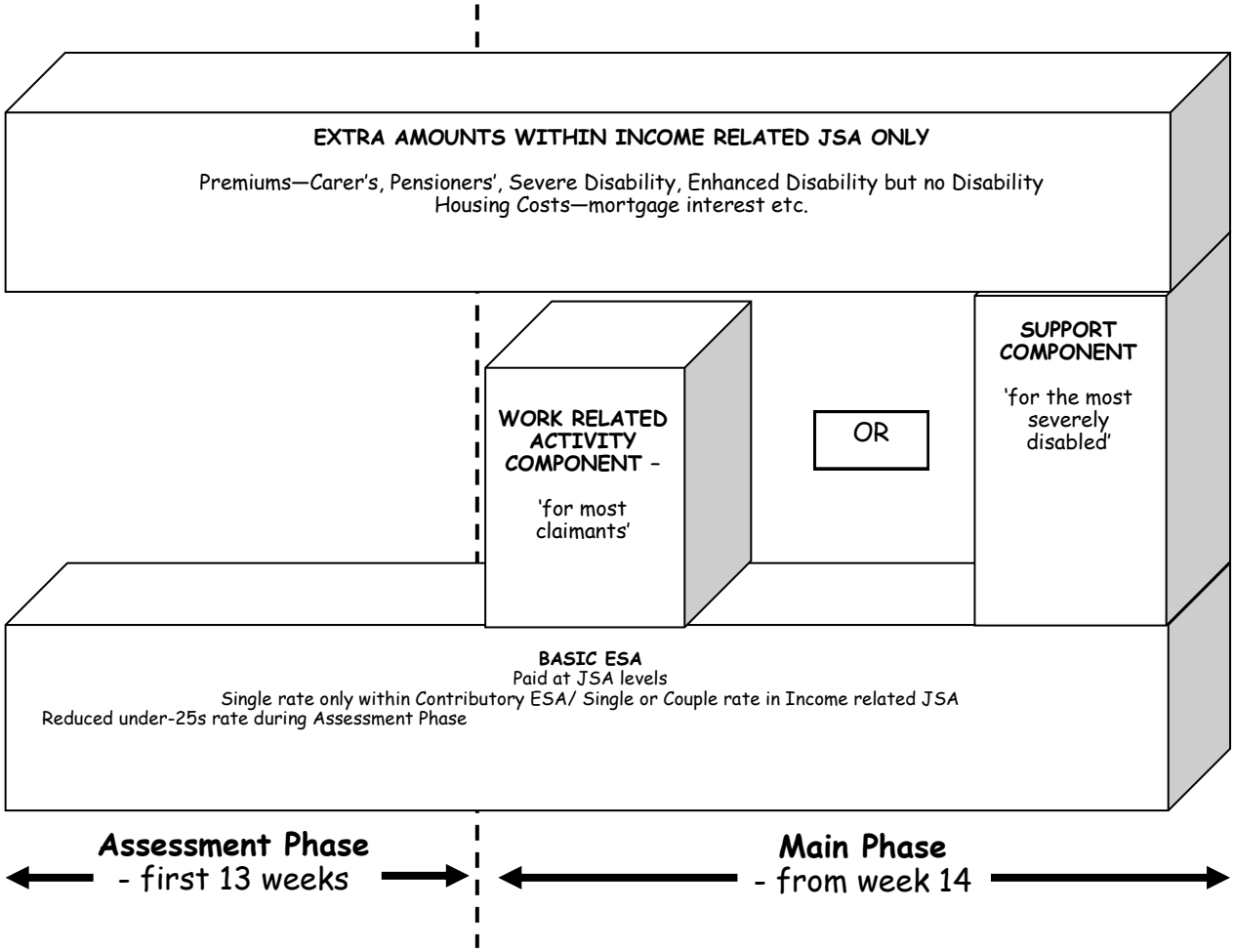
What about the Support Component?

This 'conditionality' will not apply—you will just continue to be paid as you are under the old system, although you can opt for help to get back to work if you want to.

I am a lone parent with children under 7, or I or my partner are a carer/ over 60...

In these situations you MAY be better off not claiming ESA at all and claiming Income Support, or Carer's Allowance with Income Support or Pension Credit instead—but please DO go and talk to a *good* independent advice agency before making big decisions, as every household's situation is different and needs assessing individually.

Employment and Support Allowance -
Which bits when?



Employment and Support Allowance is the 'single, simpler' sickness route benefit for all new claimants from October 27th 2008. However…

There are two kinds of Employment and Support Allowance— 'Contributory ESA' and 'Income related ESA'. For people with some familiarity with the 'old system' it may help to think of Contributory ESA as roughly the equivalent of Incapacity Benefit and Income related ESA as roughly the equivalent of Income Support through the sickness route.

People with the necessary National Insurance Contributions will be paid Contributory ESA. Depending on their income and circumstances they may also get Income related ESA on top. People who don't have the necessary NI Contributions will be paid Income related ESA, subject to a means test.
There are also two kinds of ESA claimant— those who get the 'Work Related Activity Component' and those who get the 'Support Component'. These Components kick in after the 13 week 'Assessment Phase'. Read on to find out who is likely to get what.

Claimants receiving the Work Related Activity Component have to attend and participate in Work Focused Interviews and fulfil other requirements to retain their benefit in full (see the section on Work Focused Interviews earlier in this chapter).

If someone fails to attend, or is deemed not to have participated, then the Work Related Activity Component is withdrawn in two chunks, potentially leaving people back at Jobseeker's Allowance levels until they comply. This decision can—and should—be challenged—get advice!

The Assessment Phase—weeks 0-13

During the first 13 weeks of your claim—and again from time to time - the DWP look at your 'sickness grounds' for getting benefit using something called the Work Capability Assessment. This test decides:

- Whether you are have 'limited capability for work' - and so can continue getting ESA and
- Whether you also have 'limited capability for work related activity'. If you do, then you get the 'Support Component' part of ESA. If not, you get the 'Work Related Activity Component'.

During the first 13 weeks— 'the Assessment Phase' you will be paid at Jobseeker's Allowance levels. If a decision is made about your entitlement to either Component before week 14, you will still have to wait until week 14 to receive it.

If there is a delay and the DWP are unable to carry out the Work Capability Assessment during the first 13 weeks of your claim then you will continue to be paid at Jobseeker's Allowance levels, with the amount of either component back-paid from week 14.

The Work Capability Assessment

No one is exempted from the WCA. There are, however, certain circumstances in which you will be 'treated as' as having limited capability for work, passporting you to ESA. These are:

- there would be a substantial risk to your mental or physical health - or that of others—if you were *not* found to have limited capability for work
- you are a hospital in-patient
- you are refraining from work because of a notifiable disease
- you are suffering from a life threatening uncontrolled disease
- for any week in which you are receiving or recovering from renal dialysis, plasmapheresis, radiotherapy or weekly paranteral nutrition
- during the late stages of pregnancy and for a fortnight after giving birth, or, if getting maternity allowance, within the maternity allowance period

There are also circumstances in which you will be treated as both having limited capability for work AND having limited capability for work related activity, passporting you to the Support Component. These are:

- there would be a substantial risk to your mental or physical health - or that of others—if you were *not* found to have limited capability for work related activity
- you are receiving or recovering from IV chemotherapy (planned to change at some point to include those likely to receive chemotherapy in the next 6 months—get advice)
- you are terminally ill—i.e. if your death can be reasonably expected in the next six months.
- you are pregnant and there would be a serious risk to your health or to the baby's if you were not so treated.

How the Work Capability Assessment Works...

The assessment is made up of two sets of "descriptors" (see overleaf). At some point during the coming year these are likely to be replaced by a revised test—see the end of this chapter.

People have to 'score' 15 points or more to be found incapable of work. These 15 points can come from either the physical or mental health test or from the addition of points from both.

CONCERNS:

The loss of exemptions for people receiving the highest rate of DLA Care and for those with severe mental health problems/ learning disabilities mean many very vulnerable people having to negotiate the WCA.

The WCA is considerably harder to pass than the 'old' PCA for Incapacity Benefit and Income Support through the sickness route.

The current mental health test is cumbersome and complex and uses very subjective language, which makes it difficult to understand and apply properly.

At some point soon it is planned to replace the existing test with a new—simpler one. Unfortunately 'simpler' does not mean that it will be easier to pass—read on...

WCA —'Physical Disabilities'

1) Walking (with aids)

- Cannot walk at all ** (15)
- Cannot walk up or down two steps using handrail (15)
- Cannot walk (on level ground without repeated stopping severe discomfort):
  - 50 metres ** (15)
  - 100 metres (9)
  - 200 metres (6)

2) Standing (but free to move around)/ Sitting in a chair (high backed and no arms) / Moving out of/ between chairs. Unassisted = without help from another person

- Cannot stand unassisted for more than ten minutes (15)
- Cannot sit more than ten mins. due to discomfort (15)
- Cannot rise from sitting unassisted* (15)
- Cannot move from one seat to another one alongside unassisted * (15)

(note that **both** the above limitations must apply to qualify for Support Group eligibility)

- Cannot stand for more than 30 mins. (6)
- Cannot sit for more than 30 mins. due to discomfort (6)

3) Bending/ kneeling

- Cannot bend to touch knees and straighten again (15)
- Cannot bend, kneel or squat as if to get light object from low shelf (15 cms.) and straighten unassisted (9)
- As above, as if to get light object from floor (6)

4) Reaching

- Cannot raise either arm as if to put something in top pocket of jacket (15)
- Cannot put either arm behind back e.g. for jacket (15)
- Cannot raise either arm as if to put on hat (9)
- Cannot raise either arm to reach above head height (6)

5) Picking up and moving

- Cannot—with either hand—pick up and move half litre carton of liquid * (15)
- Cannot—with either hand—pick up and move a 1 litre carton of liquid (9)
- Cannot pick up and move a light but bulky object—e.g. cardboard box—requiring both hands (6)

6) Manual dexterity

Cannot with either hand:

- Turn pages of book (15)
- Turn star headed tap* (15)
- Pick up a £1 coin* (15)
- Use a pen or pencil (9)
- Use keyboard or mouse (9)
- Manage shirt buttons (9)

Can with one hand but not the other:

- Turn star headed tap (6)
- Pick up a £1 coin (6)

Cannot pour from an open half litre carton of liquid (6)

7) Speech

- Can't speak at all (15)
- Speech can't be understood by strangers (15)
- Strangers have great difficulty understanding (9)
- Strangers have some difficulty understanding (6)

8) Hearing (with aids if worn)

- Can't hear to understand someone speaking in loud voice in quiet room (15)
- Cannot hear to understand someone speaking in normal voice in quiet room (9)
- Cannot hear to understand someone speaking in loud voice on busy street (6)

9) Vision, in daylight/ bright light with usual aids

- Cannot read 16 point print beyond 20 cms (15)
- 50% or greater reduction in visual fields (15)
- Cannot recognise a friend at 5 metres (9)
- 25% -49% reduction in visual field (6)
- Cannot recognise a friend at 15 metres (6)

10) Continence (not enurisis)

- Has no control of bowel or no control of bladder* (15)
- Involuntary full evacuation of bowels at least monthly** (15)
- Ditto bladder, weekly* (15)
- Ditto bowel, occasionally (9)
- Ditto bladder, monthly (6)
- Risk of above—bowels or bladder—if unable to reach toilet quickly (6)

Also, with urinary collecting device, catheter or stoma bag:

- Can't deal with device without help or without leakage * (15)

NOTE : Much simplified here—if continence with such aids is an issue check the regulations

11) Remaining conscious:

Has involuntary episode of lost or altered consciousness resulting in significantly disrupted awareness/ concentration:

- At least once a week (15)
- At least once a month (9)
- At least twice in the last 6 months (6)

NOTE:
*** Support Group eligibility**
**** indicates a similar but different measure within Support Group eligibility –check degree of limitation**
***** suggests *arguable* 'deemed' Support Group eligibility on 'risk to owm/ other's health' grounds—worth a try...**

N.B. AT SOME POINT—PROBABLY IN THE NEXT YEAR—A *NEW* WCA WILL BE INTRODUCED– CHECK IF IT HAS AND IF SO, READ ON...

WCA—'Mental, cognitive and intellectual function assessment'

1) Learning/ comprehending tasks

- Cannot learn /understand completion of simple task– e.g. setting alarm clock—at all** (15)
- Has to be shown a simple task repeatedly and again the next day* (15)
- Has to be shown simple task and verbally prompted next day (9)
- Has to be shown moderately complex task—e.g. using a washing machine— and prompted again the next day (6)
- Has to be told how to do a simple task and need prompting again within a week (6)

2) Awareness of hazards:

- Reduced awareness of everyday hazards (e.g. sharp objects/ boiling water) would lead to injury to self/ others or significant damage to property/ possessions (or near avoidance of) daily, so 'day-to-day life cannot successfully be managed'*** (15)
- As above, most of the time, so day -to-day life cannot successfully be managed without supervision' *** (9)
- As above, frequently but without impact on day-to-day life *** (6)

3) Memory and concentration

- Daily forgets or loses concentration so that day-to-day life can't be managed without prompting in person*** (15)
- As above, most of time*** (9)
- As above, frequently, can only manage with pre planning, making lists of 'all tasks forming daily life' (6)

4) Execution of tasks

- Can't successfully complete an everyday task *** (15)
- Takes more than twice as long as would be expected to complete an everyday, familiar task (15)
- Takes more than one and a half times as long (9)
- Takes one and a half times as long as would be expected (6)

5) Initiating and sustaining personal action

- Cannot, due to cognitive impairment, or a severe disorder of mood or behaviour, initiate/ sustain any planning, organisation, problem solving, prioritising or switching task at all* (15)
- Cannot (as above) without daily prompting* (15)
- Cannot (as above) without prompting most of the time (9)
- Cannot (as above) without frequent prompting (6)

6) Coping with change

- Can't cope with very minor, expected changes so that day-to-day life cannot be managed***(15)
- Can't cope with expected changes—e.g. pre-arranged change to routine time for lunch break—so that day to day life is significantly more difficult (9)
- Can't cope with minor unexpected changes—e.g. time of appointment that day—so that day to day life is made significantly more difficult (6)

7) Getting about

- Cannot go anywhere, even to familiar places (15)
- As above, without company (15)
- As above, most of time, without company (9)
- As above, frequently, without company (6)

8) Coping with social situations:

- Normal activities—e.g. visiting new places/ having social contact made impossible by overwhelming fear/ anxiety:
- All the time*** (15)
- Most of the time*** (9)
- Frequently*** (6)

9) Propriety of behaviour with other people

- Has unpredictable outbursts of aggressive, disinhibited or bizarre behaviour, daily disrupting others*** (15)
- As above, less often but so severe that 'no reasonable person would be expected to tolerate them'*** (15)
- As above, so frequent and severe as to cause disruption most of the time*** (9)
- As above, causing frequent disruption*** (6)

OR

- Has a completely disproportionate reaction to minor events/ criticism resulting in extreme violent outburst leading to threatening behaviour or actual violence***(15)
- Has a strongly disproportionate reaction, so that cannot manage 'overall day to day life 'when events/criticism occurs*** (9)
- Frequently has moderately disproportionate reaction but not to extent that can't manage overall day to day life when events/ criticism occurs (6)

10) Dealing with other people:

- Is unaware of impact of own behaviour so has difficulty relating to others even for a few hours, or daily causes distress to others*** (15)
- As above— so can't relate to others over the period of a day or two or causes distress to others most of the time*** (9)
- As above– so can't relate to others over a period of around a week, or frequently causes distress to others*** (6)

OR

- Misinterprets verbal/ non verbal communication causing, to self:
- Daily significant distress* (15)
- Distress most of time*** (9)
- Distress frequently*** (6)

NOTE!!! The mental health descriptors above are *considerably* simplified to try to make them a little more user friendly! The Regulations version can be found in full in the ESA 50 guide

ESA made Easy:
an at-a glance guide to surviving the first six months...

