

## **R51: Response of Disability Alliance to the Transformation of the Personal Capability Assessment paper**

Moira Henderson  
Head of Health and Benefits Division

22 September 2006

Dear Moira,

Thank you for the draft paper *Transformation of the Personal Capability Assessment*. As a member of the PCA overarching group, we welcome the opportunity to provide comment on your draft paper, having commented on the review process to date as well as appreciating that this has been a demanding undertaking in a short space of time.

However, we still have a number of concerns about the recommendations and raise these below. In our view, it is essential that these concerns are addressed if you are to ensure the transition takes place as well as is possible.

### **Recommendations**

#### **(i) to accept the proposals for revised PCA physical and mental functional assessments**

Disability Alliance feel that there must be proper resources made available for piloting and testing the new PCA, particularly in relation to time spent examining and talking to claimants, if the new assessment is to have a chance of operating effectively. Disability Alliance has some concern over the practical application of the new PCA, particularly in respect of the mental health descriptors. There are now some 15 discrete areas of assessment under the mental health descriptors, along with 11 areas measuring physical health.

Whilst there is no doubt that the proposed descriptors for mental health, represent a much more intuitive and perceptive grasp of the effects of mental health conditions, learning disabilities, and autistic spectrum disorders (ASDs), many descriptors could be extremely difficult to assess by way of medical examination and interview, as structured at the moment.

Currently, examining doctors are precluded, in law, from asking claimants any direct questions related to the mental health descriptors. Instead, they have taken a '*describe a normal day*' approach. Disability Alliance acknowledge that this test does not provide an adequate exploration of the issues and barriers to

work for people with mental health problems, but we feel that we need more details of how assessment of the new mental health descriptors will be actually be carried out before endorsing them unreservedly.

We would also raise an issue regarding several physical descriptors, for example, under the 'lost or altered consciousness', 'vision', 'hearing', 'speech', and 'reaching' headings, which all appear to have been made more stringent. We were not part of the technical group that considered the physical descriptors but we cannot recommend them without sight of the evidence to justify this approach.

We are not convinced that an examining doctor could properly carry out an adequate assessment of a client, covering the 15 mental function areas, in the time that is routinely made available to them. We also remain unconvinced that the LIMA software will have the capacity to manage this task effectively, given the nuances many of the proposed changes. More information as to how the assessment will take place could assuage these doubts.

**(ii) to test and evaluate the revised assessments, initially to validate the hypothesis that they represent a fair, accurate, and robust assessment of entitlement to benefit on the grounds of limited functional ability, during October 2006**

The proposal to compare scores to ensure that *'those people whose mental and physical functional limitation is such that it is unreasonable to require them to engage in work'* (para.31) does not, in our opinion, stand up to analysis.

If the current PCA is deemed to be unfit for purpose, and the new PCA is untried, then the case for establishing capacity, or otherwise, for work byway of comparing assessment scores simply cannot be made, particularly for previously exempt groups of claimants. We would ask for more details of exactly what criteria will be used to decide whether the new test functions in such a way as to meet this proposal?

The new PCA test can only be as good as the systemic structure within which it takes place. Thus, we believe that unless the whole PCA assessment procedure is undertaken in the round, encompassing aspects such as:

- the abilities and support needs of currently exempt claimants to undertake work,
- the new evidence gathering process, including IB50s, IB113, med certs, etc,
- consideration of medical evidence by decision makers and examining doctors,
- the revised medical assessment,

- DWP decision making (35% of IB appeals were settled in client's favour in 2005), and
- Staff training on new procedures and approaches, especially considering the implied tight timescales for testing.

then, by definition, we feel that an evaluation will overlook many potential problems or issues that could arise from the new PCA test.

**(iii) having validated the hypothesis, to carry out further testing in the early part of 2007, to make any necessary amendments to descriptors or their scores**

Disability Alliance has concerns about the approach to, and the timescales involved in, piloting and evaluating the new PCA descriptors. The proposal to carry out two assessments consecutively (para.31) appears to be unrealistic in a practical sense.

Unless sufficient time and resources are made available to examining doctors, and without proper explanation and support for claimants about what is taking place, we would express concern over whether carrying out both an 'old' and a 'new' PCA assessment will provide credible data to inform any evaluation.

**(iv) to carry out qualitative evaluation of the revised mental function assessment with claimants during 2007**

Disability Alliance has concerns over the lack of consistency in language used, particularly but not exclusively, in relation to the mental health descriptors. For example:

2. *Understanding instructions*, uses 'frequently' then 'occasionally', whereas
3. *Memory and concentration*, uses 'very frequently' and 'frequently', and
8. *Appropriate behaviour with other people*, uses 'frequently', 'sometimes' and 'occasionally', and
9. *Forming relationships with other people*, uses another combination, 'frequently', 'regularly', and 'occasionally'

We feel that there are two main problems with the lack of consistency across descriptors:

- (1) practical application of these descriptors by examining doctors is likely to be subjective and inconsistent, based on the experience of cases referred to DA's Tribunal Support Unit<sup>1</sup>;
- (2) this may create an increased number of appeals made against adverse decisions, simply on the basis of the interpretation of the words involved in the new descriptors.

