



The Work Capability Assessment – a call for evidence. Department for Work and Pensions, July 2010

Joint response from Centre for Mental Health, Mind, Rethink and the Royal College of Psychiatrists.

Who are we?

Centre for Mental Health

Centre for Mental Health is an independent, national charity that aims to help to create a society in which people with mental health problems enjoy equal chances in life to those without. We aim to find practical and effective ways of overcoming barriers to a fulfilling life so that people with mental health problems can make their own lives better with good quality support from the services they need to achieve their aspirations. Through focused research, development and analysis, we identify the barriers to equality for people with mental health problems, we explore ways to overcome those and we advocate for change across the UK.

Mind

Mind is the leading mental health charity in England and Wales. We work to create a better life for everyone with experience of mental distress by:

- Campaigning for people's rights
- Challenging poor practice in mental health
- Informing and supporting thousands of people on a daily basis

A fundamental part of Mind's work is provided through our network of over 180 local Mind associations who last year worked with over 220,000 people running around 1,600 services locally. Services on offer include supported housing, crisis help lines, drop-in centres, counselling, befriending, advocacy, and employment and training schemes. Over 30,000 people are supported by our national telephone help lines. Welfare reform is a key issue for many of the people Mind has contact with.

Rethink

Rethink, the leading national mental health membership charity, works to help everyone affected by severe mental illness recover a better quality of life. We help over 48,000 people each year through our services and support groups and by providing information on mental health problems. Rethink's National Information and Advice Service help almost 8000 people each year, including many who ask for help with the WCA.

Royal College of Psychiatrists

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

Introduction

We welcome the opportunity to respond to this consultation.

As leading organisations in the mental health field we know that the great majority of people who experience mental ill health, even those with serious conditions, see some paid employment as a contribution to and a marker of their recovery.

We also know that there is good evidence that given the right conditions and the right support, for most people work is a realistic ambition. In our response we will focus on the ways in which the WCA as it is presently constituted and delivered creates the wrong conditions for people with mental health conditions to (re)launch themselves into the world of work by creating uncertainty, anxiety and unfairness. This is a matter of great concern to us and the people we represent because it not only impacts on quality of life and hope for a better future, but can also lead to worsening mental health for which mental health services will have to pick up the tab.

"We know that people with mental health conditions can and do pursue successful careers. We know that the majority would dearly love to be gainfully employed – in fact, people with a mental health problem have the highest 'want to work' rate of all disabled groups. We know that appropriate employment improves mental health and can protect against relapse. There is a wealth of research evidence showing how we can help many people with a mental health condition to realise their ambitions, yet, in most areas, we have failed to provide this support. And the number of people with a mental health condition who are workless continues to rise". (Perkins et al, 2009)

Recommendations

In our evidence we are aware that in many ways the problems that existed for the PCA are still being replicated in the WCA process, particularly the problems with the Atos clinicians and the accuracy of the WCA medical assessment.

Centre for Mental Health, Mind, Rethink, and The Royal College of Psychiatrists recommend the following:

- Greater use of treating clinician's opinions should be made throughout the WCA process.
- A claimant's exemption should be based on the recommendation of the medical professionals who work with them that the assessment process would cause harm to health, rather than being prescribed for any particular health conditions.
- The overall assessment of claimants requires a more realistic approach to functionality, reflecting more accurately how a disability affects someone's entire life, rather than identifying which tasks they can perform in isolation.
- Policy will need adjusting to allow the long-term IB claimants who are found to be fit for work to have a period of time on ESA before being moved to JSA.
- We recommend that regular thorough and scientifically rigorous evaluations of the WCA medical assessment are undertaken to ensure that it reflects new health conditions and evidence
- The current WCA interview and associated assessments should be reconsidered and the views of clinical, service user and third sector experts used to reconsider the current interview process, the descriptors and additional ratings.
- The current descriptors should be supplemented by an additional rating that assesses the overall impact on functionality caused by claimants' conditions. These subjective aspects of distress could be used to determine an overall score of the claimant's current functioning in addition to the current descriptors. We recommend that serious consideration is given to this proposal.
- The assessment should take account of how the illness or impairment affects an individual's chances of finding work in the context of the workplace environment. We recommend that the WCA takes them into account for those people who may have reasonable functioning and may not automatically qualify for benefit, but have reduced chances of being able to work. This includes issues such as employer stigma.

