



special articles

Psychiatric Bulletin (2001), 25, 475–477

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The Disability Living Allowance Advisory Board

A recent article in the *Psychiatric Bulletin* reviewed how disability and incapacity benefits operate, the structure of the Benefits Agency, and the role that doctors played within the structure (Killoughery, 1999). The article was concerned with three benefits: Disability Living Allowance (DLA); Severe Disablement Allowance; and Incapacity Benefit. Linked to the planned introduction of DLA in April 1992, the Disability Living Allowance Advisory Board (DLAAB) was set up in September 1991. I describe here the nature, functions and activities of the Board.

The DLAAB is an independent statutory board, established under section 3(1) of the Disability Living Allowance and Disability Working Allowance Act 1991. It advises the Secretary of State for Social Security and Department of Social Security medical services doctors on matters relating directly to DLA and Attendance Allowance. The DLA replaced and extended the former Mobility Allowance and Attendance Allowance for those below the age of 65 (Attendance Allowance was retained for those aged 65 and over). The Attendance Allowance Board was dissolved in 1991, with the advent of the DLAAB.

Structure of the Board

The Board consists of a chair and up to 20 other members drawn from the medical and allied caring professions, all appointed by the Secretary of State; at least six members are disabled. Psychiatry is currently well represented on the Board, with an adult psychiatrist, a psychiatrist with responsibility for an NHS unit for the deaf and a child and adolescent psychiatrist. There is also a geriatrician.

The Board has three main designated functions:

- (a) to give advice to the Secretary of State on matters referred to by him/her
- (b) to give advice to medical services doctors on cases referred for expert advice
- (c) to present an annual report on its activities to the Secretary of State (DLAAB, 2000).

In addition, the Board holds meetings with organisations for people with disabilities, and it has an educational role in relation to the decision makers (previously known as adjudication officers).

The above description gives the bare bones of the DLAAB. I was appointed as the first psychiatric representative on the Board in 1992. Appointments are initially for 5 years, renewable for a second term.

Activities of the Board

It is important to realise that the DLAAB is an advisory board, its primary function being to give advice to the Secretary of State on matters referred to the Board by his/her office. These typically take the form of post-promulgation cases, reviews of claim packs that have already been completed to see if particular problems may have arisen for decision-making officers. Decision-making officers and medical services doctors are also invited to attend and it serves as a mutually instructive experience. Rarely, medical services doctors may refer to the Board a pre-promulgation case for advice.

Sometimes the Board may be asked to undertake more specialist studies. Recent examples include child mobility and the transition to independent walking; and deaf/blindness and difficulties these people encounter when they claim benefits. In the second case the Board received assistance from Sense, the National Deaf/Blind and Rubella Association.

The Board also holds meetings with organisations representing people with disabilities, a recent example being a presentation from the Motor Neurone Disease Association, and a future meeting is scheduled with Mind.

The Disability Handbook and DLAAB Update

The *Disability Handbook* (Department of Social Security, 1998) was produced by medical staff from the Department of Social Security, with advice from the DLAAB and contributions from many organisations representing people with disabilities. Its primary function is to help decision makers who are not medically qualified.

It is important to note that, as stated in the handbook, it contains no instruction on the level of award that should be made in a given condition. The decision makers should decide on the level of the award, using the information available in an individual case. In other words,



they decide whether the individual in the submitted claim pack has made a case for care and mobility needs. The handbook, by referring to the likely effects of the described illnesses, helps the decision maker to appreciate the resultant disabilities.

The mental illness chapters cover classification, the more severe psychotic disorders, the less severe neurotic disorders, personality disorders and substance misuse. It is in the area of chronic psychosis that most detailed assessments are recommended. Usually it is care needs, rather than mobility, that are the issue. The handbook advises obtaining a factual report from the consultant psychiatrists, as well as reports from the community psychiatric nurse or other community worker. In complex cases a medical services doctor may assist in posing questions on particular aspects of the person's needs that require clarification. To further assist the decision makers, the DLAAB produce a regular publication, the *DLAAB Update* (contact the DLAAB Secretariat, Room 624, The Adelphi, 1–11 John Adam Street, London WC2N 6HT). Psychiatric reviews have covered the topics of schizophrenia, depression and assessment of suicide and alcoholism (Lucas, 1998). Finally, workshops for decision makers were introduced in 1995, as part of the Board's educational role. As the adult psychiatry representative on the Board, I have opportunities to raise awareness of the needs posed by people with mental illness in the case review studies, in expanding the relevant chapters in the handbook, in articles in the *DLAAB Update* and in the teaching workshops.

DLA and mental illness

Working as a member of the Board contrasts in style to everyday work in adult psychiatry and it takes a little time to adjust to the format of an advisory body. The requests for the cases to be studied may vary widely, from asthma and conduct disorders in children, to osteoarthritis, schizophrenia and dementia.

The claim pack is inevitably a complex document, as it has to cover such a wide spectrum of disorders. Its refinement as an ongoing developmental process is the primary task assigned to the DLAAB by the governmental department. DLA was originally brought in for physical disorders, and the needs arising from chronic psychiatric disorders then had to be incorporated within the already established framework.

