Taking on poverty

Therapists are well placed to make a moral case for tackling poverty by tying it a core value of compassion and getting practical, writes **Patricia Murphy.**

The effects of COVID-19 continue to reverberate around the world, disproportionately affecting the most disadvantaged, especially BAME people placed at risk by their social and economic conditions. Many commentators have predicted that the impact of the virus and the associated lockdown will unleash a mental health tsunami requiring an expansion of and improved access to mental health services.

However, members of the Society and Mental Health COVID-19 Expert Group, hosted by the Centre for Society and Mental Health at King's College London have outlined the social underpinnings of mental distress in the time of COVID-19 and argue that there is an urgent need for an alternative approach.

The authors advise against pathologizing normal and understandable reactions to traumatic events and recognise that not everyone who reports

anxiety and sadness will go on to develop a mental disorder. Rather they point to the lessons learnt from previous crises which have demonstrated that the most effective support for those who experience distress is practical and this often means improving financial security.[1]

The numbers of people who have both mental health and money problems has been estimated at four million with a further four million at risk because of current financial difficulties.[2]

Due to COVID-19 these numbers are expected to rise and many people will find themselves accessing the benefit system for the first time.

The effect of UK welfare reforms over the last 12 years on people with mental health conditions has been devastating and in some cases fatal. A government watchdog found that at least 69 suicides could have been linked to problems with benefit claims over the last six years. Indeed, a National Audit Office report stated that the true number of deaths linked to claims could be far higher.[3]

As therapists we have a responsibility to make sure that we are familiar with the system so that we can effectively support our patients as they navigate its complexities. Indeed the Citizens Advice Bureau have produced a document setting out how mental health practitioners deal with people's practical problems in England and have recommended that NHS England expand the integrated care pathway to include practical support and test a range of models for screening practical needs as part of the referral pathway to IPAT and wider mental health services. They have also recommended that the government fund a pilot for integrated practical support in primary mental healthcare settings, including IAPT services.[4]

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Working as an independent practitioner I blogged about my experience of advocating for a patient going through a Personal Independent Payment (PIP) assessment a couple of years ago.[5]

Although the patient's claim was successful, the psychological impact echoed. Bearing witness to her anguish whilst unpacking a long list of personally traumatic details in front of a complete stranger only to be asked when she paused, "Is that it?" as if she was memorising a variety of domestic appliances on a game show conveyor belt was pretty heartbreaking. At one point the assessor noticed that the patient had manicured nails and artfully asked how she managed to get them done if she couldn't leave the house. It was hard not to

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view this as a trick question, an attempt to find some discrepancy in an account, evidence of untrustworthiness or subterfuge. The patient provided a truthful explanation and a legitimate attempt at dignified living was accepted. The benefit was eventually awarded followed by a deep sigh of relief and some breathing space. The sword of Damocles at bay, until the next time.

Unfortunately the next PIP review panned out a little differently. A request to have the assessment conducted at home as before was denied so arrangements were made to meet at the DWP offices. We were led to a sparsely furnished room that gave only a passing nod to hospitality by supplying us each with a chair. The assessor sat in front of a computer screen and efficiently tippity-tapped her interpretation of the patient's answers on her keyboard. As the questions continued to probe the most intimate details of her life I could see her disappear inside the folds of her clothes and we asked for a break. I found out later that she had used this as an opportunity to cut with the blade she had secreted in her handbag. When the assessment resumed it was clear that she was agitated and in a dissociative state. The assessor, who volunteered an employment history in mental health gave the impression that she understood what this meant.

Despite providing various clinical reports and testimony from other agencies involved in her care the claim was rejected and she was awarded a miserly three points for the 10 Daily Living Activities woefully short of the eight to 11 points required to be awarded the standard rate and 12 or more for the enhanced rate.

Astonishingly and despite detailed medical and clinical evidence to the contrary the patient's mental health needs had been ignored and downgraded. We spent many subsequent sessions gently removing the psychological debris this decision deposited in an already infected wound. PIP was stopped immediately which created negative adjustments to her housing benefit and working tax credits so that life became like a game of Jenga. The patient's increased financial dependency on family created tension and conflict, she was pushed into debt and her mental health deteriorated resulting in the need for crisis intervention.