		Week 23	Week 24 Work focused interviews continue at 5 -weekly intervals for Work Related Activity Component recipients. Deferral can be requested Non-attendance or non-participation leads to sanctions Decision to sanction is appealable.
Week 17	Week 18	Week 19	Week 20
Week 13	Week 14 Payment of either Work Related Activity Component or Support Component kicks in. Support Component = no more WFIs	Week 15	Week 16
Week 9	Week 10	Week 11	Week 12
Week 5	Week 6 Contact made at some point to arrange initial work focused interview 'around week eight' - to become week 14 to 16 in future Deferral can be requested. Decision not to grant deferral is NOT appealable.	Week 7	Week 8 Work focused interview—must attend and participate to sustain claim unless deferred
START Week 1 Claim registered—usually by telephone but can be by post	Week 2	Week 3 Payment—at basic assessment phase rate plus some means tested elements - has hopefully been sorted by now! Chase if not!	Week 4

The DWP hope to medically assess during the first 13 weeks—sometimes takes much longer. Will usually involve receipt and completion of ESA50 form, plus two-part medical assessment- at same time or separately. Decisions as to entitlement to ESA and which component is awarded are both appealable

The ESA50 form:

The first you are likely to know about the Work Capability Assessment having started is receiving a form called an ESA50.

The form is long and asks lots of questions both about your physical and mental health. The physical questions all bear some resemblance to the points listed on the previous pages, so it should be relatively easy to refer to these when you are working through them, so that you can see how your answers 'score'.

However in trying to simplify the horribly complex mental health descriptors to include them on the form, some of the questions they ask vary quite markedly from the difficulties that would actually score you points—e.g.

- Has unpredictable outbursts of aggressive, disinhibited or bizarre behaviour, daily disrupting others (15)
- As above, less often but so severe that 'no reasonable person would be expected to tolerate them (15)
- As above, so frequent and severe as to cause disruption most of the time (9)
- As above, causing frequent disruption (6)

has become:

'Do other people get upset with you because of the way you behave?' For example do they shout, lose their temper, argue or threaten you: often/ sometimes/ now and then' on the form.

This is of course a rather *different* test. Tolerant and understanding family members—or even employers and colleagues—may never show their stress by shouting or making threats, but that's not to say that someone's behaviour may *not* be bizarre and disruptive.

You need, then, to look at what the test REALLY is for each section and to try to frame your answers to address that as well as the simplified versions offered on the forms. I *hope* that my attempt to simplify the test three pages back is a little more relevant to the law and is probably adequate for the completion of ESA50s. When appealing a bad decision though you really should *try* wrestling with the regulations as they appear in statute— and get advice!

Even if your mental health problems cause problems which look as if they could score on the 'physical' side—e.g. your OCD makes it impossible for you to sit for more than ten minutes, or you can't get out of a chair because of depression, there's no point in telling them this under the 'physical' points—they won't count.

Many of the questions don't offer you a 'yes all the time' or 'no—not at all' option. Don't be afraid to alter these if an option not included would be more accurate.

Don't be afraid to include any information you want them to know about your mental health if it doesn't fit neatly into their categories or boxes. This is particularly important if you can think of any reason that there would be a risk to your health— or to anybody else's health—if you were found fit for work, as this could lead to you getting the 'Support Component' part of ESA and thus being exempted from Work Focused Interviews.

There are also other tests for the Support Component— many of which are not touched upon in the ESA50 form. Read on to find out what they are and include any relevant information with your ESA50 if you feel they apply to you.

It may help you avoid the 'medical' part of the test altogether if you can persuade the DWP that you 'pass' on paper, so include any supporting evidence you can get too. **Also see the 'Completing the IB50' page earlier in this chapter for other hints and tips.**

N.B. FUTURE CHANGES:

At the time of going to print, plans for a new Work Capability Assessment had just been announced—but without a date for their implementation.

The new descriptors for this are included at the end of this chapter.

When introduced, the format of the ESA50 form and medical guidance will need to change as well.

If this happens sufficiently early in the 2010/2011 benefits year, I plan to re-write the 'guide to completing the ESA50' as soon as is humanly possible, and make it freely available to those who have purchased this year's edition of the Big Book on request by email to: judystenger@googlemail.com

The Regulations say:

12. Learning or comprehension in the completion of tasks

(a) Cannot learn or understand how to successfully complete a simple task, such as setting an alarm clock, at all (15)

(b) Needs to witness a demonstration, given more than once on the same occasion, of how to carry out a simple task before the claimant is able to learn or understand how to complete the task successfully, but would be unable to successfully complete the task the following day without receiving a further demonstration of how to complete it. (15)

(c) Needs to witness a demonstration of how to carry out a simple task, before the claimant is able to learn or understand how to complete the task successfully, but would be unable to successfully complete the task the following day without receiving a verbal prompt from another person (9)

(d) Needs to witness a demonstration of how to carry out a moderately complex task, such as the steps involved in operating a washing machine to correctly clean clothes, before the claimant is able to learn or understand how to complete the task successfully, but would be unable to successfully complete the task the following day without receiving a verbal prompt from another person. (9)

(e) Needs verbal instructions as to how to carry out a simple task before the claimant is able to learn or understand how to complete the task successfully, but would be unable, within a period of less than one week, to successfully complete the task the following day without receiving a verbal prompt from another person. (6)

The Medical Guidance says:

Learning difficulty, brain injury, receptive dysphasia

Consider basic functions of personal care such as brushing teeth. This would involve remembering to put toothpaste onto a brush and brushing all areas of teeth. This may be regarded as a simple task. Other aspects of personal care may be the ability to be able to get up, showered, shave, clean teeth, select clothing items and get dressed appropriately for the weather outside. This may represent an ability to understand and retain information.

Other leisure activities that may be useful to consider may include using a TV remote control, using a stereo by loading the CD into the CD player and selecting the appropriate function on the stereo to allow the CD to play. Ability to use a Playstation or computer may be relevant in this functional category. Ability to drive, previous employment or tasks learned in training may also be relevant.

Observations:

Although the guidance suggests that this descriptor isn't aimed at people with mental health problems, it will do no harm to explain any difficulties you *do* have with concentrating on instructions and remembering them.

e.g.

- Depression—*I can feel so shut off from other people that they can be showing me how to do something/ explaining things to me and I'm just not taking it in*

- Anxiety—*I get so caught up in endlessly cycling worries that I find it really hard to keep my concentration fixed on what someone is showing me/ explaining to me*
  or
  I can read instructions but taking them in and retaining them is another thing—I need to be shown how to do things.

- Psychosis—*the voices I hear/ thoughts that come into my head can be really intrusive, making it impossible to concentrate on what people are saying or doing*

- OCD— *I get caught up in trying to do things in the proper order and checking things time and again. I'll need prompting to enable me to carry on and make progress*

Try to give examples of when things have gone wrong with the activities they mention—e.g.

- *I've often ruined clothes by putting them in on the wrong wash programme/ putting things in the machine that should be hand washed*

- *I forgot they were in the washing machine—when I eventually found them they were covered in mildew*

- *I have often come home from shopping without things I've been asked to get because I didn't take in/ remember what was said to me*

- *I know in theory how to …. but get angry/ frustrated/ lack the motivation to, so cannot apply that theory* without prompting

Part 2— Mental, cognitive and intellectual functions

By *mental, cognitive and intellectual functions* we mean things like mental illness, learning difficulties and the effects of head injuries. You may wish to fill in this form a bit at a time as it may take some time to complete. If we are able to get sufficient information about you, we may not need to ask you to attend for medical assessment.

Please use the boxes after each question to tell us in your own words how your illness or disability affects you in doing day to day things

12. Learning or comprehension in the completion of tasks

By *comprehension* we mean understanding.

Now go to question 13.

Please tick this box if you can learn how to do a task without any difficulty. ☐

. .

Can you learn how to do a simple task as long as someone shows you what to do?
By a *simple task* we mean things like setting an alarm clock, making a sandwich, using a washing machine, using a mobile phone to make a call.

Usually ☐

Sometimes ☐

Not very often ☐

Can you understand and remember how to do a more difficult task?
By a *more difficult task* we mean things like shopping for and cooking a meal, ironing clothes.

sometimes
~~**Usually**~~ ☑

Not very often, even if someone shows me what to do. ☐

The actual test:
12) Learning/ comprehending tasks

- Cannot learn /understand completion of simple task- e.g. setting alarm clock—at all** (15)
- Has to be shown a simple task repeatedly and again the next day* (15)
- Has to be shown simple task and verbally prompted next day (9)
- Has to be shown moderately complex task—e.g. using a washing machine— and prompted again the next day (6)
- Has to be told how to do a simple task and need prompting again within a week (6)

Use this space to tell us about any difficulties you have learning to do new things, and why you find it difficult

My anxiety levels can be so high that I'm not always taking in what I'm being told—it's literally in one ear and out the other.

13. Awareness of hazard

The Regulation says:

(a) Reduced awareness of the risks of everyday hazards (such as boiling water or sharp objects) would lead to daily instances of or to near-avoidance of: injury to self or others; or significant damage to property or possessions to such an extent that overall day to day life cannot successfully be managed (15)

(b) Reduced awareness of the risks of everyday hazards would lead for the majority of the time to instances of or to near-avoidance of injury to self or others; or significant damage to property or possessions, to such an extent that overall day to day life cannot successfully be managed without supervision from another person. (9)

(c) Reduced awareness of the risks of everyday hazards would lead for the majority of the time to instances of or to near-avoidance of injury to self or others; or significant damage to property or possessions but not to such an extent that overall day to day life cannot be managed when such incidents occur. (6)

Medical Guidance says:

Learning difficulty, effects of medication, brain injury, other neurological condition affecting self awareness

e.g. person with dementia lacking ability to recognise they are at risk of forgetting the cooker is on. Consider ability to cope with road safety awareness, driving, ability in the kitchen, awareness of electrical safety, responsibility for children/ pets

(Judy's comment—brings to mind a hideous IB tribunal where the presenting officer suggested the claimant's children should be in care if she had the difficulties she claimed— be ready to explain how childcare, with difficulty—is managed)

Observations:

Again not aimed at mental health, but hey, let's push the boundaries—especially as DLA Care caselaw starts from the premise that it's HOW you are affected by something that matters, not what the cause is...

Include ANYTHING that leads to risk for you/ others on a fairly regular basis —see supervision pages in the DLA chapter—and phrase your answer to explain how your mental health problems reduce your awareness of the risks.

I can see particular potential relevance for:

- *self harm*
- *anything that distracts you or otherwise impacts on your concentration—both when out and about in traffic or when cooking/ dealing with potentially harmful things at home—e.g.*
  - *I'm forever leaving the gas on*
  - *I forget to check 'use by' dates*
  - *I lose concentration and burn/ scald/ cut myself accidentally*
  - *I forget how many tablets I've taken*
  - *I get impatient and take silly risks/ shortcuts*

  due to the voices, my panic attacks, paranoid thoughts, flashbacks, the void of depression… etc.

Note that they are interpreting 'daily' (15 points) as being more often than 'for the majority of the time' (9 or 6 point) - from which I infer that 'for the majority of the time' actually means 'most days'. Oh and just to be helpful, the form asks about none of these! Use the box to try to relate your answer more closely to the regulation's definition. I would hope the answer opposite would score 9 points.

14) Memory/ concentration

The Regulation says:

(a) On a daily basis, forgets or loses concentration to such an extent that overall day to day life cannot be successfully managed without receiving verbal prompting, given by someone else in the claimant's presence. (15)

(b) For the majority of the time, forgets or loses concentration to such an extent that overall day to day life cannot be successfully managed without receiving verbal prompting, given by someone else in the claimant's presence (9)

(c) Frequently forgets or loses concentration to such an extent that overall day to day life can only be successfully managed with pre-planning, such as making a daily written list of all tasks forming part of daily life that are to be completed. (6)

The Medical Guidance says:

Lapses of memory or concentration due to fatigue, anxiety, depression, delusions, hallucinations, memory loss, brain injury, effects of medication.
If someone lives alone they are unlikely to meet any of these tests…

(*Judy's comment: If used as justification for not awarding this descriptor, this ludicrous assumption needs challenging… It directly contradicts DLA caselaw which accepts that someone not receiving help is **not** an indication that they don't need it*)

Part 2— Mental, cognitive and intellectual functions

13. Awareness of hazard or danger

Please tick this box if you can manage your daily life safely ☐ **Now go to question 14.**

Can you manage your daily life safely? By *managing things safely* we mean things like crossing the road, using a sharp kitchen knife without danger to yourself, ironing or cooking

- **Usually** ☐
- **It varies** ☐
- **Not very often** ☑
- **Only if someone stays with me during the day to make sure** ☐

13) Awareness of hazards:

- Reduced awareness of everyday hazards (e.g. sharp objects/ boiling water) would lead to injury to self/ others or significant damage to property/ possessions (or near avoidance of) daily, so that 'day-to-day life cannot successfully be managed'*** (15)
- As above, most of the time, so day-to-day life cannot successfully be managed without supervision' *** (9)
- As above, frequently but without impact on day-to-day life *** (6)

Use this space to tell us if you can avoid dangers to yourself and others, and how you cope with them. Please give us examples of problems you have with doing things safely.

I cut and burn myself deliberately most days. My mother gets upset . She says the scars will be there all my life. She doesn't understand that the feeling of release it brings helps with the scars that people cannot see—the ones on my heart. It gets in the way of life, but it also keeps me alive… my mental health issues stop me recognising the risks involved.

14. Memory and concentration

Please tick this box if you can manage your daily routines without difficulty ☐ **Now go to question 15.**

Can you concentrate on your daily routines? By *usual daily routine* we mean things like getting up, getting washed and dressed.

- **Usually** ☐
- **Only if someone reminds me to do things** ☐
- **Only if I plan ahead, for example by making lists of things to do** ☐
- **Not very often** ☑

14) Memory and concentration

- Daily forgets or loses concentration so that day-to-day life can't be managed without prompting in person*** (15)
- As above, most of time*** (9)
- As above, frequently, can only manage with pre planning, making lists of 'all tasks forming daily life' (6)

Can you remember to do your usual daily routines?

- **Usually** ☐
- **It varies** ☐
- **Not very often** ☑

. .

14) Memory/ concentration

medical guidance continued…

Attending to personal care, coping with medication, accidents at home, shopping, reading/TV, driving, dealing with finances/ bills should all be considered for this functional category. It would be expected that a severe level of cognitive impairment would be evident for any of the above descriptors to apply.

Observations:

Well at least they're willing to contemplate that this might apply in a mental health context! All the comments from the previous page—as well as day to day stuff which doesn't involve risk are relevant here. List all the activities you could do with prompting/ encouraging/ reminding about.

The descriptor invites you to weigh up:

- daily (15 points)
- for the majority of the time (9 points) and
- frequently (6 points)

which is of course a nonsense, as someone could quite legitimately describe something as happening 'frequently' actually meaning that it happened daily, or more than once daily… The form ducks the issue by asking about different measures—again try to word your answer so that it relates quite closely to the point considered in law. If you have problems daily, say so.