- We recommend that improvements are made to the clarity of the WCA medical assessment. The WCA interview could be made into a semi-structured interview which would aid the systematic collection of data and may also help improve the interaction of the assessing doctor and claimant.
- We recommend that a thorough evaluation of the ability of the medical assessors is undertaken.
- The guidance given to WCA assessors should be improved, giving more and less extreme examples.
- For fluctuating conditions we recommend that the assessment differentiates between variable conditions and variable symptoms. Assessors should be asked to evaluate the variability in several ways and use these methods to develop a judgement as to the combined effects of these fluctuations.
- The contribution of multiple conditions may be managed by improving the assessment by the Atos clinicians, making it more reliable and valid. The process should assume at least an additive model such that the scores on the individual mental and physical descriptors are summated to provide the final score.
- Evidence from the appeal should be fed into the WCA systems to ensure that those whom a tribunal has found should be on ESA do not have to present the same information to a different part of the system shortly afterwards. This would save time and reduce stress for claimants, which can cause relapse.

Response to questions

In our response, we will concentrate on the effects of the Work Capability Assessment (WCA) on people with mental health problems. We are aware that this group of people form a significant proportion of those on welfare benefits. We believe that the process that assesses the eligibility of people for welfare benefits should be fair, accurate and just. It should not discriminate against any particular group and the benefits should offer protection to people when vulnerable and should offer a means of support to improve their opportunities when they are able to do so.

1a) How effectively does the WCA correctly identify those claimants whose condition is such that they are unable to undertake any form of work related activity (the support group)

Current DWP figures for ESA claims to November 2009 show that 6.8% of those with mental health problems assessed through the WCA were placed in the Support Group and 24% in the Work-Related Activity Group, whilst 69.2% were found to be 'fit for work'.¹ The equivalent figures for those with physical problems are 11.6%, 23.7% and 64.7% (Department for Work and Pensions, 2010a). It is not known how appropriate this figure is as we know of no evaluations that assess the accuracy for the assessments of people entering the Support group, but the figure for those being found 'fit for work' is much higher than that of 49% originally estimated by the DWP (Citizens Advice Bureau, 2010).

However Mind, Rethink and The Royal College of Psychiatrists are aware through their support work that many with mental health conditions who should be placed in the Support Group are inaccurately placed in other groups. Due to limitations of the current WCA, it is likely in our experience that people who are too disabled by their condition to work, and should be in the Support Group, are assessed as ready to engage with work-related activity.

The assessment for ESA does include "special circumstances" in which claimants can automatically be considered as having limited capability, and therefore eligible for the benefit. However, these "special circumstances" cover far fewer situations than for the Personal Capability Assessment (PCA), which was used to determine eligibility for Incapacity Benefit (IB). One exemption from the PCA that is not now included in the "special circumstances" for ESA is medical evidence to show: "A severe mental illness which severely and adversely affects mood or behaviour and which severely restricts social functioning or awareness of the immediate environment". We will return to this point in our response to question 2.

It is now very common to employ Benefits Advisors in Community Mental Health Teams to advise and assist service users in making claims. These advisors, along with clinicians working in these teams, report an increase in problems with those people with severe mental illness who should be placed in the Support Group being called for assessment and being refused ESA (Citizens Advice Bureau, 2010). They also report that it is less common now for clinicians to be sent the form ESA 113 than it was to be sent IB50 forms under the previous system. These errors are damaging to the patients' mental health and costly in terms of money and resources. This means that the system ignores the expertise of mental health practitioners to accurately assess the capabilities and any support needs of their patients. The CAB report also finds that seriously sick and disabled people are being found ineligible for ESA. It is generally recognised that people who move off benefits but do not enter work show deterioration in

¹ Table 5, page 12, Department for Work and Pensions, 2010a

their health (Waddell and Burton, 2006). One example from the CAB illustrates this:

An adviser from a community mental health team reported that almost all their new clients applying for ESA are being refused benefit. In the last few months, she has helped 10 clients appeal ESA decisions: three have been resolved, and the other seven are all waiting to go to tribunal. None of these clients would be getting the very significant resources of the community mental health team if they were not seriously mentally ill. Under the IB rules, this would be used as an indicator that there was a severe mental health problem and the benefit would be awarded. The stress and worry of the ESA process is damaging the clients' mental health and delaying recovery and the possibility of an eventual return to work.

