# Neil- Written Reflection and Interview Transcript

*This document contains a written account (submitted by the participant before the interview), and a transcript of the semi-structured face-to-face interview conducted on 18 February 2020. Neil was a Welfare Benefits adviser, volunteering with a UK-wide charity. The transcript and written reflection have been anonymised, with identifying names and places removed or replaced with pseudonyms.*

## Written Reflection

**Background to client**

The client is in his early 20’s. He has a diagnosis of ADHD and is on the autistic spectrum. He also has learning difficulties and exhibits challenging behaviour. Unfortunately, this can involve violence against property and people, particularly those close to him. He was not able to cope with mainstream education and as a result attended special schools and a special unit within the local Further Education College. The client had been under the local CAMS team and is now receiving treatment from the adult mental health service.

His parents were able to claim Disability Living Allowance and at the age of 16 this was converted to PIP. The assessment at 16 involved a telephone interview with his carer and as a result he was awarded 19 points for Care and 10 points for mobility, translating into High Rate Care and Standard Rate Mobility on PIP.

At the age of 19 he was called for a reassessment and as a result he lost both allowances. His parents asked for a Mandatory Reconsideration, which was unsuccessful. They then appealed the decision and came to us for help preparing the submission. It should be noted that our client regarded the loss of PIP as his fault and his behaviour became more challenging after the assessment.

**Submission to the Tribunal**

The submission was made along the lines of the training provided by The Child Poverty Action Group.

It was evidenced by:

* a letter from the client’s consultant setting out his diagnosis and the treatment he was undergoing
* a helpful letter from the client’s GP that basically said that the Client played down his disabilities and that the GPs relied on his mother to provide an accurate picture
* a copy of the clients last Educational Assessment (formerly known as a Statement) when he started at the college

The thrust of the submission was that the assessment was deeply flawed e.g. The client was assessed as being able to deal with complex reading matter, when his Educational Assessment suggested a reading age of between 5 and 6 years old. We also emphasised that his mother was almost completely ignored at the assessment and that she was a vital source of information.

As suggested by CPAG the submission went through the [appropriate] descriptors scoring each and then comparing them with the first and second assessments. Our assessment agreed with the first assessment. Passing reference was made to case law to support the scoring of one descriptor.

**Preparing the Client for The Tribunal**

Unfortunately, we do not have the resources to support clients at the Tribunal. We do, however, provide general advice on attending the Tribunal. This is similar for all clients, be they suffering from physical, mental or a combination of disabilities.

We explain:

* The makeup of the tribunal panel and how it functions.
* The attendance (or usually non-attendance) of the DWP
* The need to review the submission immediately before the hearing
* To inform the tribunal of anything about the client’s current condition that is relevant – in this instance the client had to take additional medication to relieve anxiety before the hearing.
* The importance of the person supporting the client. In this case the client’s mother could provide key information, but in any case making sure that all the points made in the submission are covered.
* The need to be honest neither overstating, nor as is often the case, being stoic.

**Feedback from the Client’s Mother**

The client’s mother reported that she felt that she had had a fair and sympathetic hearing. She had attended a previous tribunal during the early days of her son’s claim for DLA and had also found the process to be reasonable.

**Outcome**

The Tribunal agreed with the first assessment and our submission and reawarded high-rate care and standard rate mobility. It is unfortunate that this process took approximately 40 weeks.

## Interview Transcript

I = Interviewer P = Participant

[first half of interview audio lost- interviewer notes at end of this transcript]

**I** I think we've spoken quite a bit about sort of the advice side and the process. Just wondering if you had anything that sticks out in your head about what's different about advising someone who's say got a definitely visible, well-known disability and someone that's got something that is hidden, or maybe medically is a bit less clear for people.

**P** Hmmm. Basically, I don’t think we vary the advice. I mean what we will try and do is with the hidden disabilities I guess it’s more important to get evidence if we can. So, for example from…if they are actually getting support from a MH unit that can be very useful. Just recently I've had a couple of clients transferring from DLA to PIP at the age of 18 and getting their educational report, it used to be called a statement, is invaluable. Because it takes the guesswork out of things. But, I mean, there is a general problem about how… there are certain parts which are relatively easy to deal with, preparing a meal. But obviously, that is with physical difficulties, but obviously that becomes more difficult when someone hasn’t got the desire to cook so getting support, but generally speaking, I guess the evidence, the approach is quite similar and quite often, there's a mixture of both hidden and well I suppose of you could put it as physical and mental health problems often come together.

**I** Do you think people understand it in that kind of distinction with it being mental health or physical?

**P** Yes. I think the hardest, one of the hardest things to deal with is anxiety and depression, that really is very difficult.

**I** Why is that?

**P** Well it’s proving it, it’s providing evidence. I’m trying to think of clients that I’ve had with anxiety and depression problems. I mean for a kick-off when you get to the appeal stage, you'll often get clients, well no not often, you get clients that do not want to take the appeal further because of their anxiety... to a certain extent it's a catch 22 situation isn’t it, you are trying to tell the assessor that you're depressed and anxious, and you’re appearing at an assessment so the assessor has already said well if you can… and another client who got a home assessment and the assessment said ‘the client seemed at ease with the assessment’. But they’re at home [exasperated].