The recognition of chronic agoraphobia as a qualifying category for lower rate mobility was a milestone in bringing home the point that the DLA was having to adjust to addressing the benefit entitlements for those suffering from mental illness, as well as the physically disabled. Soon after the introduction of DLA a patient with agoraphobia had their initial claim rejected on the grounds that, physically speaking, the person was capable of walking, so did not qualify for mobility allowance. The appeal against this decision was upheld on the grounds that agoraphobia was a recognised medical condition, listed in the *ICD–10 Classification of Mental and Behavioural Disorders* (World Health Organization,

1992), and that the person was incapable of going out unaccompanied.

The number of DLA claims in the area of mental health has grown considerably since the early days when it was decided that agoraphobia qualified for the lower rate of mobility allowance. Indeed, as illustrated by statistics released by the Department of Social Security (2000), mental health problems had become, during the previous year, the largest single identifiable category for receipt of new awards, that is, 38 500 awards, compared with 28 000 awards for arthritis in the year 1998/99. Overall, arthritis (447 000) and mental health problems and learning difficulties (437 000) represented 42% of all cases currently receiving DLA.

This trend has been maintained in the figures for the year ending February 2001 (Department of Social Security, 2001). The number receiving DLA had increased by 5%, to 2.2 million; the two main causes of disability were arthritis (465 000) and mental illness (479 000), which together represented 43% of all cases.

Some further thoughts

As an advisory body, the DLAAB has a defined remit primarily to monitor the DLA claim pack to ensure that people are receiving their appropriate disability entitlements. Its opinion may be sought on related new government initiatives, such as the proposals for Working Families Tax Credit and Disabled Person's Tax Credit, but it has not, as yet, been involved in the assessment of the working of this area of legislation in practice (Inland Revenue, 1999).

There are a number of questions that inevitably arise in one's mind, as a psychiatrist, through working for the Board. Should assessment of the needs of those with chronic psychoses be separated from assessments of those with incapacitating physical disorders? Should there be some way of establishing national guidelines for the minimal community support network for those with chronic psychoses? Should their benefit entitlements be separated from their social support and community placement requirements? These are questions that lie well outside the remit of the Board.

My personal view is that the needs of those with chronic psychoses differ from the needs of those with incapacitating physical disorders. There are currently anomalies in the system of entitlements for benefits for those suffering from chronic mental illness, depending on whether or not a community residential place is viewed as an extension of the hospital. Patients often express dissatisfaction with the benefits that they receive, with very limited 'pocket money'. Clothes may have to be bought for them through voluntary funds.

Voluntary organisations, such as Mind offices, are working hard on behalf of clients who cannot well represent themselves, trying to get them extra benefits. Consultants are often requested to write in support of an appeal claim and are asked to word their responses carefully to maximise the chances of a person receiving benefit. One is left with an uneasy feeling, at times, that



the claim pack has a framework originally devised in relation to physical disability, and appeals have to be framed in that context. For example, a patient may be able to dress himself, get a take-away, go out on his own to the betting shop, and yet be severely mentally disabled and need supervised care for his own and others' safety.

Perhaps the College, through its Rehabilitation Section, may be stimulated to set up a working party, in conjunction with the involved voluntary agencies, to review the working of the current benefit systems in relation to the needs of people with a severe mental illness. Such a project might throw up ideas on ways to improve the current state of affairs, for the benefit of the most needy of our patients.

Further information on the DLAAB and its activities can be obtained from its website (<http://www.dlaab.org.uk/>).

Acknowledgements

I thank Professor Grahame, Chairman of the DLAAB, and the DLAAB Secretariat for their help in preparation of this article. The further thoughts expressed at the end of this

article are entirely the personal view of the author, and in no way related to the work of the Board.

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Psychiatric Bulletin (2001), **25**, 477–480

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A survey of psychiatrists' and nurses' views of mental health advocacy

AIMS AND METHOD

Advocacy is assuming an increasingly important role in the delivery of mental health services, but many psychiatrists feel threatened by it. This study was performed to ascertain how much doctors and nurses know about advocacy and their attitudes towards it. We interviewed five senior house officers, five staff nurses and four community psychiatric nurses (CPNs) to examine their understanding, experience and opinions about advocacy. A full-

time advocate was also interviewed to establish his views about how well staff understood his role.

RESULTS

In general there was poor understanding of the background and training of advocates, and their Code of Practice. There were also important differences in the way in which different groups of staff saw advocacy, with CPNs having the best understanding. Experiences of

advocacy were positive and it was seen as being helpful both for clients and staff, despite fears that advocates might work to their 'own agendas'.

CLINICAL IMPLICATIONS

There is a need to improve psychiatrists' understanding of what advocacy is, through the involvement of advocates and service users in their training. This would help to allay their anxieties about the role of advocates.

To advocate is to speak on behalf of someone else. Peer advocacy, as defined by the UK Advocacy Network (UKAN), is "support from advocates who themselves use or have used mental health services" (Conlan *et al*, 1994). This is an important provision, especially for those detained under a section of the Mental Health Act

because of the powers given to staff. Under these circumstances advocacy is valuable, and has an important ethical function (Thomas & Bracken, 1999). Peer advocates are independent of mental health service staff and have usually had first-hand experience of using mental health services themselves. They can therefore be seen as