1b) How effectively does the WCA correctly identify those claimants whose condition is such that they are currently unable to work due to illness or disability (the limited capability for work group?)

Without further evaluation of the accuracy of the WCA to place people in the correct eligibility groups it is not possible to give a firm answer to this. However, from the official statistics we are aware that of the overall appeals against the decision of fitness to work, 40% of the decisions are overturned.² Up until November 2009, 66% of those assessed were found to be 'fit for work'³ so if the 40% error rate were applied across all those people then a further 131,400 would be found to be eligible giving a total rate of eligibility of 60%, and would account for some of the overall rates of eligibility being 20% less than the government originally expected (Citizens Advice Bureau, 2010).

A potential error rate of up to 40% in the WCA process implies some serious inaccuracies in the assessment system. If there was a more accurate assessment of people's eligibility for benefit, this would result in a reduction in the number of appeals to the decision, and ultimate cost savings to the DWP, and a reduction in distress for those making the appeal (Department for Work and Pensions, 2008). Where decisions are not appealed, inaccurate assessment has a detrimental effect on the wellbeing of the person with mental illness, as they are put through a programme which is not suited to their needs or denied support tailored to their situation, further damaging their confidence and ability to work.

"I have had to appeal a decision for my benefits that said, after a medical assessment, that I did not qualify due to the points system on certain issues they use. I did win my appeal though went through a lot of stress which was hard to deal with, particularly with a mental health condition. Now, only months after winning the appeal, I have been called to another medical assessment" – Rethink Supporter with severe mental illness

² Table 1, page 7, Department for Work and Pensions, 2010b

³ Tables 3 and 4, pages 9, 10, Department for Work and Pensions, 2010b

This not only results in worsened health but also denies appropriately tailored support to those who most need it. Within a competitive job market and where employers still hold stigmatising attitudes towards those with mental illnesses, this can increase rather than reduce an individual's distance from the job market.

Our responses to questions 1a and 1b indicate that there is overall evidence that the WCA is not sufficiently accurate in identifying people with ill-health who are eligible for ESA. This suggests that the WCA process is not efficient in providing a structure in which information is processed and it is likely that the medical assessment is not being carried out adequately and is not able to identify people who are unable to work due to ill health or disability. However we know of no published data that allows us to examine differences in outcome (correct identification of eligibility for ESA) between people who have mental health problems and those with physical impairments or disabilities. Such data would be essential to examine any bias or inaccuracy in the WCA process.

1c) What are the main characteristics that should identify claimants for each group, where these may differ from the current assessment?

Identification of all claimants needs a more realistic and evidence-based approach to functionality. The test needs to more accurately reflect how a disability affects someone's entire life, rather than identifying which tasks they can perform in isolation. This should take into account how their quality of life, and health would be impacted, both in the short and long term, by any work that they are performing. Clinical practitioners who know an individual well, such as their GP or psychiatrist, could play a vital role in providing this contextual information and in reducing the risk of inaccurate assessments and subsequent appeals or loss of income.

The assessment also needs to take into account the quality of the support that will be available to individuals in the different groups and the external barriers they may face in finding work. Particularly for existing IB claimants, many of whom will not have worked for a long time, a 'fit for work' decision based on a purely functional assessment does not address the fact that they will inevitably face difficulties in actually returning to the workplace after such a long time away from it. These claimants in reality may not be able to access the support that would be necessary to overcome these realities – it is unfair for the system to work as though this support is available when in many localities it is not and claimants should not be penalised for this lack of provision.

2) What evidence is there to suggest that any issues with the operation of the WCA are as a result of the policy design and what evidence is there to suggest that they are a result of delivery?