**I** Have you found that that is the case, that being able to deal with the assessment is taken as, well they’re not that bad then…

**P** Not exactly, but you get the hidden vibe that that is the case. The fact that they walked into the interview room tends to indicate that they can move. The same with anxiety.

**I** It seems to be that one of the key issues with the fluctuation with a lot of the symptoms, a lot of medical conditions is one day you can be fine the next day you are in private so it can be hard to explain that because you can’t see it.

**P** Well, if possible, what we try to do is get the client, if we’ve got time certainly for an appeal I’d do it, I’d get clients to do a diary because obviously what you're looking for is that they are, their bad days are 50.5% of the time. I mean actually one of the criticisms at CPAG, the guy doing the CPAG course, was that the forms are very badly designed, whether its high conspiracy or cock up. They tend sometimes to …you know you have ‘are you affected all the time’, ‘not affected’, or ‘sometimes’. And basically, I’m very wary about ticking the ‘sometimes’. Always try and quantify it. So, we actually pushed the client, so all my bad days are 4 days out of 7, a week out of a month, whatever it is, so we can quantify it.

**I** Is that something that's quite difficult to get out of clients?

**P** Oh yeah, yes very difficult. As I say thinking about it the diary is particularly helpful with people with hidden disabilities.

**I** Do you think it’s helpful to you or helpful to the overall process?

**P** Well, what we try to do is provide evidence. And again, the issue is that you want to provide evidence to tribunal standard. Here is a contemporary record. It is after the original assessment so, there are problems there, but this is how the client has been over the last month and look, actually their bad days are two quarters of the time.

**I** Do you sort of know how those different pieces of evidence that you've mentioned are taken, so you've got some of the medical evidence, statements…

**P** At what stage?

**I** At any stage that you are familiar with, so medical evidence in comparison to the diary for example.

B I think at the assessment very little. Um… I think at mandatory reconsideration a little bit more. I think it’s only when it gets to tribunal stage that the evidence is really scrutinised quite thoroughly. Because I think at mandatory reconsideration the decision maker is basically looking to see if there are any gross errors in the assessment and they will take the assessors word as being their version. At that stage they don’t seem to take into account… so unless you can really nail them… with something that is so blatant…

**I** Has it got to be something that is definitely wrong in the assessment?

**P** Yes it seems to be that way.

**I** So you had said you sort of help make the cases for tribunal, but you don’t support people to go, but you do give them advice before going?

**P** Oh yes. So, we will tell them what to expect. So, there’s a number of sites where there… some of them there are videos and there is all sorts out there. You’ve got to be a little bit careful because some of it is a bit… we’d only give advice from reputable sources.

**I** What do you mean by some sites that are...?

**P** Well you go onto uhh… YouTube and there are all sorts of things if you put PIP assessment.

I I’ve never thought to do that [laughs].

P [laughs] Well do! Because you’ll find there’s some very good ones and there’s ones where it’s basically just someone slagging off the system. So, we’ll tell them what to expect, so you know, it is a court of law and there will be a Judge, but they’ll be in a lounge suit or jacket and there’ll be a doctor there and someone who will be an expert in your sort of disability. And the DWP may deem to turn up but they usually don’t and go through the process. And we always try and encourage people to go with somebody particularly if it’s a carer. Umm and if we can talk to the carer tell them about what they can do. Classic stuff, like you read the submission before you go and if you’ve got a carer with you, if they can almost go through and tick things so that if something is missed, they can say ‘oh by the way this has been missed’. And we will tell them that the assessment, basically, at the assessment and at the tribunal as well, as soon as they walk into the building it matters.

**I** What do you mean by that?

**P** Well certainly with the assessment and certainly with tribunals as well, that you know…if they come in clicking their heels and bouncing up and down and they’re trying to go for mobility, not that we’re trying to encourage people to be dishonest, but they need to be aware of that.

**I** You said you have had a few people that have gone through the tribunal and appeal. Do they come to you afterwards to talk about the outcome?

**P** Some yes, we encourage them, we encourage people to come back to us at any stage to see how they’ve got on. In general, I have to say that the feedback is generally positive. They felt they were being listened to. I’ve only had one client who was very, very unhappy umm… and my assessment was she could adopt quite an aggressive attitude and basically, I think she just upset them.

**I** It’s interesting about that needing to present yourself, how much does that become a factor in whether it’s a weak case and how much that sort of evidence is going to be bolstered by your good performance…

P It will be inevitably, as in any court…if you are defending yourself on a burglary charge and you look shifty perhaps the chance of getting a guilty verdict increases…

[Break- recording paused]

**I** Is there anything else that pops into your mind about when you support people with disabilities so what I'm looking at is some sort of conditions that are not well understood like ME and fibromyalgia and that side of stuff. How that looks with the medical evidence, whether it's difficult to get that for certain people.