15) Execution of Tasks

The Regulation says:

(a) Is unable to successfully complete any everyday task. (15)
(b) Takes more than twice the length of time it would take a person without any form of mental disablement, to successfully complete an everyday task with which the claimant is familiar. (15)
(c) Takes more than one and a half times but no more than twice the length of time it would take a person without any form of mental disablement to successfully complete an everyday task with which the claimant is familiar (9)
(d) Takes one and a half times the length of time it would take a person without any form of mental disablement to successfully complete an everyday task with which the claimant is familiar. (6)

The Medical Guidance says:

Obsessive-compulsive disorder, learning disability or brain injury, the effect on a person of experiencing a panic attack –
a specific and overwhelming experience of fear, precluding any form of normal activity. It is also intended to reflect the impact on carrying out a task that hallucinations or delusions may have on individuals with psychotic or dissociative states. It may be compounded by the
effects of medication.
Reflects increased time to complete a task, not lack of motivation - e.g. a person with severe OCD may take several hours to manage to get washed and dressed due to hand washing rituals preventing them from continuing a task.
Should reflect a person who would struggle to get through the basics of a day… as a result of tasks taking so long to complete that they would be unable to cope with work for this reason. For example those who have severe and continuous disabling anxiety where they struggle to even get out of their bedroom may come into this category. Consider routine activities and what would be reasonable for a person taking into account normal variation in a population without any form of mental disablement.
Physical signs—those with anxiety or depression would be expected to… be extremely distracted or sweating. In those with significant depression, there may be evidence of slow speech or psychomotor retardation. *(Judy's comment—dress warm, move slow… and mumble...)*

Observations:

Basically this is ALL about how long it takes you to finish doing something— if you can at all. In answering, try to be specific about how much longer it takes you—see the shortened descriptor opposite! They recognise in the medical guidance that this could be due to various things—OCD, psychosis, panic, depression as well as the side effects of medication

16) Personal action

The Regulations say:

Cannot, due to cognitive impairment or a severe disorder of mood or behaviour, initiate or sustain any personal action (which means planning, organisation, problem solving, prioritising or switching tasks). (15)
(b) Cannot (as above) without requiring verbal prompting given by another person in the claimant's presence for the majority of the time. (15)
(c) Cannot (as above) without requiring verbal prompting given by another person in the claimant's presence for the majority of the time. (9)
Not a typo—or at least a Government one— yes, (b) and (c) ***are*** *identical other than the points they score…)*
(d) Cannot, (as above_ without requiring frequent verbal prompting given by another person in the claimant's presence. (6)

Part 2— Mental, cognitive and intellectual functions

14. Memory and concentration continued

Use this space to tell us what sort of help you need to remember things, and what things you need help with.

It's not that I need reminding so much as prompting—I get caught up in my rituals and checking behaviour, so that I'm sort of oblivious to other day-to-day stuff. This happens every day.

15. Execution of tasks

By this we mean doing jobs and finishing them

Now go to question 16.

Please tick this box if you can finish daily jobs without difficulty or without taking a long time ☐

Do you have difficulties finishing routine daily jobs? By *daily jobs* we mean things like washing up, dressing, cooking and shopping.

Usually ✓

Not very often ☐

It varies ☐

15) Execution of tasks

- Can't successfully complete an everyday task *** (15)
- Takes more than twice as long as would be expected to complete an everyday, familiar task (15)
- Takes more than one and a half times as long (9)
- Takes one and a half times as long as would be expected (6)

Use this space to tell us how long it takes you to do daily jobs. Tell us what stops you doing these jobs, and why it is difficult for you. Tell us if you get help to do these things

I'm terribly slow doing things. I get caught up in my thoughts, and also in the order of my rituals. Five feels 'safe' to me , so I have to repeat everything I do five times before I can move on to the next step. It means doing things takes five times as long as it should...

16.

Initiating and sustaining personal action

By this we mean starting jobs and continuing them.

Please tick this box if you have no problems organising yourself to start and keep on with routine jobs. ☐

Can you organise yourself to start and keep on with routine jobs? By *routine jobs* we mean things like washing clothes, preparing and cooking a meal, getting drinks, getting up and dressed to leave the house and attend an appointment.

Usually ☐

Not very often ✓

It varies ☐

16) Initiating and sustaining personal action

- Cannot, due to cognitive impairment, or a severe disorder of mood or behaviour, initiate/ sustain any planning, organisation, problem solving, prioritising or switching task at all* (15)
- Cannot (as above) without daily prompting* ? (see left) (15)
- Cannot (as above) without prompting most of the time ? (see left) (9)
- Cannot (as above) without frequent prompting (6)

. .

16) Initiating/ sustaining personal action—continued

The Medical Guidance says:

Depressive illness that result in apathy, or abnormal levels of fatigue, or abnormal levels of anxiety. It is also common in some people with people with schizophrenia. It may be compounded by the effects of medication.
"Personal action" may include ability to plan and organise a simple meal; to get up, washed, dressed and ready for work in the morning and to cope with simple household tasks e.g. sorting laundry and using a washing machine.
Consider activities such as: making travel arrangements, writing shopping lists, organising finances, planning a simple meal, getting washed and dressed, ironing clothes for the next day, caring for children: preparing clothing, lunches etc.
General memory and concentration will be important areas to consider. Intelligence and severity of depression should be considered.

Observations:

Note the confusing duplication in the scoring! Try to explain what stops you from starting routine things or completing them, Basically they're looking for 'I can't motivate myself/ haven't got the energy type answers. If you stay in bed or just sit in a chair, here's the place to say so.

17) Coping with change

The Regulations say:

(a) Cannot cope with very minor, expected changes in routine, to the extent that overall day to day life cannot be managed. (15)
(b) Cannot cope with expected changes in routine (such as a pre-arranged permanent change to the routine time scheduled for a lunch break), to the extent that overall day to day life is made significantly more difficult. (9)
(c) Cannot cope with minor, unforeseen changes in routine (such as an unexpected change of the timing of an appointment on the day it is due to occur), to the extent that overall, day to day life is made significantly more difficult. (6)

The Medical Guidance says:

Severe learning disability, autistic spectrum disorder, brain injury, or psychotic illness
Is not intended to reflect simple dislike of changes to routine, but rather the inability to cope with them.
Reflects a level of disability where small changes result in day to day life being significantly affected i.e. made significantly more difficult or cannot be managed.

Consider use of public transport, shopping, dealing with appointments at hospital, GP or Jobcentre Plus, coping with children and their out of school activities. dealing with telephone calls.
e.g.

- A claimant who becomes so upset by the phone ringing that they cannot function beyond that, rather than just feeling stressed or anxious.
- A claimant with a severe form of mental disablement who may become so distressed by the supermarket being out of stock of their usual brand of breakfast cereal that they cannot continue with other activities or complete the rest of their shopping.
- A claimant who would be unable to cope with the train being cancelled and would return home rather than wait for the next train

They may have poor rapport and be extremely anxious at interview. **It may be that they have been completely unable to attend for assessment. It would seem unlikely that a claimant who manages to attend the MEC alone would meet the level of severity of functional restriction.** *(Jude's comment— take company if you can—but needs to be challenged if used in justification!)*

Observations:

I'm surprised and truly disappointed by the medical guidance's very limited list of 'conditions' in which they'd expect to find these difficulties occurring - in my experience changes in routine can be threatening for people over a *much* wider range of diagnoses including anxiety, depression and—very obviously—OCD—see facing page.

Again don't be afraid to push the boundaries—if you can relate to not being able to cope with change - for whatever reason - say so!

- I cope day-to-day only by doing the same things in my own way and time. If something happens to delay me, or which means that I have to rush I fall apart.
- When they changed the timetables for the Day Services activities I found it impossible to adapt.
- When I was on JSA I'd cope with going to the Jobcentre but once they asked me to do anything unexpected—something that wasn't routine for me—I'd go to pieces. They suggested I should be on ESA.

Part 2— Mental, cognitive and intellectual functions

16. Initiating and sustaining personal action continued

Do you need encouragement from someone else to start and keep on with routine jobs?

Every day	✓
Most of the time	
Not very often	
It varies	

Use this space to tell us how often you need other people to encourage you to organise yourself to start and keep on with your routine activities

As ticked above, daily—and often during the day.

It's not a question of someone needing to encourage me to 'organise' myself, it's a question of not having the motivation to start or the concentration to see things through. properly. Even if I do get started, the checking starts getting in the way. I also give up on things due to feeling exhausted.

17. Coping with change

Please tick this box if you do not have problems Now go to question 16.
Coping with change.

Please note _ I cannot cope with changes—expected or unexpected—<u>at all, ever</u>.

Can you cope with small changes to your routine if you know about them before they happen?
By *changes to your routine that you knew about before they happen*, we mean things like having a meal earlier or later than usual because you are going out.

Usually	✓
Not very often	✓
It varies	✓

Can you cope with small changes to your routine if they are unexpected?
By *unexpected changes* we mean things like appointments being cancelled, or your bus or train not running on time.

Usually	✓
Not very often	✓

17) Coping with change

- Can't cope with very minor, expected changes so that day-to-day life cannot be managed*** (15)
- Can't cope with expected changes—e.g. pre-arranged change to routine time for lunch break—so that day to day life is significantly more difficult (9)
- Can't cope with minor unexpected changes—e.g. time of appointment that day—so that day to day life is made significantly more difficult (6)

Use this space to tell us more. Explain your problems and give examples if you can.

Routine is vital to me and I become anxious or distressed even if I know things are going to change beforehand. If I have to do anything I have to plan it down to the last detail, often getting up hours in advance . I have to have company to go to appointments even if they are not changed. I cannot use public transport—partly because of distress if things do not go to plan.

18) Going out

The Regulations say:

(a) Cannot get to any specified place with which the claimant is, or would be, familiar. (15)
(b) Is unable to get to a specified place with which the claimant is familiar, without being accompanied by another person on each occasion. (15)
(c) For the majority of the time is unable to get to a specified place with which the claimant is familiar without being accompanied by another person (9)
(d) Is frequently unable to get to a specified place with which the claimant is familiar without being accompanied by another person. (6)

The Medical Guidance says:

Disorientation; or agoraphobia causing fear of travelling unaccompanied by another person
Does not reflect lesser degrees of anxiety about going out. Nor does it reflect planning and timekeeping. It would be expected that evidence of severe anxiety would be apparent to support the level of functional restriction in this area. Lesser degrees of anxiety would not fulfil the criteria. The descriptor reflects true panic disorder or severe agoraphobia. Shopping, attending the chemist, attending hospital or GP appointments, walking the dog, supervising children outdoors should be considered.

Observations:

Again a very limited list of example diagnoses is offered by the medical guidance—again don't feel you have to be limited by them!

If you cannot leave home at all, or DO get disabling panic attacks then this is definitely the place to tell them all about them. Beware though of saying you can't go out at all, as it could threaten any award of DLA lower mobility you have! (see that chapter for a fuller explanation).

If, however, your inability to cope with even familiar places—and that is the test here—is due to something other than anxiety/ phobia say so:

- my paranoid thoughts and feelings of persecution lead me to get aggressive with others
- my OCD can get so overwhelming when outside the 'safer' environment of my home that, without support, I have to give up on what I'm trying to do and return home.
- The increased potential for my flashbacks to be triggered—and my behaviour when they are—mean I need company.

19) Social situations

The Regulations say:

(a) Normal activities, for example, visiting new places or engaging in social contact, are precluded because of overwhelming fear or anxiety. (15)
(b) Normal activities, for example, visiting new places or engaging in social contact, are precluded for the majority of the time due to overwhelming fear or anxiety. (9)
(c) Normal activities, for example, visiting new places or engaging in social contact, are frequently precluded, due to overwhelming fear or anxiety. (6)

The Medical Guidance says:

lack of self-confidence in social situations greater in its nature and its functional effects than mere shyness or reticence
Reflects levels of anxiety that are much more severe than fleeting moments of anxiety such as any person might experience from time to time. A specific and overwhelming experience of fear, resulting in physical symptoms or a racing pulse, and often in feelings of impending death such as may occur in a panic attack. Consider use of public transport, shopping, talking to neighbours, use of phone, hobbies and interests, social interaction with family.

Rapport is likely to be poor with lack of eye contact. The claimant may be sweating and finding the consultation difficult. They may be somewhat timid in demeanour at interview. **It would seem likely the person would require a companion to attend due to the level of anxiety that this descriptor would normally be expected to reflect.**

Observations:

At first glance this descriptor is quite similar to the previous—or at least the feelings of anxiety/ panic it describes are. This one though specifies unfamiliar settings, so is much more like the test for the lower rate of DLA mobility. It's not, though, asking about your need for company, and has an element of being deeply uncomfortable when meeting other people.

- If the neighbours are in their garden I can't go out into mine
- I am utterly unable to deal with public transport—feel trapped and frightened

Medical guidance relating to 'use of phone' and 'interaction with family' may lead DWP doctors to draw wrong assumptions— make it quite clear to them that you cannot deal with social situations. If the fact that you attended unaccompanied is used in justification to dismiss this descriptor, this needs challenging.

Part 2— Mental, cognitive and intellectual functions

18. Going out

Please note _ I hope I was right to carry on answering this question as the part below and the question to the left seem to ask the same thing.

Please tick this box if you are confident enough to leave home on your own. ☐ **Now go to question 19**

Do you feel confident enough to leave home on your own and go out to places you know?

- **Usually** ☐
- **Not very often** ☑
- **It varies** ☐

7) Getting about
- Cannot go anywhere, even to familiar places (15)
- As above, without company (15)
- As above, most of time, without company (9)
- As above, frequently, without company (6)

If you said **not very often or it varies**, do you only feel confident about going to a place you know if

- someone goes with you every time ☐
- someone goes with you sometimes? ☑
- someone goes with you the first few times until you get used to it? ☐

Do you feel you cannot go out even if someone was there to go out with you?

- **No** ☐
- **Yes** ☑

Use this space to tell us why you can not always get to places that you know well

I feel like this most of the time so I ticked 'yes'. Even with company it can sometimes all feel too overwhelming or threatening, even if it's somewhere I know well.

When the panic comes on it just hits me like an overwhelming wave—I can't breathe, feel sick and it feels like my heart is going to explode. I know the theory of breathing exercises ,but find it impossible to do them unless someone is talking me through them

19. Coping with social situations

I have this problem all the time but I do sometimes go out—on my rare good days, with company but not to social situations. I didn't know what box to tick.

Please tick this box if you do not have problems mixing with other people ☑ **Now go to question 20**

Does the thought of meeting new people or going to new places make you anxious or scared?
By *social situations* we mean things like going to a new place, parties or meetings.

- **Often** ☐
- **Sometimes** ☐
- **Not very often** ☐
- **I never go out** ☐

19) Coping with social situations:
- Normal activities—e.g. visiting new places/ having social contact made impossible by overwhelming fear/ anxiety:
- All the time*** (15)
- Most of the time*** (9)
- Frequently*** (6)

20) Propriety of behaviour with other people

The Regulations say:

20. Propriety of behaviour with other people.

(a) Has unpredictable outbursts of aggressive, disinhibited, or bizarre behaviour, being either: sufficient to cause disruption to others on a daily basis; or of such severity that although occurring less frequently than on a daily basis, no reasonable person would be expected to tolerate them. (15)

(b) Has a completely disproportionate reaction to minor events or to criticism to the extent that the claimant has an extreme violent outburst leading to threatening behaviour or actual physical violence.(15)

(c) Has unpredictable outbursts of aggressive, disinhibited or bizarre behaviour, sufficient in severity and frequency to cause disruption for the majority of the time. (9)

(d) Has a strongly disproportionate reaction to minor events or to criticism, to the extent that the claimant cannot manage overall day to day life when such events or criticism occur. (9)

(e) Has unpredictable outbursts of aggressive, disinhibited or bizarre behaviour, sufficient to cause frequent disruption. (6)

(f) Frequently demonstrates a moderately disproportionate reaction to minor events or to criticism but not to such an extent that the claimant cannot manage overall day to day life when such events or criticism occur. (6)

The Medical Guidance says:

episodic relapsing conditions such as some types of psychotic illness, as well as conditions resulting in consistently abnormal behaviour.