Policy design

Current policy affects the operation of the WCA in several ways:

1. Migration from Incapacity Benefit

Policy suggests that 1.6 million IB claimants will be migrated onto ESA by March 2014. None of this group are likely to be eligible for contribution-based JSA if they are found fit for work and the majority who are not eligible for a top-up on their current sickness benefit are not likely to qualify for income-related JSA. Thus, many of those migrating who are then found ineligible for ESA will have no benefit to replace the income they have lost as a result of their illness or disability. Many of these people, even if they are found to be legitimately fit for work, will have been on benefits for many years, often without the right support to find paid work, and thus will take time to adjust to the demands being made of them and will in the interim face distress and hardship. As the current system of assessment is presently not sufficiently efficient they will be doubly disadvantaged. Policy will need adjusting to allow the long-term IB claimants who are found to be fit for work to have a period of time on ESA before being moved to JSA.

In addition there are concerns that there may not be the capacity to process the migration from IB to ESA. The House of Lords Merits of Statutory Instruments Committee (2010) notes that the DWP has revised its estimates of those likely to be found to be fit for work during phase 2 from 15% to 23% but they comment that there is no indication of how robust is this assumption. They also have concerns about the lack of evidence to support the methods of migration:

“... the Committee’s view that, from the limited evidence we have seen, a major project with a potential impact on the lives of some of the most vulnerable in the community is being conducted in a rather ad hoc fashion. The second phase is being rolled out before the first has been evaluated and although better information will be sought on the outcomes, the Department’s intended course of action, and evidence to support it, all seem rather vague.” House of Lords Merits of Statutory Instruments Committee (2010).

The Social Security Advisory Committee report (2010) echoes this concern:

“It is of particular concern to the Committee that the Department is moving ahead with the migration of existing claimants of incapacity benefits without a solid evidence base for either the decision to migrate or the proposed migration arrangements. The Committee notes that the evaluation of ESA for new claimant is not planned to be complete until 2011 by which time the proposed migration arrangements will have commenced.”

2. Greater areas for exemption

Some people with mental health conditions, particularly those being seen by Community Mental Health teams may be too unwell to work. In addition, participating in the process of the WCA itself is further detrimental to their mental health. Under the previous IB system those with severe mental illnesses were exempt from having to undertake the PCA (see: our response to Q1.a). There are also specific problems for the group of people with mental health conditions who have limited awareness into the nature of their illness and who may complete the self-assessment ESA50 form on the basis of this and thus not be found eligible for ESA despite being unable to work.

Rethink have collected many examples of cases of people attending Community Mental Health Teams (CMHTs) for whom the WCA process does not work well. These have been highlighted in the CAB *Not Working* report (Citizens Advice Bureau, 2010), for example:

“A client with a diagnosis of schizophrenia who lacked insight into his mental health and was non-compliant with treatment. He had paranoid thoughts, had hallucinations and heard voices, and had suicidal thoughts, having previously attempted suicide. He claimed DLA and was awarded higher rate care and lower rate mobility. He was detained under Section 3 of the Mental Health Act 1983 (MHA83). Regulations state that a claimant should be treated as having limited capability for work on any day that they are receiving hospital treatment – thus he should have been automatically placed in the support group. He received the ESA50 in hospital and returned it while he will still detained. The ESA50 was not completed accurately as he was acutely unwell, but he attended a WCA a few months later and was found fit for work.”

“An adviser with a community mental health team recorded grave concerns about a client diagnosed with bipolar disorder but who had no insight into his condition. He had a WCA and was found fit for work. The client signed on and was delighted because he believed that is showed he was right all along and was not ill. The psychiatrist wanted this decision to be challenged but it was not possible because the client did not want to appeal.”

Considerable amounts of money and resources are invested in treating and supporting the patients of CMHTs, who are mainly diagnosed as being seriously ill. CMHTs have expert and often long-term knowledge of the people they see and it is this expertise and knowledge that should be sought, rather than decisions made on the basis of an assessment by a generalist health care professional. Greater weight should be given to supplementary evidence provided by the claimants' own physicians and carers. Incorrect decisions are damaging the work done by the CMHTs, thus costing further resources to the public purse.