Following a failed appeal and after lengthy discussion we decided to take it to tribunal. The hearing date was set for November and due to COVID-19 restrictions was conducted by telephone. As a patient advocate I was allowed to join the call and my patient and I set up a simultaneous Zoom call beforehand, during and after for additional support.

These are some of the key practical lessons we learnt.

1. Be psychologically and practically prepared. Preparation begins way before the tribunal. If you are a designated patient advocate you will be asked to submit all evidence relating to the claim. In order to produce something meaningful you will need to review previous submissions and add anything that may have been omitted first time around referring always to the PIP assessment criteria. I found a document produced by the Royal College of Psychiatrists particularly helpful in breaking down the information needed to address the daily living and mobility components. Always offer to share your report with your patient before it is sent and encourage revisions and edits as necessary. Be mindful that seeing all the things you have difficulty with set down in black and white for others to read is excruciatingly exposing and can make for extremely painful reading. Make sure your patient knows that you are sensitive to this and explain why the detail is necessary. Many patients feel demoralised by the exposition of all the things they struggle with. Remind them of their strengths and value and use compassion-based interventions to challenge the shame and stigma that can so easily corrode the dignity and self- worth of those needing to claim benefits. [6]

2. If you feel you have no new evidence to support the claim but believe that your patient was not awarded the correct descriptor points this may be due to the assessor failing to interpret the law accurately. This is particularly relevant with regard to the 'engaging with other people face to face' activity. We discovered that a recent Supreme Court judgement found that the definition of social support and prompting needed to engage with other people was frequently being misinterpreted. Crucially, if the prompting necessary is only effective if provided by someone trained or experienced the patient is likely to score four instead of two points. Up until recently the DWP had always taken the view that any social support necessary had to be provided during the social activity or immediately before it. The Supreme Court held that social support does not have to take place during or immediately before a social engagement, it could take place weeks before or even after the event. For CBT therapists used to planning and evaluating behavioural experiments with patients, understanding our role in providing social support is crucial and means that people who had previously been awarded zero points would now be eligible for four. [7]

3. Provide context and a voice. Therapists are repositories of patient stories. We take detailed personal histories, collaborate on formulations and case conceptualisations and help patients develop fresh perspectives. We are well placed to understand the complexities and contradictions in patients' lives. When the tribunal judge queried an entry in the patients GP records which seemed to contradict her account of difficulty with a daily living task I was able to provide the context for this. Patients with mental health problems often find it difficult to articulate the ways in which their condition fluctuates and affects functioning and can struggle with self-expression. You can be their voice.

I'm happy to say that a week after the tribunal hearing the patient was informed that her appeal had been allowed. She was awarded 13 points together with the enhanced rate for daily living. Payment was backdated for a year.

The discrepancy between the original decision and tribunal finding demonstrates the flaws inherent in our welfare system. In a special article in the BJPsych Bulletin in October 2020 Jed Boardman powerfully articulates the catastrophic effects of welfare reform in the UK, especially those on low incomes. He cites a Court of Appeal judgement in 2013 which judged the Work Capability Assessment (WCA) to "substantially disadvantage people with mental health problems and said that the DWP had failed to make reasonable adjustments to ensure that people with mental health problems were treated fairly in the system". He calls for an overhaul of the current system starting with the ways in which people are assessed for ESA and PIP. [8]

One in two people who appeal in a court against a decision to deny them disability benefits are successful. It takes huge reserves from the patient to pursue a tribunal but as therapists we can ensure that they are fully supported by ensuring that all available evidence is considered and by providing contextual information which allows for more reasoned and balanced decisions.

In the meantime it remains to be seen whether a COVID-fuelled recession will add another notch to the austerity belt. If it does our patients are going to need us to roll up our sleeves and help them to use their stories to change the culture and shift the poverty plot away from one in which the individual is disbelieved, blamed and punished. If footballer Marcus Rashord's incredible campaign to end child food poverty is anything to go by, a cultural shift to fight poverty and not the poor may well be under way. ■

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