"Reaction to minor events" is intended to reflect difficulties that may be encountered by people with autistic spectrum disorder and other conditions in which minor adverse events causes a moderately disproportionate or significant reaction outwith that which might normally be expected.

An example of a strongly disproportionate reaction would be a response to very minor criticism involving actions such as shouting, crying and storming out of the room .

e.g. a comment such as "the soup could have been warmer" when eating the dinner prepared for them by the claimant results in the claimant crying and storming out of the room.

A moderately disproportionate reaction would be sitting shaking and crying in response to a minor criticism.

(Judy's comment—lucky he didn't end up with ihe soup in his lap… Seriously though, why is storming out of a room when someone disses your cooking more disproportionate than sitting shaking and crying when someone makes a small criticism? (see below...)

There must be evidence of mental disablement that causes a pattern of behaviour triggered in different circumstances not just directed towards one individual.

There is likely to be evidence of reduced insight. Cognitive function should be carefully addressed. Evidence of addiction or thought disorder should be carefully assessed. Rapport may be poor and communication difficult.

Consider any activity involving interaction with others where criticism may occur such as previous occupational history, shopping, childcare, parents nights at school, relationships with neighbours, ability to cope at appointments: GP/ Hospital etc, ability to cope with bills and on the phone, dealing with finances and bills at the post office, appointments with official persons such as the Bank Manager/ Social Worker/ Benefits Personnel

Observations:

The hideously convoluted nature of this descriptor is due to two different descriptors drawn up by the original authors of this test being merged into one—and hugely complicated—by DWP lawyers. I've tried, on the facing page, to unscramble it again.

Again the list of likely conditions in the medical guidance is artificially limited and the questions asked by the form are, frankly, not helpful.

If you can say 'yes, often' to 'do you get upset by little things/ being criticised? you should score 6 points—and this could be the case over almost the entire range of mental health diagnoses.

If you do lose it—either verbally or physically - with other people, here's the place to say so—if you feel able to describe times when it's happened then it'll give a clearer picture. Similarly if you've ever been arrested because of behaviour linked to your mental health or sectioned, then it may well be relevant to say so here.

But what the form fails to address at all—yet the descriptor specifically mentions—is 'disinhibited' or 'bizarre' behaviour; again, if when you're unwell people might describe your behaviour this way, try to explain how it impacts on them—and you.

Part 2— Mental, cognitive and intellectual functions

19. Coping with social situations continued

Use this space to tell us why you think it makes you scared or anxious to mix with other people. Tell us what makes mixing with people difficult for you

I wish I knew why I feel this way .

When I'm with other people I feel overwhelmed and paranoid—as if they're all looking at me and thinking 'what makes her think she has the right to be here'. I constantly feel like I'm intruding—unwelcome—out of place.

20. Propriety of your behaviour with other people

By this we mean behaving in a way that could upset other people

Now go to question 21.

Please tick this box if your behaviour does not cause you or other people any problems ☐

Do other people get upset with you because of the way you behave?
For example do they shout, lose their temper, argue or threaten you?

- **Often** ✓
- **Sometimes** ☐
- **Now and then** ☐

Do you get so upset by little things or by the way other people behave that it affects your daily routine?
By little things we mean things like someone calling at your home when you don't expect them, or over-reacting to being pushed or jostled in a crowd.

- **No** ☐
- **Sometimes** ☐
- **Yes** ✓

Can little things lead you to behave in a violent way?

- **No** ✓
- **Sometimes** ☐
- **Yes** ☐

20) Propriety of behaviour

- Has unpredictable outbursts of aggressive, disinhibited or bizarre behaviour, daily disrupting others*** (15)
- As above, less often but so severe that 'no reasonable person would be expected to tolerate them'*** (15)
- As above, so frequent and severe as to cause disruption most of the time*** (9)
- As above, causing frequent disruption*** (6)

OR

- Has a completely disproportionate reaction to minor events/ criticism resulting in extreme violent outburst leading to threatening behaviour or actual violence***(15)
- Has a strongly disproportionate reaction, so that cannot manage 'overall day to day life 'when events/ criticism occurs*** (9)
- Frequently has moderately disproportionate reaction but not to extent that can't manage overall day to day life when events/ criticism occurs (6)

Use this space to tell us why your behaviour upsets other people or why you get upset about things. And tell us how this happens.

People say I get everything out of proportion. Little things upset me to the point where I often end up unable to do anything because I'm in floods of tears .

21) Dealing with other people

The Regulations say:

(a) Is unaware of impact of own behaviour to the extent that: has difficulty relating to others even for brief periods, such as a few hours; or causes distress to others on a daily basis. (15)
(b) The claimant misinterprets verbal or non -verbal communication to the extent of causing himself or herself significant distress on a daily basis. (15)
(c) Is unaware of impact of own behaviour to the extent that: has difficulty relating to others for longer periods, such as a day or two; or causes distress to others for the majority of the time. (9)
(d) The claimant misinterprets verbal or non-verbal communication to the extent of causing himself or herself significant distress to himself for the majority of the time. (9)
(e) Is unaware of impact of own behaviour to the extent that: has difficulty relating to others for prolonged periods, such as a week; or frequently causes distress to others (6)
(f) The claimant misinterprets verbal or non-verbal communication to the extent of causing himself or herself significant distress on a frequent basis. (6)

The Medical Guidance says:

A variety of conditions, including autistic spectrum disorder, psychotic illness, and brain injury, which affect understanding and applying social norms of communication.
Consider in particular presence/absence of insight. It is likely that the claimant will have very little insight into their behaviour. Intelligence and cognitive function may also be important to consider.
Addictions and thought disorder will be important areas of the Mental State Assessment. Rapport is likely to be poor where these descriptors apply, establishing good communication in the interview is likely to be more challenging.
Consider activities such as: social occasions, friends and family, previous occupation and problems, conflict with authorities or exclusion from local amenities, shopping, public transport, relationship with GP/ receptionists, frequently removed from Practice lists etc.
The first descriptor also includes any situation where lack of ability to self–care and to maintain personal hygiene causes the claimant to be totally unacceptable to other people.
(Judy's comment— I have long suspected that advising people to go along to medicals unwashed / unshaven and in dirty clothes might be what it actually takes to convince EMPs of their problems— well it seems we have written confirmation of it now—in fact a brand new route to ESA… <sigh>)

Observations:

Another one of those descriptors which has become a bit of a jumbled mess thanks to the DWP lawyers - again I've done my best to untangle it on the facing page.

THREE things are being considered here then—

- any lack of insight into how your behaviour affects other people—and how long it goes on for OR
- how often your lack of insight into your behaviour causes 'distress' to others
- the frequency with which you might get worried, upset, frightened or angry because you've got the wrong end of the stick/ misinterpreted others' actions or meanings

This is one of those 'damned if you do, damned if you don't' situations—if you *agree* that you lack insight, then by definition you're being insightful… if you deny that you do, then you've just scored 'nul point'… Probably best then to try to come across simply as bemused as to why people get upset/ angry with you.

The last question on the form only ask about your getting annoyed with people quickly, whereas the descriptor phrases it as 'distressed' - which to me could cover worry/ being upset/ feeling paranoid/ persecuted or frightened too. It also makes NO reference whatsoever as to quickly or slowly— a whole *extra* test created by the form then.

Predictably, the medical guidance covers a limited range of diagnoses, ignoring the fact that

- feelings of self-doubt, guilt or worthlessness associated with many diagnoses could result in you finding negative meanings in others' words or behaviour
- that the 'shut off' depths of depression can leave you oblivious to how your behaviour is impacting on others.

The guidance also predicts that if you have these difficulties, you will find it hard to 'establish good communication' during the medical interview—oh and confirms that you could qualify for ESA simply by smelling badly enough...

Part 2— Mental, cognitive and intellectual functions

21. Dealing with other people

Please tick this box if you have no problems getting on with other people, and they have no problems getting on with you. ☐ **Now go to the next page.**

Do you get upset because you can not get on with other people?	**Often**	✓
	Not very often	☐
Does your behaviour upset other people but you don't know why?	**Often**	✓
	Not very often	☐
Do you find yourself getting annoyed with other people very quickly?	**No**	✓
	Yes	☐

10) Dealing with other people:

- Is unaware of impact of own behaviour so has difficulty relating to others for a few hours, or daily causes distress to others*** (15)
- As above— so can't relate to others over the period of a day or two or causes distress to others most of the time*** (9)
- As above- so can't relate to others over a period of around a week, or frequently causes distress to others*** (6)

OR

- Misinterprets verbal/ non verbal communication causing, to self:
- Daily significant distress* (15)
- Distress most of time*** (9)
- Distress frequently*** (6)

Use this space to tell us why you find it difficult to get on with other people, and why you get distressed , and how often this happens

I can't understand why people get so upset with me—it can go on for days . I know I often get upset by small things , but the way people react is just over the top. Their reaction makes me worse. I don't get annoyed quickly, but I do find myself get ting distressed and tearful most days because of misunderstanding things people have done or said.

. .

The Support Component:

As well as being a test of who can get ANY ESA, the Work Capability Assessment also looks at who can get what level of ESA.

Many of the things that might get you awarded the Support Component are not addressed on the ESA50 form at all.

Most of them relate to having a quite severe degree of difficulty—and indeed the Medical Guidance underlines the need for a 'severe disorder of mood or behaviour to be present' and for 'diagnosis, medication and level of Healthcare Practitioner input to be consistent with a severe disability'

HOWEVER I feel this is challengeable at Appeal level—DLA Care caselaw says that as long as you *have* a certain level of difficulty, then you ARE severely disabled—and any of us who have experience of the world of mental health services know that it is sometimes the most needy and vulnerable who are LEAST able to 'engage' with services. Take for instance some rough sleepers, or people pushed from pillar to post under the questionable diagnosis of 'Personality Disorder'…

I've tried to paraphrase the Support Component descriptors—and one other—on the facing page.

The 'one other' is the first one—i.e. that there would be 'a substantial risk to anyone's physical or mental health if you were found fit for work'. This is NOT a condition for getting the Support Component—it's a test for getting any ESA at all—which the ESA50 also fails to ask about. I've included it here because I feel that a lot of people who could say 'yes' to that could also say that there would be a substantial risk involved in having to turn up regularly at the jobcentre. go on courses, work trials etc. Have a think about it.

Medical Guidance says...

Risk—will only be applicable in claimants with severe problems. The wording of this Support Group criterion should be particularly noted. The risk to others or the person must be substantial. It refers to work related activity e.g. supported placements and training etc, not just actual work. Circumstances where this may apply may be for example in those with severe personality disorder where violence is a substantial risk or where the claimant has severe mental function problems such as florid psychosis.
(Judy's comment—as I say, REMEMBER THIS IS JUST GUIDANCE. If there is substantial risk of any sort in work-related contexts, then one or both of these descriptors could apply.)

Eating and Drinking - Should look for evidence to confirm a severe disorder—e.g. hospital admission for a claimant with anorexia who refuses to drink as well as eat. Someone with a lesser degree of depression associated with reduced appetite, who requires occasional encouragement to maintain nutrition, would not fall into the support group in this category.
(Judy's comment—what bizarre guidance! Someone who did not drink at all would pretty rapidly die. Again this BADLY needs challenging—the descriptor as it appears in the regulations says 'food or drink' not 'neither food nor drink'. Certainly if I were working with someone whose health was threatened because although they took liquids, they refused food, I would argue for this descriptor to be applied.)

Personal Action - e.g. conditions such as severe depressive illness with resulting apathy, or very severe levels of fatigue, or very severe levels of anxiety. It may be a problem in some claimants with schizophrenia.
(Judy's comment—probably one of the more useful descriptors. Again you may well have argue that if someone needs this prompting/ encouragement then by DLA definition they WOULD be deemed to be severely disabled...)

Communication—A claimant with this level of disability would struggle to communicate with a stranger—by any means—that they were in some kind of danger, and would be unable to go out in unfamiliar environments unassisted. The descriptor associated with misinterpreting verbal or non verbal communication may represent the difficulties faced by those with the more severe levels of autistic spectrum disorder or those with a severe psychotic illness. 'Cannot make self understood' relates to those with severe disorder of mood or behaviour who have virtually no ability to communicate on a very basic level with others.

The other potentially quite useful descriptor is the one about 'daily misinterpreting verbal or non-verbal communication, leading to distress' —see my comments on exactly this point on the previous page.

Any supporting evidence you can enclose from others indicating that you meet one or more of the Support Component descriptors would be particularly valuable.

Other information

Please use this space to tell us either why your form is being sent in late or anything else you think we might need to know

If any of the following apply, here would be a good place to say so:

- There would be a substantial risk to anyone's physical or mental health if you were found fit for work (which would passport you to being able to get ESA)

The medical guidance doesn't seem to recognise that the above test exists—it very clearly does in the regulations though!

Or—to also passport you to the Support Component:

- There would be a substantial risk—as above—if you were awarded ESA but had to go to regular Work Focused Interviews/ possibly attend training courses/ do voluntary work or other 'work related activity' or
- Your mental health problems lead to you losing control of your bladder or bowels at least once a week
- Your mental health problems mean you cannot keep yourself clean without help or prompting
- Your mental health problems mean you do not eat or drink, or chew/ swallow without help or prompting
- You can't learn or understand a simple task—such as making a hot drink—at all
- You have to be repeatedly shown simple tasks before you can do them—and even then would need to be shown again the next day
- You can't motivate yourself to start or sustain 'personal action' - i.e. routines/ things involving planning, organising, problem solving, prioritising or switching tasks:
    - at all; or
    - only if prompted/ reminded daily
- You cannot speak, nor write, nor type, nor use sign language to equivalent of Level 3 British Sign Language because of your mental health
- You daily misinterpret verbal or non verbal communication, leading you to feel distressed
- You can't make self yourself understood—or, arguably—could be misunderstood—because of being psychotically unwell

What next?

Medical Assessment

You are usually required to attend a medical interview as part of the Work Capability Assessment. See the sections at the end of this chapter about the Atos Medical service and attending a medical.

The interview is in two parts. One of these is an interview which will later be used by a DWP Decision Maker to decide:

- whether you can continue to get Employment and Support Allowance and
- if you can, which Component of ESA you will get on top of the basic rate.

Work Focused Health Related Assessment

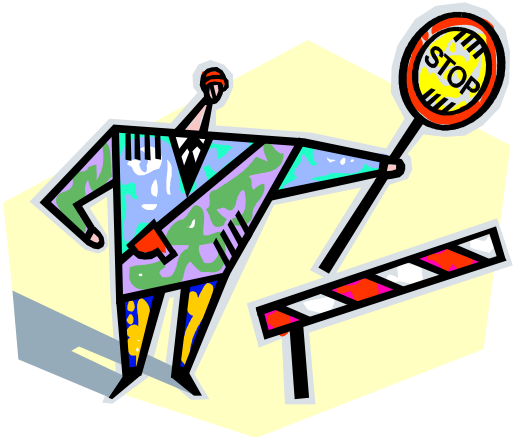
A second interview—a 'Work Focussed Health Related Assessment' with another medical professional —also takes place—usually separately, and potentially by telephone - to look at the extent of your capability for work.