Your paper states that as well as tightening up these definitions during the drafting process for regulations, there will be guidance available to describe the practical meaning of the descriptors for examining doctors. Again, we would raise two points:

- (1) the drafting lawyers will be primarily concerned with ensuring the robust nature of the regulations in a legal sense. They will not necessarily be considering the practical application of the regulations, and unless specifically instructed to, could fail to consider each descriptor in the wider context of all of the descriptors used within the PCA,
- (2) guidance is simply that – it has no legal standing, and can be used or ignored, as each individual decision maker or doctor sees fit.

Good regulations should be clear in intent, and clear in application. The drafting lawyers could standardise the words used within the descriptors but this could also change the original intentions of the new mental function descriptors in capturing the full range of conditions and limitations that will require measurement and assessment.

- (v) to develop and pilot a revised IB 50 self-assessment questionnaire during 2007**
- (vi) to complete work in hand reviewing medical evidence gathering, and to pilot the proposed new medical certificates and Ib 113 factual reports during 2007**

The Disability Rights Commission report '*Equal treatment: closing the gap*' notes that despite high levels of ill health, over 50% of people with mental health problems and/or people with learning disabilities said they experienced difficulties when trying to see their GP. We feel this raises very important issues for consideration, in terms of the review of medical certificates (37-39) and factual medical reports (40-42).

There is also an issue around designing appropriate IB50 forms for claimants with learning disabilities and autistic spectrum disorders.

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<sup>1</sup> See also, ***A Bitter Pill, Medical Services Failing Disabled People***, DIAL, 2002, which found evidence of 'doctors making subjective comments in reports'

**(vii) to complete work in hand developing the work-focused health-related assessment, and to pilot the assessment, during 2007**

Disability Alliance has concerns about clients with learning disabilities and autistic spectrum disorders agreeing to undertake unrealistic work-seeking activities (again with the threat of benefits sanctions if not carried out properly) unless Personal Advisers are properly trained to understand the nature of these conditions.

Further, one of the likely reasons for the success of the Pathways to Work pilot scheme so far is the role of the Incapacity Benefit Personal Advisers (IBPAs). Recent research<sup>2</sup> carried out for the DWP found that IBPAs regarded themselves as enablers rather than enforcers; *'they felt that allowing customers to move forwards at their own pace, and emphasising the voluntary nature of participation, were critical to gaining customer commitment and co-operation'*. The researchers go on to note that *'if further elements of compulsion are introduced, care [is] needed that it is not detrimental to the enabler role of IBPAs'*.

IBPAs reported that pre-work focused interview (WFI) contact with customers was important in overcoming customer fears and anxiety. This is interesting because Government introduced the compulsory element of WFIs in the belief that it was necessary to get people to co-operate. In practice, it appears that IBPAs had to counteract that message in order to encourage people into the programme. IBPAs reported using early WFIs to build trust, give information and provide reassurance to customers.

**(viii) in the longer term, to consider exploring development of a combined physical and mental function PCA**

We note that you refer to *'some difference of opinion as to whether sub threshold physical and mental descriptors should be combined'* (para.21). You also state that there is no *'robust evidence'* for the *'greater disability'* concept. Our view is that not allowing these descriptors to be combined, may leave many vulnerable groups without the full support required.

This has been evidenced to a degree by the recent Disability Rights Commission report *'Equal treatment: closing the gap'* which clearly demonstrates that people with mental health problems and learning disabilities:

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<sup>2</sup> ***Incapacity Benefit Reforms: Personal Adviser roles and practices - qualitative research*** by Tim Knight, Sarah Dickens, Martin Mitchell and Kandy Woodfield for the DWP. 2005

*'are more likely to experience major illness, to develop serious health conditions at an earlier age and to die of them sooner than other people.' Yet they are also less likely to receive some of the important evidence-based treatments and health checks than others with the same condition but without a mental health condition or learning disability'.*

The report also notes that people with learning disabilities and mental health problems also experience *'diagnostic overshadowing'* - that is, reports of physical ill health being viewed as part of the mental health problem or learning disability, and so neither fully investigated nor treated appropriately. This appears to be exactly the scenario unrolling with the new format of the PCA, whereby people presenting with mental health problems, learning disabilities or autistic spectrum disorders may find themselves unable to have any physical health problems assessed under the new PCA.

Given the fact that the physical and mental health descriptors are now structured and scored within very similar frameworks, Disability Alliance feel that there is a strong case for the concept of the *'whole person'* approach to interpreted such that all the descriptors, physical and mental can, potentially be explored at each PCA examination. As above, this depends on the DWP ensuring that examining doctors have the time and resources to undertake comprehensive assessments.

We believe that claimants should not be subject to partial or incomplete PCA assessments, or be forced to identify a 'major' incapacitating condition, over other more 'minor' conditions. Disability Alliance has previously raised concerns over the sub-threshold scores being abolished, and the use of a combination of physical and mental health scores being combined, without a rigorous evidence base to support these moves.

Finally, the current exemptions from the PCA are much wider than simply learning disabilities or ASD's. The removal of all low-scoring descriptors, the downgrading of some current physical descriptor scores, and demarcating physical and mental functions in the proposed new PCA assessment, could all serve to give an impression that IB claimants will find their entitlement under threat simply due to the goal posts shifting, rather than any demonstrable improvement or change in their overall medical condition.

We trust that you will find these comments useful and incorporate them when passing your report forward to the Minister.

*'Breaking the link between poverty and disability'*

Yours Truly

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Disability Alliance