We believe that this aspect of current regulations should be changed to protect those using secondary mental health services from being subject to unnecessarily entering the WCA process and being allowed to enter the Support Group at an early stage. We suggest that this group are exempt from the process as they were for the PCA under the IB system. We recommend that their exemption should be based on the recommendation of the medical professionals who work with them, rather than being prescribed to any particular conditions.

3. The WCA process re-starts too soon after settlement of an appeal

We are also concerned that clients who have won their appeals are being reassessed through the WCA within a very short time frame. Rethink has been in touch with a supporter who was initially put onto JSA, but who appealed and had won his appeal. He was sent an ESA50 form within months of the appeal being settled, and has now been called for a further medical assessment. This is causing him great distress and could potentially impact on his health, causing unnecessary expense for the NHS; particularly as he was assured it would be at least a year before he is reassessed.

We would like to see evidence from appeals being fed into the WCA system to ensure that those whom a tribunal has found to be eligible for ESA do not have to suffer the distress of presenting the same information to a different part of the system shortly afterwards.

Delivery

There are several problems with the current delivery of the WCA process:

1. The medical assessment interview of the WCA has never been subjected to scientific scrutiny

For any test to be able to correctly identify individuals as experiencing any problem (in this case having reduced functioning that impairs their ability to work) it must be both valid (correctly measuring what it is intended to measure) and reliable (provides consistent and reproducible results). It should also be comprehensive and easy to administer. The WCA was a revision of the PCA and claimed to be a more robust, accurate and fair assessment than its predecessor (Department for Work and Pensions, 2006). The WCA has been re-assessed (Department for Work and Pensions, 2009; 2010c) but it has never been exposed to any rigorous evaluation and its validity and reliability is not known (Verbeek and van Dijk, 2008).

The evidence given above (Questions 1a and 1b) shows that the current WCA is subject to a high rate of errors suggesting poor reliability and validity. There is much at stake for the WCA. Not only does it dominate the provision of sickness benefits, it also determines the financial survival of many people with incapacities owing to illness. As it stands, the WCA does not yet pass the test of a fair and

just process. We recommend that a thorough and scientifically rigorous evaluation of the WCA is undertaken, with a view to a more scientific approach to redesign if necessary.

2. Current content of the medical assessment

The medical assessment interview component of the WCA currently contains ten descriptors relating to mental health but the DWP's internal review proposes to reduce the descriptors to seven (Department for Work and Pensions, 2010c). These represent a much revised version of the original WCA (Department for Work and Pensions, 2006) and have not yet been evaluated.

In addition to the lack of evaluation, these specific descriptors are limited as they do not assess the overall impact of performing the tasks mentioned in the descriptors. This could be addressed by the overall assessment process by paying greater attention to the 'subjective' experience of the claimant, which the current score of ability to perform tasks or present well does not capture. These subjective experiences potentially include: overall distress experienced; chaotic thinking, difficulty organizing self or routine; feeling overwhelmed; tolerance for frustration; self confidence; fear of others' expectations; debilitating side effects of medication; and difficulty coping with stress. We need assurance that these things are considered when assessing people's ability against the descriptors. We are told by our beneficiaries that these aspects of their condition are not taken into account. Data on these issues is currently being collated through a major survey being conducted by Rethink on behalf of the Disability Benefits Consortium and we will be able to report results in October this year. We recommend that serious consideration is given to this proposal.

In addition, the WCA has further problems that need to be addressed:

a. Evaluation of variability

The WCA is not sufficiently robust to deal with either the variation of the conditions, or the variability of symptoms. For example, a person with a mental health problem may find that 30% of the time their mood is low and at other times they cannot concentrate or at other times they are irritable or have to withdraw to deal with their auditory hallucinations. Perhaps none of these factors, on their own, may affect the items on the WCA sufficiently to achieve the desired points, but together they are sufficient to affect their overall functioning. The same may apply to the variation of these individual symptoms.