It focuses on things like your barriers to getting and keeping work, possible adaptations which could make it easier for you to work, whether you might benefit from a 'Condition Management Programme' and so on. Taking part in this interview is part of the 'conditionality' of ESA and if you don't, you could find your money being cut as a result.

A report drawn up as a result of this Interview is sent to your DWP personal adviser to be looked at within Work Focused Interviews. Assurances have been given that it won't be used as evidence in deciding if you are well enough to work or not.

Which Component of ESA?

The Support Component:



Some ESA claimants receive the Support Component of ESA.

The Government say these people are 'the most severely sick and disabled'. Around a third of people getting ESA fall into category—a far higher proportion than originally envisaged because more people are being found fit for work.

The decision as to who gets the Support Component may be made from:

- Information gathered before you attend the medical assessment interview and/ or
- Information gathered at the medical interview.

Some people are 'deemed' to pass the test for receipt of the Support Component, others get it because they meet certain levels of illness or disability. The criteria for both are listed overleaf.

Getting the Support Component gives you two major advantages—firstly you are paid a little more ESA than other claimants and secondly you are exempt from having to attend Work Focused Interviews (although you can opt to get help with staying in or finding work).

CONCERNS:

The Government say they hope that most people who end up getting the Support Component will be identified from initial information gathering but the loss of group exemptions inevitably means more vulnerable people now having to face interviews.

Under the old system, the many bad assessments and decisions surrounding entitlement to sickness - route benefits happened at the fringes of entitlement: Was the claimant well enough to work or not? And as a result those who missed out were, in theory at least, the 'weller' sick.

ESA however has created a two-tier scheme *within* the world of accepted and acknowledged ill health, where those adversely affected by bad assessments and decisions about Support Component entitlement are, by definition, *the most severely sick and disabled.*

Limited Capability for Work Related Activity

(i.e. eligibility for Support Component)

Physical health:

- Has a progressive disease and can reasonably be expected to die within 6 months
- Receiving/ recovering from chemotherapy—to include 'likely to receive' in the future
- There would be a substantial risk to anyone's physical or mental health if found not to have limited capacity for work related activity
- Is pregnant and there is serious risk to the health of mother or unborn child if she does not refrain from work-related activity

1) Moving on level ground (with aids)

- Cannot walk, move, or manually propel wheelchair more than 30m without repeatedly stopping, experiencing breathlessness or severe discomfort

2) Rising from sitting/ transferring
Cannot both:

- Rise from sitting to standing

AND

- Move from one seat to another alongside without help

3) Lifting and carrying with upper body/ arms

- Cannot pick up and move half litre carton of liquid with either hand

4) Reaching

- Cannot raise either arm as if to put something in top pocket of jacket

5) Manual Dexterity

- Cannot, with either hand, turn a star headed tap
- or pick up a £1 coin

6) Continence (not enuresis)

- Has no voluntary control over bowels
- Has no voluntary control over bladder
- Involuntary evacuation of bowel or bladder at least once a week
- Cannot fix, remove or empty urinary collecting device or stoma without help from another person or leakage

7) Maintaining Personal Hygiene
Cannot cleanse torso (not back)

- Without help
- Without repeatedly stopping, experiencing breathlessness or severe discomfort

8) Eating and Drinking
Cannot move food or drink to mouth

- without help
- without repeatedly stopping, experiencing breathlessness or severe discomfort
- Cannot chew or swallow food or drink
- Cannot chew or swallow food or drink without repeatedly stopping, experiencing breathlessness or severe discomfort

9) Communication

- Can neither speak, nor write, nor type so as to be understood by strangers, nor use sign language to equivalent of Level 3 British Sign Language

N.B. ALL SUPPORT COMPONENT CRITERIA ARE LIKELY TO ALTER DURING THIS BENEFIT YEAR—
see pages at end of chapter for planned changes

Mental health:

- There would be a substantial risk to anyone's physical or mental health if found not to have limited capacity for work related activity

1) Continence (not enuresis)

- Involuntary evacuation of bowel or bladder at least once a week due to severe disorder of mood or behaviour

2) Maintaining Personal Hygiene

- due to severe disorder of mood or behaviour cannot cleanse torso (not back) without physical help or regular prompting

3) Eating and Drinking

- due to severe disorder of mood or behaviour cannot move food or drink to mouth without help or regular prompting
- cannot chew or swallow food or drink without physical help or regular prompting

4) Learning/ comprehending tasks:

- Cant learn or understand simple task such as preparation of a hot drink at all
- Must be repeatedly shown a simple task and need to be shown again the next day
- Cannot do either of the above because of a severe disorder of mood or behaviour

5) Personal action:

- Can't initiate or sustain any personal action (planning, organising, problem solving, prioritising, switching tasks)
- Can't initiate or sustain personal action without daily verbal prompting from another person in the presence of claimant
- fails to initiate or sustain basic personal action without daily verbal prompting owing to severe disorder of mood or behaviour

6) Communication:

- Can neither speak, nor write, nor type, nor use sign language to equivalent of Level 3 British Sign Language because of a severe disorder of mood or behaviour
- Daily misinterprets verbal or non verbal communication causing distress to self
- cannot make self understood to others because of disassociation from reality owing to severe disorder of mood or behaviour

The Work Related Activity Component:

People who are accepted as eligible for ESA (i.e. those who score 15 points) but who do not meet the criteria for the Support Component receive the Work Related Activity Component instead.

This pays less than the Support Component and—in many cases—less than the 'old' sickness route benefits did.

To keep the Work Related Activity Component you will be expected to attend and participate in Work Focused Interviews, Work Focused Health Related Assessments and, in the future, some form of Work Related Activity.

If you do not comply with the above then your Work Related Activity Component can be withdrawn in two slices—50% followed by a further 50% after 4 weeks.

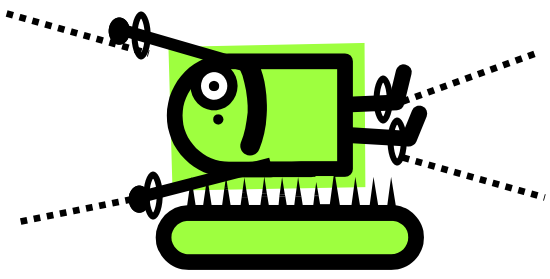
The decision to do this is appealable—get advice! Once you 'comply' the component will be re-instated in full, but not backdated.

CONCERNS:

Some people who should be on the Support Component end up on the WRAC.

They—and others—can struggle to meet the conditionality of the WRAC and as a result *could* end up no better off than Jobseekers.

Others struggle to put a brave face on their difficulties and could end up pursuing unsustainable work related activity only to fail—along with the negative impact on their mental health, self esteem and confidence.



How Much does ESA pay?

Contributory ESA:

Claimant 16 to 24:	£51.85*/ £65.45
Claimant 25+	£65.45
Plus either one of:	
Work Related Activity Component:	£25.95
Support Component	£31.40

*lower figure during first 13 weeks of claim

Income Related ESA:

Personal Allowances:	
Single claimant 16 to 24:	£51.85*/ £65.45
Single claimant 25+	£65.45
Lone parent aged 16 or 17	£51.85*/ £65.45
Lone parent aged 18+	£65.45
Couple one or both aged under 18	varies
Couples both aged over 18	£102.75

*lower figure during first 13 weeks of claim

Plus the highest of these:	
Work Related Activity Component	£25.95
Support Component	£31.40
Pensioner Premium £67.15 (single)	£99.65 (cpl.)

*lower figure during first 13 weeks of claim

Plus any/ all of these premiums:	
Carer's	£30.05
Severe Disability	£53.65
Enhanced Disability	£13.65(single) 19.65 (couple)

See 'Means Tested' Chapter for more details

CONCERNS:

Although the Government promised otherwise, many people are actually worse off on ESA than they would have been under the old system through loss of age additions/ dependant additions

Having no equivalent of the old 'couple' rate for Disability Premium is a further significant cut.

Setting the amounts for Contributory and Income Related ESA at exactly the same rates mean some people losing out on passported benefits like the Social Fund and free prescriptions.

Supporting Evidence for sickness-route benefits:

Supporting evidence will help at several stages in a claim:

- If it's decided someone does not have good cause for not attending/ participating in a Work Focused Interview— in which case see the 'good cause' table earlier in this chapter
- To suggest exemption or deemed Incapacity (Incapacity Benefit/ Income Support only) or 'treated as' Support Component/ Work Related Activity (Employment and Support Allowance)
- To accompany an IB50 (Incapacity Benefit/ Income Support) or ESA50 (Employment and Support Allowance) form used to assess someone's initial or continuing entitlement to benefit
- When a decision about entitlement to benefit needs to be challenged
- When a decision about which component someone should receive needs to be established or challenged (Employment and Support Allowance only).

Providing supporting evidence that directly addresses the point in question can make a claimant's path to benefit so much easier, possibly avoiding attendance at medicals/ work focused interviews/ disallowance or reduction in benefit.

To suggest exemption from PCA (Incapacity Benefit/ Income Support only) or 'treated as' entitled to ESA/ Support Component entitlement (Employment and Support Allowance)

Incapacity Benefit/ Income Support	Employment and Support Allowance
People can be exempted from the Personal Capability Assessment either because they get *DLA at the Higher rate of Care* or because they have a 'Severe Mental Health Problem' - '*an illness which severely and adversely affects someone's mood or behaviour and which severely restricts their social functioning or awareness of their immediate environment.*' People can also be deemed to pass the PCA because there is *'a substantial risk to anyone's physical or mental health' if they were found fit for work.* If someone has received an IB50 and you know any of the circumstances apply, try picking up the telephone to the DWP first—it may save you having to write. Certainly exemption based on receipt of DLA higher Care should be easy to clarify by telephone. No one is exempted from the Work Capability Assessment but people can be 'treated as' entitled to ESA—see list on page 47—or to ESA *and* the	Support Component—again listed on page 47. If you think any of these apply to someone you're supporting, try picking up the telephone to the DWP —it may save a lot of hassle.
To allow exemption on grounds of severe mental illness or if arguing risk grounds for 'deemed' status the DWP technically need *medical* evidence—e.g. from a psychiatrist, GP, CPN, Psychologist, Occupational Therapist, Nurse Therapist. If you can't provide this yourself can you arrange for someone else to? See overleaf for suggested wording.	

Dear Sir/ Madam, I write with concern regarding my patient Mr I.M. Blue of 26 Down the Road…. and his continuing claim for **Incapacity Benefit**, which I understand is currently being reviewed. Mr Blue has been suffering from clinical depression for the last 4 years. His illness severely affects his social functioning and ability to deal with everyday life; his lowness of mood will regularly lead to reduced awareness of his environment and he is withdrawn and isolated. Our CMHT welfare rights adviser tells me that this might suggest he should be treated as passing something called the Personal Capability Assessment? I know that having to attend any form of assessment would be nigh on impossible for him and hope that this information is helpful to you. Please do not hesitate to contact me if you need further details Yours, I.M.A. Jabber—Community Psychiatric Nurse	Dear Sir/ Madam, I write with concern regarding my patient Mr I.M. Blue of 26 Down the Road…. and his claim for **Employment and Support Allowance.** Mr Blue has been suffering from clinical depression for the last 2 years, has been receiving counselling for the last 3 months but has struggled to continue claiming Jobseeker's Allowance until recently. His illness is considerably worsened by any form of stress and his health has deteriorated significantly over the last weeks as he has struggled to claim ESA and deal with a long Jobcentre interview about his health which he found very distressing. Our CMHT welfare rights adviser tells me he faces many more of these unless he is awarded something called the 'Support Component'. I write to ask you then to postpone any further interviews and consider whether he may be eligible for this. I certainly have grave concerns regarding further deterioration in his health if he has to continue to engage with your department as at present. Yours, I. Listen — Nurse Therapist
Dear Sir/ Madam, I write with concern regarding my patient Mr I.M. Blue of 26 Down the Road,... and his ongoing claim for **Incapacity Benefit and Income Support.** Mr Blue has been suffering from clinical depression for the last 2 years, has been receiving counselling for the last 3 months but has struggled to continue claiming Jobseeker's Allowance until recently. His illness is considerably worsened by any form of stress and his health has deteriorated significantly over the last weeks as he has struggled to focus on something called an IB50. Our CMHT welfare rights adviser tells me he faces considerably more stress if found fit for work and is forced to claim as a Jobseeker. I hope this information is useful to you—I also addend a detailed report based on what our Welfare Rights Adviser tells me are the points relevant to his Incapacity status. Yours, I. Adapt—Occupational Therapist	Dear Sir/ Madam, I write with concern regarding my patient Mr V.Cross of Red Rag Street… and his claim for **Employment and Support Allowance**. Mr Cross has a borderline personality disorder and associated difficulties with anger management. He has had numerous compulsory admissions to hospital and has been detained in custody on several occasions because of incidents linked to his diagnosis. Our welfare Rights Worker tells me that until recently he was exempted from sickness route assessment due to his DLA award, but a break in his sickness benefit claim whilst he disastrously tried a spell of work means he now falls under new rules. I can confirm that there would be substantial risk –both for him and potentially for others—if he had to deal with a long assessments, interviews or work focused activity. Yours, I. Label — Consultant Psychiatrist

- To accompany an IB50 (Incapacity Benefit/ Income Support) or ESA50 (Employment and Support Allowance) form used to assess someone's initial or continuing entitlement to benefit OR
- When a decision about entitlement to benefit needs to be challenged

Think descriptors - i.e. the 'points scores' listed earlier in this chapter—is the golden rule if you've been asked to provide supporting evidence for someone to go with their forms or for a revision or appeal challenge to a decision. The only way the decision maker or Tribunal can use your evidence will be by 'sorting' it and 'scoring' it according to the descriptors.

You can put it in your own words and add whatever you like on top, but make sure that the basic evidence is there and that it adds up to at least the score your client needs.

Like most people, Tribunals and DWP Decision Makers are impressed by the top and bottom bits of letters - the notepaper and letters or titles you can put before or after your name! It's in this respect that the powers of lowly Welfare Rights Workers (mere Members of the Institution of the Persistently Argumentative) pale into insignificance.

Medical evidence is best, and as a rule the more impressive the qualification of the person signing the letter the better, but letters from social workers, mental health or community workers, carers etc, can all go some way towards avoiding medical examinations or challenging bad decisions.

To:
The Chair of the Tribunal
Re. Mrs. Ann Zeity,
NI no AB 12 34 56 C
Dear Sir/Madam,

I have known Mrs. Zeity for three years now in my capacity as her ..... Mrs. Zeity has also been seeing ..... on a regular basis during this time. She takes ..... and .....

I understand that she has lost her **Incapacity Benefit** and been found fit for work.

Having worked closely with her for some time now, I can confirm that because of her mental health problems Mrs Zeity suffers from poor concentration, often sits for hours doing nothing and cannot concentrate to read a magazine or to watch television. She becomes very anxious when the 'phone rings and will often not answer it unless she is expecting a call from someone she knows. She will not answer the door unless she knows and trusts the person who is calling - indeed she hides if she hears an unexpected knock.

Mrs Zeity suffers from frequent panic attacks in her home and is too frightened to go out alone. Although we have been working with her to try to overcome this fear for some time now, she is still quite unable to go out without the support of someone she trusts. She is very upset by her anxiety and chooses to avoid other people if she can - she feels she can no longer communicate with them and is embarrassed by her own behaviour when she becomes scared. She is convinced, as am I, that a return to work would worsen her anxiety.