**P** Well, I mean, I think there's a general problem getting medical evidence, the days where the GP always saw the same patients are gone and GPs are so overwhelmed that they seem to be very reluctant to produce reports. Now we've, we've got… I will basically give the client letters to ask their doctors, which are, it's getting a medical professional, it’s not the diagnosis, it's the affect that’s the important thing. Yeah, they’re very good at saying x y z has got such and such syndrome, but not very good at saying more. This gives them constant pain *and* as a result her thought processes are affected etc, etc. We do again what I’d always do if it’s something like even if it’s something like MS, I’ll have a look on the appropriate charity’s websites because you can find a lot of useful information there to help a client put their case forward. So, it's not only, it's not only hidden conditions, it's variable conditions because as you can be very badly affected, or you can be hardly affected at all.

The vast majority of clients we’re dealing with have got a combination of problems, it’s not … it can be a mixture of both.

I When they have a combination of those two, do you need to highlight one issue more than another say?

P What I would tend to do is if it's, you know, if it's that they've got a part of their illness and they have a specific diagnosis that affects specific indicators I would tie the two together.

I Really interesting what you said about Dr sort of being out to say the diagnosis is, because it seems like that's the shift from DLA to PIP was supposed to be about, was how it affects you every day. So, it's like the, a bit of a lag in catching up?

P And I think the problem is, in the last 5-10 years, as I say, very, very few clients now seem to have a GP that they go to that knows and understands them.

I They don’t know them as a person.

P Yeah. So, they'll look at the records, which these days are excellent, but it doesn’t really tell them about the person.

I So that’s where your diary evidence would come in to fill that gap, so you get the diagnosis from the doctor and then actually how...

P Yes this is how that is affecting.

I Basically I could keep you here all day talking, but thank you it has been really useful and if there is anything else that comes up you can get in touch…

Interview recording ends

[talked outside of recording for 15mins about clients]

## Interviewer notes

* Volunteering for 7 years at [UK-wide advice charity] - wanted to contribute.
* The best bit of the job is making a difference to a client.
* Client that has lost PIP and the associated benefits that come with getting it and getting it reinstated for them.
* Ironically if she had come in earlier then they would have advised her not to submit a change in circumstances
* Some clients are just not capable
* Most significant bit was PIP changing the criteria- tightening up the mobility criteria and stinging benefits
* People here in this area people are dependent on a car as it is a rural area
* PIP transitions from DLA to PIP is quite difficult
* Depends on what stage people come to them at
* At any stage. Believe what they tell us do an assessment based on the descriptors. If they have a good case then we tend to help. Especially if they are not so capable
* Weak case we signpost to other services. Doesn’t mean that they don’t have problems but we don’t have the time or resources to help them.
* Medical reports, carers and produce as much evidence as possible. Practice is to go through as if you are preparing a case at tribunal to keep it consistent.
* MR cases the success rate is low- had more success at the tribunal than MR. Sometimes stopped by the DWP before the tribunal. Submitted a case- happened twice and then the DWP change. But never had success at MR
* At each stage assess the need for support. Not support a weak case.
* People are stoical. Look for a number of things. We don’t do a physical exam but basically do what they would at the assessment and observation.
* Observation based on instincts and experience.
* People accept the condition that they’ve got. They could have pain all the time and if there is more pain then that is just how life is for them. Common with people with disabilities to underplay.
* We tell them to be honest but to make it clear. i.e., if they are anxious and need to take more medication before the assessment because of their anxiety then they should tell the assessor that. Tell people to talk and not underplay.
* It is personal information.
* Assessor looking for quotas- judging by the cases that I have seen. Not necessarily representative because I see the worst ones.
* They [assessments] should be recorded but it has to be a two-track recorder which people don’t have. This would solve all of the issues with people
* We are not impartial; we are on the side of the clients. I guess we are impartial in that we are looking at the criteria
* Assessment is difficult especially for people with hidden disabilities.
* They are looking to fail people.
* I don’t know the % of clients that actually go through the tribunal. Around 30-40% clients that come to me don’t have a good case.
* Look at the reasons for the score and why our score is different- told not to spend too much time ‘rubbishing’ the assessment. Advised this because it is better to make positive points, not negative, and look for evidence, gather information and case law.
* Difference in advice for hidden and physical- we don’t vary our advice- with hidden its even more important to get evidence. For example, if someone is receiving MH support then that is good because you can get information on that.
* Couple of clients were moving from DLA to PIP and had an educational report- that used to be called a statement- that is really useful evidence
* Often people have a mixture of physical and mental health. MH are the hardest to deal with anxiety and depression. Providing evidence and proving it.
* At the appeal stage people don’t want to continue to appeal so they are in a catch 22.
* If possible and we’ve got the time I ask people to do a diary- we are looking for them to have bad days 50.5% of the time
* CPAG training, the man said that the forms are badly designed. I am always wary of ticking the ‘sometimes’ box. For bad days a diary is particularly helpful.
* Provides a contemporary record for the tribunal, of how they are over the past month
* Assessment gives very little weight to evidence like this…MR and Assessment it seems to be more at tribunal. The tribunal is where the evidence is more scrutinised.
* The MR decision maker is looking to see if there is a gross error and mostly take the assessor’s word. It has to be something definitely wrong.