The present guidance states that "For conditions which vary from day to day a reasonable approach would be to choose the functional descriptors which apply for the majority of the days." However, for those with variable conditions this is not sufficient or reasonable as they may be fit for work on their better days, but on their bad days they may not be able to work. Symptoms may be so severe on the minority of days that they need to be given greater weighting.

b. Combining physical and mental descriptors

For people with more than one condition, the evidence suggests that the combined effect may be more than the sum of the two conditions (Scott et al, 2009). Many people with mental health problems also have physical problems and their combination is not taken into account in the WCA. These combined problems often make adaptation to work difficult.

This is a particular concern for those with mental health conditions where some elements of the condition can impact on others. For example, if a person is unable to cope well with change and is also unable to deal well with other people, they are likely to become worse at dealing with other people in times of change. This will then compound the anxiety about the change and create a problem which is greater than the WCA would reflect.

Citizens Advice (2010) found that when there are physical problems as well as mental health problems, the mental health problem is more likely to be ignored in the WCA. They cite this example in their report:

“A Midlands bureau saw a client with a long history of depression, as well as many other problems including back problems and diabetes, and who was also having investigations for possible epilepsy following a series of blackouts. The assessment only seemed to have considered the physical problems and the client was awarded no points. Yet at that point, the client’s mental health was causing more concern than the serious physical problems. The client had made three suicide attempts that year, still had suicidal thoughts and was unable to go out the house on their own. The bureau noted that the client had a social worker who confirmed all the details.”

This point will be returned to in our response to question 4.

c. Relating the assessment to the ‘real world’

The current assessment takes no account of how the illness or impairment affects an individual’s chances of finding work in the context of the workplace environment, such as the impact of long-term unemployment, adapting to the workplace and the barriers to getting into work. People with mental health problems face particular prejudice and discrimination from employers. The WCA does not take these factors into account. We recommend that the WCA is expanded to take these factors into account for those people who may have reasonable functioning and may not automatically qualify for benefit.

3. The competence of the WCA medical assessors to undertake effective assessments for people with mental health problems

One possible reason for a lack of reliability in the WCA system may be the ability of the medical assessors to accurately assess the level of functioning in this group of people.

There is no published data on the quality of the assessments carried out by the WCA medical assessors, but the reports of people who have been assessed suggest that this is poor. In 2006, Citizens Advice questioned the quality of the medical assessments for the PCA, reporting that these did not give sufficient consideration to mental health problems, were often hurried, that many clients reported encountering rude or insensitive examining doctors, and that reports were inaccurate and took answers out of context. (Citizens Advice, 2006). In their latest report Citizens Advice paint a similar picture for people with mental health problems (Citizens Advice, 2010). They found repeated evidence of people with severe mental health problems being found fit for work, that the impact of mental health problems was being underestimated in the presence of coexisting physical problems, and that people's mental health difficulties were downplayed.

There seems little doubt that the medical assessors still have a poor awareness of mental health problems. People attending consultation events facilitated by Mind and Rethink, during the development of the original WCA in 2007, highlighted that assessors tend to make judgements on a person's capability based on their appearance or ability to articulate their problems rather than on their capability to work as measured by the WCA.

There are reports of claimants who are assessed being frequently confused about the purpose of the medical assessment and not understanding why the doctors performing the assessment reach a different conclusion to their own doctor. Communication about the assessment needs to be more accessible and provide a clear explanation of the purpose of the assessment should be provided.

Further to this, the ability of the medical assessors to carry out high-quality assessment for all claimants has been questioned by the findings of the CAB report (Citizens Advice, 2010). The report highlights several important factors including: the accuracy of the medical history in the clinician's report; distortions of what they were told in the interview; poor questioning by the clinician; inadequate recording of claimants' responses; a failure to observe accurately; a lack of understanding of the criteria; poor recording of variable conditions; the downplaying of the severity of conditions; and overuse of referral for repeated medicals.

The evidence gathered by Citizens Advice and others over the years points to the need to evaluate formally the ability of the medical assessors to accurately assess the functioning of the claimants. It also suggests that there may be

systematic problems in relation to those with mental health problems. At present the process run by Atos is opaque and has not been subject to external scrutiny. Some of this may be improved by improvements in the clarity of the WCA medical assessment. The WCA interview could be made into a semi-structured interview which would aid the systematic collection of data (as with many research interviews) and may also help improve the interaction of the assessing doctor and claimant. Such an interview design would also allow for improved training of the assessors and a ready means of evaluating the quality of their interviews and rating. We recommend that a thorough evaluation of the competence of the medical assessors is undertaken.