Yours,

Dear Sir/Madam,

I write regarding Mr P of ..... with whom I have worked for some time now in my capacity as a Counsellor at ..... I understand that as well as his mental health problems, Mr P also suffers from Irritable Bowel Syndrome. I understand his **Incapacity Benefit/ Income Support** entitlement is being reviewed.

Mr P is unable to go out unless supported, encouraged and accompanied because of anxiety. This, obviously, has a knock on effect on his ability to communicate and to socialise as well as to keep appointments etc. The anxiety symptoms he experiences affect him to such a degree as to leave him cut off from his surroundings, almost in a state of collapse and unable to ask for help. His symptoms include derealisation, giddiness, nausea, loss of bowel control and profuse sweating, necessitating physical help with toiletting and personal hygiene both at home and outdoors as well as support and guidance to deal with other anxiety symptoms. At night, anxiety and depressive thoughts intrude on his ability to get to sleep.

He finds it very hard to eat as regularly as he should because of anxiety and nausea, and requires repeated prompting and encouragement to do so. His wife also has to encourage and support him in order to enable him to attend and communicate during appointments - he finds talking to anyone difficult, but talking about himself particularly hard.

The limiting effects of his difficulties mean that Mr P suffers from periods of feeling very low in mood, spends much time crying and also self-harms. At other times, his anxiety results in aggressive behaviour, putting himself at risk of injury.

In terms of the precise points I understand you consider when looking at someone's capacity or otherwise for work, I have no doubt that Mr P's difficulties would, at present, severely impinge on his ability to hold down paid employment and feel, as does he, that any attempt at work would worsen rather than improve his state of health.

Indeed I suspect that it is largely because of the communication problems he experiences that he has been found fit for work in the first place; it has taken a considerable time even within the counselling relationship for Mr P to be able to be open about the symptoms he has, and I know that he has also experienced difficulties communicating with others of my colleagues.

These difficulties with communication affect him within his home as well as when dealing with strangers; in fact it is extremely rare for him to even feel able to pick up the telephone because of his anxieties. As previously stated, much of Mr P's day is spent in an inactive state, with him feeling unable to motivate himself to be productively active in any way. As a result of his low mood and previously mentioned poor sleep patterns, he feels extremely lethargic in the mornings and has to be encouraged to get up and dress.

For him to start any activity requires much prompting and encouragement and tasks begun will either be abandoned because of feelings of tiredness and frustration, or will become all-consuming, triggering checking rituals because of his anxiety. Indeed he has considerable problems with obsessive checking rituals which in themselves require support, intervention and prompting to enable him to be productively active or accomplish basic tasks. He describes routines as being very important to him in coping, and becomes quite distressed if something out of the ordinary or unexpected happens to impinge on those routines.

Mr P's mood can change very rapidly, turning from feelings of depression and anxiety to frustration and aggression in minutes; his wife describes how even a relatively everyday task such as trying to look up a phone number, or simply finding some fault with a meal can frequently lead to items being flung across the room.

His concentration and tolerance levels have dropped dramatically, and he is no longer able to participate in social activities or previous hobbies he undertook such as rugby and photography. His anxiety and poor concentration also mean that he is not as aware as he might be of common dangers; indeed I understand that shortly before he had to finish work he caught his hand in a guillotine when concentration was lost.

I hope this information will be helpful to you in reaching your determination,

Yours,

Dear Sir/ Madam,

Please excuse the handwritten nature and brevity of this letter but I am writing it during a busy surgery.

I understand from Mr Green that he has recently been turned down for ***Employment and Support Allowance****. Having hastily conferred with our practice Adviser as to the criteria used in these decisions I can confirm that due to his Post Traumatic Stress Disorder Mr Green frequently experiences completely disproportionate reactions to minor events resulting in extreme violent outbursts and threatening behaviour.*

Additionally social situations and visiting unfamiliar places are impossible for him most of the time—he has not 'socialised' for two years and he has to have company whenever he visits the surgery.

Please give this information your immediate attention.

Dr V. Busy—General Practitioner

Dear Sir/ Madam,

I am writing on behalf of Mr D. Stressed , NI no. DD 33 44 55 C. Mr Stressed, a lone parent has a diagnosis of Obsessive Compulsive Disorder. I understand that he is applying for **Employment and Support Allowance.**

I have been seeing Mr Stressed for 3 months now, using Cognitive Therapy to try to ameliorate his symptoms. He has made some but not considerable progress and the structures of our service means that our contact will soon end.

Having conferred with our Welfare Rights Adviser as to the criteria used in assessment for this benefit I can confirm that due to his OCD Mr Stressed daily takes more than twice as long as would normally be needed to complete everyday, familiar tasks such as keeping his home clean and tidy, dealing with washing and ironing, making shopping lists, dealing with correspondence etc. His progress with such activities is hampered by the need to repeatedly count and check things, perform tasks in a certain order or a significant number of times.

He is heavily reliant on routine and cannot cope with minor unexpected changes—e.g. if I have needed to vary the time of an appointment at very short notice he has been unable to alter his own routines to attend. His day to day life is made significantly more difficult as a result.

He also has a phobia of germs/ contamination and as a result social contact is impossible for him due to overwhelming anxiety.

Mr Stressed has lived with these difficulties for many years now and I do not—given the limited impact our contact has had—expect things to change significantly for him in the foreseeable future.

I hope this information will be useful for you

I. C. Patterns—Cognitive Behavioural Therapist

Dear Sir/ Madam,

Excuse a note scribbled on the back of an appointment card but I am visiting Martin this morning and understand he is seeing you about his **Employment and Support Allowance** this afternoon. He is very worried about this as he fears that you and the Government are part of a dark force persecuting him.

I understand that he may have indicated that he suffers from depression on his form, but he was diagnosed with schizophrenia when he was 18— 7 years ago. Anti Psychotic medication only partially controls his symptoms and he still experiences paranoid ideation and intrusive auditory hallucinations when stressed. Negative symptoms include lack of motivation with self care and inappropriate and flattened responses to social contact.

His delusional thinking means that he frequently misinterprets both verbal and non verbal communication causing him considerable distress and also frequently has unpredictable outbursts of disinhibited and bizarre behaviour.

I hope the appointment goes well.
I.M. Rushed, CPN

Note that this 'letter' only definitely identifies 12 of the 15 points Martin needs with a hint of a further 6. Ms Rushed needs to be more explicit about Martin's difficulties with social contact or consult her Big Book more closely!

- When a decision about which component someone should receive needs to be established or challenged (ESA only).

Establishing Support Component entitlement within ESA (and thus gaining your client both extra money each week and freedom from Work Focused Interviews) requires a very similar approach to writing supporting letters for basic entitlement to benefit.

However instead of using the points scores listed for physical or mental, intellectual and cognitive functioning, it's the list relating to 'Limited Capability for Work Related Activity' that you need to consider. No points scoring or addition here— fitting your client to any ONE of the conditions is enough to establish Support Component entitlement.

The conditions are though very limited and you might find it easiest to argue 'substantial risk to self or others if not found to have limited capability for work related activity' either alone or to back up other possible grounds.

Dear Sir/ Madam,

I am writing on behalf of Ms D Seal, in my capacity as an Approved Social Worker. Ms Seal has a diagnosis of bipolar disorder.

I understand that she recently attended a medical assessment as a result of which she has been awarded the Work Related Activity Component of Employment and Support Allowance. I write in connection with her request for a revision for this decision and in the light of a disastrous week since she attended the Jobcentre for an interview.

At the interview she eagerly accepted referral to a Condition Management Programme which, frankly, is wholly inappropriate for someone with her diagnosis. Since being asked to consider her options for self employment she has obtained a substantial loan secured on her home with which she plans to set up a dating agency and by the time I called to see her had already committed £3,690 to printing brochures, business cards and letterheads. She had also been trawling internet chatrooms looking for potential customers and had given her name, address and bank details to several complete strangers who wanted to 'make direct deposits'.

I hope you can appreciate then that her delusional thinking is such that she daily misinterprets verbal and non-verbal communication, causing distress and potential harm to herself. She is also often misunderstood by others due to her disassociation from reality.

I feel certain that there will be an ongoing and substantial risk to her health if she continues to have to engage with the delusion that she is fit for work-related activity and trust you will give this matter your urgent attention.

In the meantime could you also please advise me as to how to register a complaint regarding the medical assessment and how to seek compensation, given that my client's considerable financial loss resulted directly from it.

Yours,

I. Rate— Approved Social Worker

Dear Sir/ Madam,

I am writing on behalf of Mr. B. O'Connell in my capacity as his Community Psychiatric Nurse. Mr O'Connell has longstanding diagnoses of Schizoaffective Psychosis and alcoholism. He had been living rough for eighteen years before recently being housed and now needs to claim Employment and Support Allowance.

He is continually bothered by intrusive visual and auditory hallucinations and his mood is extremely low. His personal care is affected by this - his lowness of mood, negative symptoms associated with his psychosis and conviction that there are 'signals in the plumbing' stop him washing, a problem compounded by regular bladder incontinence linked to his long misuse of alcohol. He is also occasionally incontinent of bowel.

Should Mr O'Connell need to be assessed by your doctor I will be glad to arrange to accompany him. In the meantime I hope this information is helpful to you.

Mr B. Stone CPN

Dear Sir/ Madam,

I write regarding Miss Heledd Llewellyn who has been a patient of ours for 2 years now. She recently left school and is in the process of claiming Employment and Support Allowance.

Heledd has a diagnosis of Anorexia and has had to be hospitalised on three occasions when her weight has dipped to a dangerous level. Her eating has to be carefully monitored and she requires much encouragement and support in this area.

I understand from our Unit's welfare rights worker that one of the criteria for receipt of the Support Component is being unable to swallow food without regular prompting and wonder if her difficulties might qualify her under this route?

She also self harms and has expressed suicidal ideation from time to time.

She is generally withdrawn and finds engaging with strangers difficult and distressing. All in all then I believe that there would be a substantial risk to her mental and, potentially physical health if she was to be required to engage with work related activity.

Yours,

S. Owens SHO

Medical Assessments:

Around 60 percent of people completing an IB50 form will be asked to attend a medical examination. This figure rises steeply for people with mental health problems. Around 90% of people completing an ESA50 form will be called for a medical.

A company called Atos Origin are paid to provide these services by the DWP. Not all of their medical assessors are bad, and not all medical examinations result in people losing their sickness route status. The picture welfare rights workers get of the system is probably skewed by the fact that we are never contacted for help by people who keep their benefit, who found the doctor charming and sympathetic, and who felt they had been given plenty of time to explain their difficulties...

It should also be remembered that at the end of the day, the actual decision on incapacity status is taken by a DWP Decision Maker who DOES have the power to question and discount the medical service's choice of descriptors - but in practice it seems rare for them to do so.

A high proportion of decisions finding people fit for work are overturned at appeal; time and time again appeals are won simply because the quality of the medical reports are poor and therefore easily challenged. Assessors are required to justify their choice of descriptors and where they have failed to do so properly, the DWP decision maker simply shouldn't accept them in the first place. To try to counter this, 'mouse-driven' interviews were introduced in 2003 where computer software prompts the assessor, with the hope of reducing the subjectivity in the process—see next page.

As well some reports being inaccurate or inconsistent in their findings, there are many all-too-real horror stories about some examinations being cursory at best, distressing and insulting at worst. If you feel your medical examination was not conducted properly, then jot down the details whilst it's still fresh in your mind and consider complaining. It's also worth recording how long the interview lasted; this sort of information can be very valuable when it comes to appeal.
The administration of the mental health part of the assessment seems particularly fraught with problems. The assessor will not usually ask you directly about the mental disability descriptors, but will draw his or her conclusions from other questions - e.g.. a positive response to the question "Do you speak to your mother on the phone?" has later resulted in a doctor deciding that the claimant can take a telephone message reliably! Another woman who mentioned that she was stressed was told "Not today you're not - I'd have to fill more forms in."!!

Another doctor examining a claimant with a bad back as well as mental health difficulties decided that because she has varnished toenails her back problem didn't exist. Had he chosen to ask her about this at the time he would have found that her grand-daughter visited every Sunday and loved to paint Gran's toenails - but he just jumped to his own (wrong) conclusion.

It's also worth remembering that there is benefits case law which states that evidence from a claimant's own doctor should be given more weight than that of a doctor who has only met the claimant once. Unfortunately though, because GPs have been told by the DWP that there's no longer any need for them to be involved in sickness route decisions, it can be difficult to get supporting letters from them. It's still worth trying though! However, tribunals will often value supporting evidence from other mental health workers… as long as they relate to the descriptors!

Attending a medical and how to complain...

A high proportion of people completing an IB50 or ESA50 form concerning mental health problems will then be invited to a local centre for an interview with a health professional contracted to carry out services for the DWP.

Appointments are more often than not now initially agreed by telephone before confirmation is sent out. Our local 'medical boarding' office will usually allow one change of appointment but are less helpful if you ask for two, saying the 'computer won't allow it'. When we persisted though because a complication was no fault of the claimant's, the computer seemingly changed its mind… be polite but persistent…

If you are asked to attend, it doesn't mean that what you've said on your form has been disbelieved in any way - it's just another step in the assessment process - albeit one that can feel like quite a threatening one. If you feel you couldn't attend at the Centre, you can ask for a home visit - although they are likely to want some 'back up' before agreeing to this - e.g. from your GP. Ring the number on the letter that came about the examination and ask them about this.

If you feel that you may have difficulty explaining your problems to the examining medical practitioner in person, it may be helpful for you to take along copies of your IB50/ ESA50 and any supporting evidence which you can leave with them. You might also want to take a friend with you for company/ moral support.

Be aware that they will be looking for information relating to the mental health 'points' even though they may not ask you direct questions about these - indeed they often draw their conclusions from what might feel like 'friendly chit-chat' to you.

Although he or she may WELL be a friendly person, at the end of the day they have a time limited slot in which to collect the evidence they need for their report. Try to answer their questions as fully as possible, stressing any limitations you experience- e.g. I speak to my family on the phone but I always ring them. I don't pick the phone up if it rings unexpectedly...'

You may also find that the person conducting the interview is spending a lot of time looking not at you but at a computer screen. This is because they work with computer software designed to prompt them to consider the descriptors which might be expected to apply, given your diagnosis. If they choose to 'over-ride' the suggestions made by the computer, they have to explain why in their reports. Being distracted by a computer does not improve communication and resulting reports have been criticised as being both impersonal and inconsistent. One benefit however is that the report is at least printed rather than in handwriting that needs to be deciphered before you can read it...

You have a right to be treated courteously and with respect and the report that goes back to the DWP should be an accurate record of what happened.

Not many people complain—Welfare Rights Workers suspect that when people realise that they have been found fit for work, they get tied up coping with the DWP's Appeal procedures and often don't find the time or energy to complain about the medical assessment directly, even though it's from there that many of the disallowances stem.

If you are unhappy in any way about the service you receive, please do try to find the support you need to complain to Atos about it, because as far as they seem to be concerned, low complaints levels suggest that there can't be much wrong...

Leaflets on how to complain should be available at the Centre you attend, or by telephone request from your regional office. Advice Agencies will be able to help you get in touch and put your complaint into words.

What Can be Done when Sickness Status is Lost?