4. Problems with the guidance

There are some areas where the guidance to the assessing clinicians may contribute to underestimating the degree of incapacity. The guidance often cites the most extreme example of impairment, rather than providing suggestions around more borderline cases which may allow assessors to make more balanced decisions. For example, descriptor 15 (execution of tasks) has the following guidance:

“The pattern of typical day activity should really reflect a person who should struggle to get through the basics of a day due to their mental disablement as a result of tasks taking so long to complete that they would be unable to cope with work due to the length of time required for basic tasks. 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”

By citing such an extreme case, it can overshadow less extreme, but still serious, cases and may lead to them being under assessed.

3) What is the best way to ensure that the effect of fluctuating conditions is reflected in the recommendation of the WCA?

We have covered the problems with fluctuating conditions and symptoms above.

While there seems no single reliable way of assessing this, we recommend that the assessment distinguishes more clearly between variable conditions and variable symptoms.

Assessors should be asked to evaluate variability in several ways and use these methods to develop a judgement as to the combined effects of these fluctuations. These multiple ways could include not only the assessment of a ‘typical day’, but also a ‘typical week’. A judgement should also be made of the claimant’s functioning at its worst. Each of the functional descriptors rated could be assessed as to how often they apply, and the worst case scenario could be used to provide a reliable rating. The subjective components that we outlined above

could be assessed in a similar way. The use of a semi-structured format to the interview as outlined above would also facilitate this process.

We would like to see the WCA reflect the nature and severity of variations in mental health conditions. At the very least, we would like individuals to be provided with a greater explanation of how the effect of fluctuating conditions is assessed in the WCA. This would allow individuals to be clear in explaining how their condition does vary.

4) What is the best way to ensure that the effect of multiple conditions is reflected in the recommendation of the WCA? Are there specific conditions that should be regarded as contributing to or adding additional weight to others, where both are present?

We know from past research that mental health problems are at least as disabling as common physical conditions (Moussavi et al, 2007) and that mental and physical disorders are known to co-occur at greater than chance levels (Scott et al, 2009; Buist-Bouwman et al, 2005). There are two main ways of considering the effects of co-existing mental and physical disorders: first that their effects are *additive* i.e. that the individual components of these coexisting disorders have independent effects on functioning and thus the total effects are equivalent to the sum of the parts. The second view is that this co-existence is interactive and is associated with significantly greater levels of dysfunction than predicted by a simple sum of the main disorders i.e. the total dysfunction is greater than the sum of the parts. By contrast there is no evidence that mental health and physical health problems add up to less than the sum of their parts, yet in the operation of the WCA this is often how they are interpreted.

There is evidence for both additive and interactive effects when mental and physical disorders co-exist. A recent large international survey (Scott et al, 2009) found that people with depression and anxiety are more likely to be severely disabled than those with physical disorders and that those with combined physical and mental disorders are more likely to be severely disabled than those with one condition alone. Those with combined disorders also had higher levels of disability than predicted by the sum of the disability attributable to the individual disorders.

The evidence suggests there may be an alternative method of managing the contribution of multiple conditions. We recommend making the assessment more reliable and valid by the means suggested above and by ensuring that equal weight is given to the assessment of mental and physical conditions.

5) What is the best way to give adequate weighting to additional (or initial) evidence outside of that through the WCA? How can any changes be achieved without placing a burden on GPs and health care professionals, and without compromising their relationships with their patients?

We believe more weighting should be given to the professional opinion of those clinicians in contact with the individual making the claim. This would help not only to reduce the number of people erroneously judged to be fit for work but would assist in dealing with some of the problems of fluctuating conditions and symptoms and of combined mental and physical disorders. These clinicians would also have a greater understanding of how the condition affects the individual and how it might impact on their ability to work.