You can:

- ☞ GET ADVICE! And if possible arrange for representation... Statistically, people who are represented at their Appeal have a far better chance of winning!
- ☞ Accept the decision and consider any other route you may have to receiving benefits—e.g. claiming as a Jobseeker (signing on, carrying out Jobseeking activities etc), or as a carer if you look after someone who gets either DLA at the appropriate rates or Attendance Allowance. Remember though that you may get less weekly money this way and that a very high percentage of people found fit for work DO get the decision altered in the end.
- ☞ Decide to challenge the decision. You can do this by:
    - Writing to the DWP asking for a revision within one month of getting the decision. A revision—the DWP taking another look at the decision on paper —can be faster than an appeal, but in our experience very few sickness route revisions are successful. Don't be daunted if the decision is not changed at this stage. AND/ OR
    - Using an appeal form—available from any DWP office—to ask for an Appeal. Again you must do this within one month of the decision finding you fit for work, or within a month of a letter telling you your Revision was unsuccessful.
- ☞ Under the 'old' route you can also claim Income Support (at a reduced level) between the time an Appeal has been lodged and the hearing. Within ESA you can receive it at assessment phase level—i.e. minus the 'Components' pending appeal.
- ☞ If you don't already get it, claim Disability Living Allowance. A successful claim will help to replace lost income and restore entitlement to the Disability Premium within Income Support/ Jobseekers Allowance. Unfortunately it will not restore Components within ESA.
- ☞ Request copies of the medical report and the Decision Maker's decision from the DWP. These will make it easier to see why you have been found fit for work and will help when you start to challenge the decision.
- ☞ Seek / provide what supporting evidence you can—from Consultant, GP, CPN, Social Worker, Drop-in worker etc. Give them a list of the 'descriptors' and ask them to comment on them as specifically as they can, as they apply to you. Send these to the Appeals Service.
- ☞ If you feel unable to attend a tribunal, you can ask for it to be held 'on the papers' and either prepare a 'statement of evidence' yourself or with help—but statistically you have a far better chance of 'winning' if you attend the Appeal. You can also ask people to go with you or instead of you to speak on your behalf.
- ☞ If there are any health problems the old claim didn't address, or your 'old' health problem gets worse, you can apply again whilst waiting for your appeal to be heard.
- ☞ Contact your MP and tell them what being found fit for work has done to you, your family and your health. The harsh new rules of ESA will never be changed unless there is political pressure to do so.

So What's the Big Deal?

The Consequences of Losing Sickness Route Status:

Failing the Personal Capability Assessment or Work Capability Assessment means that you lose all entitlement to sickness route benefits.

Even though being found fit for work does not automatically bar you from receiving Disability Living Allowance, losing sickness route status can also sometimes lead to a 'review' of your DLA, no matter HOW long it was initially awarded for. It IS possible to be left with no income at all. More usually it means people being forced to sign on as unemployed, claiming Job Seeker's Allowance, unless they have another route to benefit.

The problem with JSA is that it pays less and if you were relying on Incapacity Benefit or contributory ESA—e.g. because your partner was working—you lose your own benefit altogether due to the means tested nature of JSA. Around half of those who come off ESA will not be able to get any other earnings-replacement benefit.

And as we've already seen it's quite possible to have serious problems but still be found fit for work - and yet to qualify for Job Seekers' Allowance you have to meet a stringent set of criteria.

There are many examples of people being found fit for work and yet being told by Job Centre based staff that they are not well enough to be actively seeking work. In addition, heavy financial penalties can be imposed on people who find it impossible to comply with various 'job seekers directives'. See the means-tested benefits chapter for information which might be useful if you end up on JSA.

The effect of losing sickness route status can also be distressing and humiliating - to find yourself seemingly branded a cheat or a liar. We are aware of cases of hospital admissions and even suicide attempts when people have been wrongly found fit for work.

People who lose their sickness route status do, of course, have a right to appeal, and are often vindicated by the result, but have to wait months on reduced benefits before their case is heard.

And although many decisions are overturned at appeal, some people never get this far in the system. It is likely that a large proportion of these simply feel too anxious or intimidated by the process to do so.

The other consequence of bad decision making is the chip-chip-chip effect it has on people's confidence in the system which is theoretically there to support you when you most need it.

Perhaps you've not been wrongly found fit for work, but if you spend time with other people with mental health problems, chances are you know someone who has, and who has had to go through the considerable ordeal of challenging that decision.

This in turn can leave you living in dread of the next time the IB50 or ESA50 drops through the letterbox... and increase your anxiety about going for the medical, so that by the time you're there, you're not able to answer the questions the doctor asks as fully as you'd like to... As a result you're found fit for work...

The sickness route to benefits for people with mental health problems has been an unfair mess for years. Only drastic reform would have restored people's confidence in the system…

Unfortunately the reforms of 2008 have been drastic in completely the wrong way...

ESA Appeals

The early statistics emerging on ESA adjudication have revealed:

- A *much* higher disallowance rate than predicted by the Government
- A *much* higher than predicted proportion of the people actually *passing* the WCA then going on to be awarded the Support Component—presumably partly due to the fact that so many people are actually being found fit for work that there are far fewer left to be awarded the Work Related Activity Component.
- A disappointing level of success at appeal.

Anecdotally though, the experience of Welfare Rights Advisers from across the UK meeting in Cardiff in March 2010 was that *with representation,* people still have a *very* good chance of having their ESA appeal allowed.

Why is this happening?

It is possible of course that because people can go on receiving the assessment phase rate of ESA whilst waiting for their Appeal to be heard, fewer of them are actually seeking advice/ representation than would have normally done so under the old system.

It is also possible that because people are undergoing medical assessment earlier in their claims than under the old system, they have not yet had time to be referred through to specialist providers of mental health services—and the access to:

- more precise diagnosis
- signposting to advice services
- potential for better supporting evidence

that is often associated with this.

It is also possible that tribunals— lacking confidence with the new legislation and without the body of caselaw to help them interpret and apply particular descriptors—are being less inquisitorial and more ready to fall back on what is before them on the day— e.g. the ESA85 medical report.

Happily, tribunal's uncertainty as to how to deal with ESA also means that they—again anecdotally— seem on the whole to be very ready to be guided through the legislation/ hearing by appellants' representatives.

What can I do if found fit for work under ESA?

Firstly, to make sure that you keep receiving some money wherever possible, read the 'what can be done when sickness status is lost?' page earlier in this chapter.

Then, if you decide to go ahead and appeal against the decision finding you fit for work, *seek advice and representation as soon as you can.. Statistically, people who have representation do FAR better at appeals than people who don't.*

Of course many claimants are more than capable of gathering together their own evidence and arguments—but even so I would *still counsel seeking advice.*

Your representative isn't there to take over from you— you of course remain the person central to the appeal and—even with representation - the tribunal will certainly want to hear directly from you—and quite possibly at length!

But good representatives will have the broader benefits knowledge, experience of appearing before a tribunal—and, to an extent—the detachment to almost invariably be an useful aide on the day. It is, after all, possible to be *too* closely involved in the hearing—and tribunals do not *always feel* like the enabling, independent arena they should be. Understandable feelings of frustration, upset, anger, nervousness and fear can then all easily bubble up when we feel in such a vulnerable situation, impacting directly on how easily we can put our cases over.

Considerations for advisers:

Where, then, do we stand so early in the lifetime of ESA?

Well, working against us we have the fact that:

- we all feel a little lacking in confidence with this new system
- the information gathered pre-appeal often has little direct relation to the descriptors as they appear in law
- the quality of appeals papers and DWP submissions seem almost universally poor
- the mental health descriptors are complex and widely open to interpretation
- we have no body of ESA caselaw to fall back on.

Working in our favour, we have the fact that:

- we *all* feel a little lacking in confidence with this new system—including tribunal members/ DWP presenting officers at appeal hearings. We can turn that lack of

Working in our favour, we have the fact that:

- We *all* feel a little lacking in confidence with this new system - including tribunal members/ DWP presenting officers at appeal hearings. We can actually use their lack of confidence to our advantage when representing appellants by sounding as if we know what we're doing! Welfare Rights advisers have reported that Tribunals seem particularly glad of guidance on ESA

- The information gathered pre-appeal often has little direct relation to the descriptors as they appear in law - but then that is nothing new in the field of mental health sickness route benefit appeals…
  - ⇒ *Use* the descriptors *as they appear in law.* Base a written submission around them, so that the tribunal are fully aware of which ones you would like them to consider
  - ⇒ Go into the tribunal armed with all the examples/ supporting evidence/ witnesses you can.

- The quality of appeals papers and DWP submissions seem almost universally poor —again this can work to the appellant's advantage in that there is unlikely to be anything in the papers which will directly address the descriptors.
  - ⇒ As with 'old' sickness route medical reports, the ESA ones are predictably poorly justified and self-contradictory, so it's well worth highlighting any discrepancies/ inaccuracies as with old Incapacity tribunals
  - ⇒ also be prepared to argue that neither the ESA50 *nor* the ESA85 report addresses the precise qualifying criteria for ESA.

- The mental health descriptors are complex and widely open to interpretation. *Both* these factors mean that tribunals will probably be more easily persuaded to see/ interpret something your way…

- The complexity of the test also makes it easy to argue that the doctor/ claimant didn't understand what was being assessed.

- We have no body of ESA caselaw to fall back on —so as yet everything is up for argument/ grabs! It's an exciting time to be an adviser!
  - ⇒ Where there *is* helpful caselaw from the old Incapacity system—or from DLA/ AA— use it. I definitely see potential for example of using existing caselaw to undermine some of the more outrageous statements/ assumptions contained within the medical guidance… e.g. the banging on about how severely disabled someone must be for certain descriptors to be applicable. DLA caselaw has already established that the definition of 'severely disabled' is that someone meets the qualifying criteria, NOT the other way around.
  - ⇒ Where something is truly still open to interpretation, then argue this to make your point - ditto the wooliness of many of the words/ concepts used in the descriptors –e.g.
    - what *is* a simple task—the descriptors and medical guidance contradict each other with examples here.
    - what is meant by *significant* damage? or *significantly* more difficult? or *significant* distress?
    - how long would it reasonably take a person to complete a given task?
    - what is a *completely/ strongly/ moderately disproportionate reaction?*
    - what might constitute *bizarre* behaviour?

Additionally:

- Don't forget the Support Component and consider the criteria for this at the same time as looking at the ordinary descriptors.

- If you have an argument for the Support Group being appropriate, you could try presenting this first at Appeal— the complexity of the test means that tribunals may well be glad of the chance to 'pass' someone on risk criteria rather than having to wade through the other descriptors!

Submission re. tribunal ref.1234567—Employment and Support Allowance

21/3/10

Re. Mr. David Davies, 321 High Street, Lower Town, Fishguard

Background information:
Mr Davies is 53 years old. He lives with his wife and his adult son, who has learning disabilities. Mr Davies spent the first part of his working life in the mining industry. Following redundancy in 1986, he set up his own business as a taxi driver, an occupation he enjoyed and which he pursued for over two decades. During this period he was active in community life, a keen follower of rugby, volunteered with the local lifeboat crew until the age of 45 and was active in the Crossroads Care scheme from the time his son was a teenager until until three years ago.

His world changed in 2007, when he was the victim of a night-time stabbing when at work. Although Mr Davies' physical injuries were relatively insignificant, the psychological impact was profound; although he continued to trade as a taxi driver for some eighteen months after the stabbing, he was troubled by nightmares and waking flashbacks to that night. He gradually became increasingly anxious about carrying fares, began suffering from debilitating panic attacks and became more and more withdrawn. He has also developed a quite extreme temper which he tells me 'he didn't know he had before'.

Things came to a head for him last summer when he 'lost it' with Bryn, his son. Bryn has had quite profound learning difficulties since birth and needs help with most aspects of his personal care. During a meeting prior to this interview Mr Davies explained to me how—one night last June—Bryn woke him in some distress, having soiled himself on the way to the toilet. His usual patient reaction was replaced—unexplainably—by a sudden fit of rage which left Bryn in tears. It was this incident which finally prompted Mr Davies to visit his GP. Initially diagnosed with anxiety and depression, I understand that he has recently been seen by a psychiatrist who feels him to be suffering from Post Traumatic Stress Disorder. He is being referred for counselling.

The medical examination/ ESA 85 report:
Having made a claim for ESA on 26th June 2009, Mr Davies was called for a medical on 5/8/09. His wife attended with him. You will see that the Tribunal papers suggest the interview took 40 minutes, but Mr and Mrs Davies tell me that they were with 'in and out in just over 20 minutes'. They are so certain of this because they were able to get an earlier than anticipated bus home. Additionally Mrs. Davies recalls that a considerable amount of the time that they were *with* the doctor was spent with him using the computer. She reports that 'he couldn't get something to work and had to turn it off and back on again a couple of times. I remember David was getting really wound up'. She will be present at the tribunal should you wish to question her further.

Other than disagreeing with the doctor's choice of descriptor, Mr Davies would also like to point out two potentially misleading errors in the report. He no longer drives as his concentration can be suddenly and dangerously interrupted by flashbacks and secondly the 'holiday' they took last August was a long weekend in Llangollen, not a holiday in Lanzarote.

The findings of the Decision Maker:
Firstly I would ask the Tribunal to consider the relevance of both the ESA50 and the ESA85 to the actual ESA descriptors as they appear in law. I would question how effectively the decision maker has been able to weigh up the evidence and apply appropriate scoring given that the information recorded in both sources falls rather short of addressing the correct qualifying criteria.

Secondly I am sure that in your careful study of the papers, you will already have noted the four places in which the ESA85 appears to directly contradict itself.

Thirdly, Mr Davies and I would ask you to consider the following descriptors:

15(b) Takes more than twice the length of time it would take a person without any form of mental disablement, to successfully complete an everyday task with which the claimant is familiar.
Mr Davies frequently gets 'lost' in everyday tasks, his concentration lapsing without warning. His wife reports that she will frequently walk in on him to find him 'just staring into space'. He describes this as 'different' to his flashbacks— 'feeling nothing… blankness… a dark sadness…'

16(d) Cannot, due to cognitive impairment or a severe disorder of mood or behaviour, initiate or sustain any personal action (which means planning, organisation, problem solving, prioritising) without requiring frequent verbal prompting given by another person in the claimant's presence.
As explained above, Mr Davies more often than not needs talking through tasks—especially ones which require thought/ prioritisation etc.

17(c) Cannot cope with minor, unforeseen changes in routine (such as an unexpected change of the timing of an appointment on the day it is due to occur), to the extent that overall, day to day life is made significantly more difficult.
Routine has become vital to Mr Davies as a 'coping' strategy; he and his wife have both independently described to me how small, unexpected alterations in plans or occurrences which necessitate change to the 'ordinary' can result in Mr Davies feeling utterly overwhelmed, panicked and unable to cope. I witnessed this myself recently when I needed to change my appointment with Mr Davies—he became at first disproportionately angry, accusing me of being 'just like the rest' and then tearfully expressed feelings that he was 'worthless'. When Mr Davies becomes upset in this way day-to-day life is made more difficult for all family members. He has also expressed feeling that others would be 'better off without him'.

19(c) Normal activities, for example, visiting new places or engaging in social contact, are frequently precluded, due to overwhelming fear or anxiety.
The flashbacks, panic attacks and feelings of anxiety and depression which Mr Davies experiences mean that he has withdrawn from all but essential contact. As explained he was, previously, an outgoing personality and a very active member of his local community, active both with the RNLI and the Crossroads support scheme for carers. Now though he has become utterly withdrawn as even the thought of social contact feels so frightening for him. He was, recently, unable to attend his grand-daughter's christening due to fear that he would have a panic attack or flash-back.

20(d)Has a strongly disproportionate reaction to minor events or to criticism, to the extent that the claimant cannot manage overall day to day life when such events or criticism occur.
Mr Davies has become, as his wife describes it 'hyper-sensitive' to innocuous comments. He denies this himself, saying that people 'wind him up on purpose' but she feels that his reactions are wholly out of character for the mild-,mannered man she married. She tells me that something small upsetting him can lead to him slamming out of a room, shouting and consequently upsetting others as well as himself. She became very tearful when describing this to me.

Consequent to the above and in conjunction with the supporting evidence from Mr Davies' GP— who has been his family doctor for the last fifteen years— I would also ask you to consider whether, in your opinion, Mr Davies might meet either the 'treated as' criterion that:

1) there would be substantial risk to himself or others if were not found to have limited capability for work— or, even, whether there might not be

2) substantial risk to himself or others if he were not found to have limited capability for work related activity— thus qualifying him for the Support Component.

Thank you for giving these matters your consideration...

Submission re. tribunal ref.7654321—Employment and Support Allowance

21/3/10

Re. Mr. John Rees, 77 Foel Drygarn, Mynachlog Ddu

Background information:
Mr Rees is 20 years old. Up until September 2009 he lived on the family farm where he grew up but he has recently been found accommodation by the Preseli Housing Association following the breakdown of his relationship with his parents.

Mr Rees has had an unhappy past; he tells me he has been aware of being 'different' from an early age and had 'no friends' in school. His feelings of isolation grew when he lost his grandfather—to whom he was close— in 2004 and his sister—his only sibling - died in a road accident in 2006. Academically Mr Rees was quite bright, but feels that his teachers 'had it in for him'. He started in college in 2007 but didn't complete his first year. Influenced by others he met there he stopped attending with any regularity, started taking street drugs and developed a regular drink habit. He tells me that at this time he would get 'paralytic' four or five times a week.

He has had three jobs since leaving full time education, all arranged for him by his father. Two ended in his being sacked—once within a month of starting for his timekeeping and on the other occasion because of an argument with threats of violence after he had been there a fortnight. The third job lasted three days before he walked out. He tells me his employers were 'tossers'. Last year things became particularly fraught when his parents were feeding and housing him but refusing to give him money. This lead to frequent arguments and violence on two occasions and the police being called out once.

There followed a very brief but difficult period of his claiming as a jobseeker, but his relationship with DWP staff - both advisers and security—was on the whole not good.

He made a claim for ESA in November 2009. His Housing Support worker has explained to me the difficulties she has had persuading Mr Rees to see a doctor— to which he eventually agreed only because his claim for Housing Benefit had broken down and he was threatened with eviction. After four months on anti depressants he is now awaiting assessment by a Psychiatrist. He does not personally feel he is depressed, seeing the problems as being other people's, not his.

The medical examination/ ESA 85 report:
Having made a claim for ESA on 13/11/09, Mr Rees was called for a medical on 12/1/10. His Housing Support worker attended with him. You will see from the Tribunal papers that Mr Rees became agitated during the interview and left after some 25 minutes—before the examining medical professional felt it was completed. Initially the DWP refused to process his claim further but intervention on Mr Rees' behalf by his Housing Support worker lead to them eventually proceeding with his claim far enough to find him fit for work with a score of 0 points.

Further observations :
You will note from Mr Rees' ESA50 that he does not, himself, feel he is ill and has not completed the mental, cognitive and intellectual functioning part of the form in useful detail. I enclose, however, a short letter re-affirming his GP's belief that he is not well enough to work and confirming his referral to statutory mental health services for assessment. When asked about the obscenities he had written on the ESA50 Mr Rees said he couldn't remember writing them. Further discussion over three interviews however reveals that Mr Rees can, actually, relate to several of the ESA descriptors as they appear in law. I would ask you to consider the following:

14(a) On a daily basis, forgets or loses concentration to such an extent that overall day to day life cannot be successfully managed without receiving verbal prompting, given by someone else in the claimant's presence.
and
15—Execution of Tasks—please see below
and
16(d) Cannot, due to cognitive impairment or a severe disorder of mood or behaviour, initiate or sustain any personal action (which means planning, organisation, problem solving, prioritising) without requiring frequent verbal prompting given by another person in the claimant's presence.

Mr Rees tells me that his mother used to see to all the detail of everyday life whilst he lived at home. He reports however that his father was 'always having a go' about tasks he had failed to complete and his Housing Support Worker expresses her concerns in the attached letter about Mr Rees' ability to manage his accommodation, tenancy and personal care.

Further questioning revealed that although Mr Rees no longer uses street drugs and drinks only moderately he feels there are long spells of each day when 'he isn't there in his head' - when he feels 'the rest of the world is like a film'. He says he will even sometimes hear a 'running commentary' in his head, telling him other's thoughts.

In spite of repeated questioning I have been unable to establish quite how much longer it might take Mr Rees to complete a task than someone else — indeed he became quite impatient with me when I tried to pursue this line.

19(c) Normal activities, for example, visiting new places or engaging in social contact, are frequently precluded, due to overwhelming fear or anxiety
and
20(d)Has a strongly disproportionate reaction to minor events or to criticism, to the extent that the claimant cannot manage overall day to day life when such events or criticism occur.
and
21(a) Is unaware of impact of own behaviour to the extent that: has difficulty relating to others even for brief periods, such as a few hours; or causes distress to others on a daily basis/ (b) The claimant misinterprets verbal or non -verbal communication to the extent of causing himself or herself significant distress on a daily basis.

Talking to Mr Rees reveals that in spite of his combative, aggressive reactions, he actually feels frightened of having to have contact with people/ deal with new places. He recognises that when he feels this way he is far more likely to 'lose it'. He describes his outbursts as something that 'comes from outside—I can't control them' and finds them impossible to remember in detail afterwards. Whilst feeling people 'wind him up on purpose' he does accept that his behaviour can be 'hard to live with'.

His Housing Support worker hopes to be present at the Tribunal to detail some of the difficulties he has had relating to other tenants in the accommodation where he lives/ frequent incidents which have arisen because he has misinterpreted minor things others have said or done.

Consequent to the above I would also ask you to consider whether, in your opinion, Mr Rees might meet either the 'treated as' criterion that:

1) there would be substantial risk to himself or others if were not found to have limited capability for work— or, even, whether there might not be

2) substantial risk to himself or others if he were not found to have limited capability for work related activity— thus qualifying him for the Support Component.

Thank you for giving these matters your consideration...

STOP PRESS!
Work Capability Assessment to be reformed...

All change—yet again…

At the time of going to print, the medical test for Employment and Support Allowance stands as covered by the rest of this chapter. In late March however, a Government report revealed plans to change the test. When this will happen is not known at the time of going to print, but the new descriptors have been published, approved by the Secretary of State and are reproduced here for your perusal.

At first I assumed that the review had taken place in the light of the unexpected numbers of people failing the Work Capability Assessment— but not a bit of it, it would seem—the WCA as revised will, says the report, lead to an estimated *increase* of around 5 percentage points in the overall number of new claims found ineligible for ESA.

However the report does make a distinction here between the changes made in physical and mental health assessments - '*the impact is far greater upon scores in relation to physical function. This is not unexpected as the majority of the changes that are proposed in this area encompass adaptation. The changes to mental function will have a less significant impact upon entitlement as these predominantly focus on simplification and clarification of the assessment*.' says the report. Time will tell.

What is going to be easier for certain—thank goodness—is actually *understanding* the mental health descriptors. They still use odd concepts in places—e.g. 'sequential personal actions' is their speak for doing one thing after another—like getting up and then dressing—but they have at least de-bulked and mostly debunked them. This is good news for all who have to consider the descriptors - claimants, advisers, medical assessors, decision makers and appeals tribunals.

But what they've also done is reduced the number of functional areas over which you can score points for your mental health problem from ten to seven, making it *more* difficult to mix and match points to the value of fifteen.

Particularly significant losses—in my opinion—are descriptors relating to:

- misinterpreting verbal or non verbal communication
- having a disproportionate reaction to minor events/ criticism
- problems with memory and concentration
- taking a long time to complete tasks

Interestingly, the working group who came up with most of the suggested changes discuss the conundrum of the difference between 'capability' and 'employability' - i.e. that there will increasingly be numbers of people found fit for work who will, in reality, find it very hard to ever get a job because they still have health problems:

'In appreciation of the fact that there will be individuals in receipt of JSA with health conditions and disabilities, in addition to the provisions already made, the Department is doing further work to address the risk that this group may experience longer durations on benefits' (sic).

The Support Component will apply when someone meets:

- one of the current 'treated as' criteria
- when someone is deemed to meet one of *some* of the 15 point descriptors

A further change will see being 'likely to receive chemotherapy in the next 6 months' being included in the 'treated as' criteria.

STOP PRESS!
Pathways to Work to be scrapped—new regime of more personalised support

Earlier in this chapter, I reported that having once formed the flagship for the Government's welfare reforms, Pathways to Work had now been discovered to have no measurable effect on the number of people actually entering jobs.

Jobcentre based Personal Advisers had also been reporting dissatisfaction with the fact that during the first—and sometimes during the second and even the third—Work Focused Interview, under current arrangements it is not known who will

- be awarded any ESA
- be awarded the Support Component

They spend time then planning the positive support they can offer people, only to find that many are either subsequently awarded the Support Component—so do not need to attend further interviews, - or more commonly are found fit for work…

The Government have recently reacted to this by announcing, from April 2011:

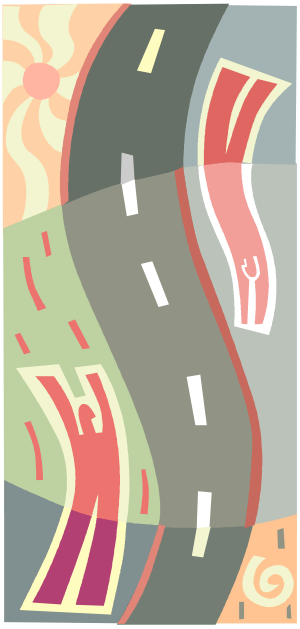
- significant changes in the timing of Work Focused Interviews,
- a personalised timetable to be reassessed as a condition of receiving benefit
- a personalised regime of support and requirements to take up that support
- a maximum of two years between medical assessments

Essentially—and very sensibly—they have decided to delay the first Jobcentre based interview until *after* the outcome of the Work Capability Assessment is known.

It will also be left to the Personal Advisers to decide how and when future Work Focused Interviews will happen;
'Our aim is to provide more personalised support and give greater autonomy to advisers to find the right support package that meets the customer's needs. So the personal action plan will form the starting point for a personalised series of interviews for the customer. This regime will be determined by the adviser in discussion with customer so that it is tailored to the customer's needs and aspirations.

'We recognise that for some people it will be better for them to focus on their treatment or recover from a health condition first, while others may require more intensive support near the start of their claim. So the regime will be based on a core level of support for all customers that will enable them to stay in touch with the labour market.'.

Also announced is access to a number of training/ skills schemes aimed at getting people back to work as well as more in-work support for those who get there.



All proposed future developments covered here are, of course, subject to change depending on the outcome of the General Election which is yet to be held at the time of going to print...

1) Mobilising unaided by another, but with any aids that can reasonably be used:
Cannot:
- Mobilise more than 50m—on the level—without stopping to avoid significant discomfort or exhaustion *(15)
- Repeatedly mobilise 50m within a reasonable timescale due to significant discomfort/ exhaustion *(15)
  - As above, 100 m (9)
  - As above, 200m (6)
- Cannot mount or descend two steps with handrail unaided by another person(9)

2) Standing and sitting
Cannot—most of the time:
- Move from one seat to another alongside without help from another *(15)
- Remain at a work station, standing or sitting, for more than 30 minutes before having to move away due to discomfort/ exhaustion (9)
  - As above—for more than an hour (6)

3) Reaching
Cannot raise either arm—i.e. has to apply to *both*— as if to:
- Put something into breast pocket *(15)
- Put on hat (9)
- Reach for something above head (6)

4) Picking up and moving/ transferring by use of upper body and arms—i.e. could be wedged between arm and body rather than picked up using hand… Cannot:
- Pick up and move a 0.5 litre carton of liquid *(15)
- Pick up and move a 1 litre carton of liquid (9)
- Transfer light, bulky object—e.g. cardboard box (6)

5) Manual Dexterity
Cannot—with either hand:
- Press a button– e.g. on a phone keypad *(15)
- Turn the pages of a book *(15)
- Pick up £1 coin/equivalent (15)
- Make a meaningful mark with a pencil/ pen (9)
- Use a suitable keyboard or mouse (6)

6) Making self understood through speaking, writing, typing or other means normally used without help from another person
- Cannot convey a simple message—e.g. the presence of a hazard *(15)
- Has significant difficulty conveying a simple message to strangers (9)
- Has some difficulty conveying a simple message to stranger (6)

7) Understanding Communication—verbal (e.g. hearing/ lip reading) and non verbal - (e.g. reading 16pt print) means unaided by a person but using any aids
- Cannot understand a simple message—such as location of a fire escape *(15)
- Has significant difficulty understanding a simple message from a stranger (15)
- As above—some difficulty (6)

WCA —'Physical Disabilities' - revised version—implementation date yet to be confirmed at time of going to print

Support Component criteria are marked with an asterisk

8) Navigation and maintaining safety, using a guide dog or other aid if normally used due to sensory impairment:
Cannot, without being accompanied by another person:
- Navigate around familiar surroundings (15)
- Safely complete a potentially hazardous task such as crossing a road (15)
- Navigate around unfamiliar surroundings (6)

9) Absence or loss of control leading to evacuation of the bowel or bladder, despite the presence of any aids/ adaptations normally used
- At least once a month experiences extensive evacuation of the bowel/ voiding of bladder/ substantial leakage from collecting device sufficient to need cleaning of self & changing of clothes*(15)
- At risk of the above if cannot reach a toilet quickly (6)

10) Consciousness during waking moments:
Has an involuntary episode of lost/ altered consciousness resulting in significantly disrupted awareness or concentration:
- At least once a week (15)
- At least once a month (6)

11) Learning tasks Cannot: • Learn how to do a simple task, such as setting an alarm clock *(15) • Learn anything beyond a simple task, such as setting an alarm clock (9) • Cannot learn anything beyond a moderately complex task, such as steps involved in operating a washing machine to clean clothes (6)	**14) Coping with change** Cannot: • Cope with any change to the extent that day-to-day life cannot be managed *(15) • Cope with minor planned change—such as pre-arranged change to routine time scheduled for lunch break to the extent that day to day life is made significantly more difficult (9) • Cannot cope with minor unplanned change (such as the timing of an appointment on the day it is due to occur) to the extent that day to day life is made significantly more difficult (6)	**16) Coping with social engagement due to cognitive impairment or mental disorder** • Engagement in social contact is always made impossible due to difficulty relating to others/ significant distress *(15) • As above, social contact with someone unfamiliar, all of the time (9) • As above, social contact with someone unfamiliar, most of the time (6)
12) Awareness of everyday hazards (such as boiling water or sharp objects) Reduced awareness of everyday hazards leads to a significant risk of injury to self or others, or damage to property or possessions , requiring supervision to maintain safety: • Most of the time *(15) • Frequently (9) • Occasionally (6)	**15) Getting about** • Cannot get to any specified place with which the claimant is familiar (15) • As above, without being accompanied (9) • Cannot get to a specified place with which the claimant is unfamiliar without being accompanied (6)	**17) Appropriateness of behaviour with other people, due to cognitive impairment or mental disorder** Has uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace: • Daily *(15) • Frequently (15) • Occasionally (9)
13) Initiating and completing personal action (which means planning, organisation, problem solving, prioritising or switching tasks Cannot—due to impaired mental function reliably initiate and complete at least 2 sequential personal actions • Always *(15) • Most of the time (9) • Frequently (6)	WCA —'Mental, cognitive and intellectual function' - revised version— implementation date yet to be confirmed at time of going to print Support Component criteria are marked with an asterisk	