We would suggest that clinicians are routinely sent ESA 113 forms at the early stages of the process and that these should be sent to CMHT clinicians if appropriate. The clinicians who carry out the WCA assessments should also have sight of these medical assessments when they see the claimants and should be obliged to fully account for a decision which contradicts the advice of the relevant clinicians in terms of the claimant's ability to work.

While it could be argued that this may place an additional burden on clinicians, we believe that supporting service users in their employment aspirations should be a core function of NHS workers. Many clinical teams already offer benefits advice and where a service user is subject to an inaccurate WCA, this can increase the burden on clinical teams. Therefore, involving professionals up-front in getting the assessment right would be a more cost-effective option than leaving them to pick up the pieces of a poorly administered WCA.

To support this it would be helpful to have a named person from the DWP system to be responsible for each claimant's benefits claim who could be contacted by the claimant or clinicians when queries are required and who can assist in guiding the claimant through the benefits system.

6) Is there any evidence to show that there has been particular problems with the WCA for any specific groups? These groups may include, but are not limited to, men and women, people from black and minority ethnic backgrounds, or people from differing age groups.

The information outlined above provides evidence for the specific problems with the WCA faced by those with mental health conditions.

7) Do you have any suggestions for how the WCA process could be improved to better assign people with health conditions to the most appropriate part of the benefits system?

In our evidence we are aware that in many ways the problems that existed for the PCA are still being replicated in the WCA process, particularly the problems with the Atos clinicians and the accuracy of the WCA medical assessment.

Our recommendations are outlined at the beginning of this document.

References

Buist-Bouwman, M.A., de Graaf, R., Vollebergh, W.A.M., Ormel, J. (2005) Comorbidity of physical and mental disorders and the effects on work-loss days. *Acta Psychiatrica Scandinavica* 111, 436-443.

Citizens Advice Bureau (2006) *What the doctor ordered? CAB evidence on medical assessments for incapacity and disability benefits*. London: CAB.

Citizens Advice Bureau (2010) *Not working. CAB evidence on the ESA work capability assessment*. London: CAB.

Department for Work and Pensions (2006) *Transformation of the Personal Capability assessment. Report of the Physical Function and Mental Health Technical Working Groups*. London: Department for Work and Pensions.

Department for Work and Pensions (2008) *Impact Assessment of the Employment and Support allowance Regulations 2008 – Public Sector Impact only*. London: Department for Work and Pensions. <http://www.dwp.gov.uk/docs/impactassessment180308.pdf>.

Department for Work and Pensions (2009) *Work Capability Assessment Internal Review. Report of the Working Group* London: Department for Work and Pensions.

Department for Work and Pensions (2010a) *Employment and Support Allowance: Work Capability Assessment by Health Condition and Functional Impairment. Official Statistics*. London: DWP.

Department for Work and Pensions (2010b) *Employment and Support Allowance: Work Capability Assessment.. Official Statistics*. London: DWP

Department for Work and Pensions (2010c) *Addendum Work Capability Assessment Internal Review. Technical review by the Chief Medical Adviser* London: Department for Work and Pensions

House of Lords Merits of Statutory Instruments Committee (2010) *First Report of Session 2010-11. HL Paper 7*. London: The Stationary Office.

Moussavi, S., Chatterji, S., Verdes, E., Tandon, A., Patel, V., Ustun, B., Depression, chronic diseases and decrements in health: results from the World Health surveys. *Lancet* 370, 851-858.

Perkins, R., Farmer, P., Litchfield, P. (2009) *Realising ambitions: Better employment support for people with a mental health condition*. London Department for Work and Pensions.

Scott, K.M., Von Korff, M., Alonso, J. et al (2009) Mental-physical comorbidity and its relationship with disability: results from the World Mental Health Surveys, (2009), *Psychological Medicine*, 39, 33-43.

Social Security Advisory Committee (2010) *The Employment and Support Allowance (Transitional Provisions, Housing Benefit and Council Tax Benefit) (Existing Awards) Regulations 2010 (S.I.2010 No.875)*. London: The Stationary Office.

Verbeek, J. and van Dijk, F. (2008) Assessing the ability to work. *British Medical Journal* 336, 519-520.

Waddell, G. & Burton, A. (2006) *Is work good for your health and well-being?* London: TSO.