

Rec'd 31/1/2011

26th January, 2011

DLA Reform Team
1st Floor
Caxton House
Tothill Street
London
SW1H 9NA

Dear Sir

Please find enclosed my response to the DWP consultation request on changing the DLA assessment process.

To place my response in context I wish to make it clear that all of my remarks are made purely from personal experience. I have no connection, association, or affiliation to any organisation that seeks to speak for, or represent, those claiming DLA, or any other welfare benefit.

My submission is from the perspective of a husband caring for his wife. [REDACTED] was first diagnosed with Bipolar Affective Disorder in 1993, and was hospitalised three times over the next three years; the last time she was forcibly sectioned under the mental health act. Subsequently, my wife was assessed under the "All Work Test" and deemed unable to work again, and in consequence of that has been in receipt of Incapacity Benefit ever since. A few years ago we became aware that [REDACTED] may have an entitlement to DLA, and made a claim. [REDACTED] was assessed and awarded the care component at the high level, and the mobility component at the low level.

With respect to confidentiality and use of any information contained in my submission, all I would ask is that you substitute [REDACTED] name with something suitably anonymous, and change any direct reference to [REDACTED]

Yours faithfully

[REDACTED]

[REDACTED]

Question 1. The use of the word disability in this question is predicated on the ability of an assessor to accurately and objectively identify and quantify the claimants limited or absent function. In this scenario, the diminished function may vary over time, but typically the rate of change would be slow and predictable in nature (eg – multiple sclerosis). In turn, determining “the problems or barriers that prevent disabled people participating in society and leading independent, full and active lives” becomes a process that can be documented, allowing for the creation of a pseudo-scientific methodology that, notionally, removes subjectivity from a disabled person's assessment of needs. The end result will require an assessor to follow a pre-defined series of steps to objectively identify the “barrier(s)” facing a disabled person - which by its very tone speaks of a physical obstacle – and prescribe a sequence of steps/actions that allow the “barrier(s)” to be overcome. With this information in the putative claimant's hands, it then becomes the responsibility of a potential employer or service provider to modify their environment to eliminate the said barrier(s), and hence remove the individual's need to DLA support. However, such an approach only works where the barrier(s) experienced by the disabled person is/are readily identifiable, quantifiable, and relatively static over time.

This leaves us with the problem of the disabled person who: does not have a well-defined absence of physical function; whose condition can vary in the short to medium term from complete disablement to full remission; whose disability presentation is not readily or objectively quantifiable; but who, nevertheless, is an individual whose condition is chronic, and has a poor long-term prognosis.

It is in the field of Bipolar Affective Disorder (BAD) that I now possess some expertise. As is clear from my own experience, and supported by entries on the DWP website, BAD is a wide spectrum disorder. Some individuals experience a single episode during their entire lives, whilst others are plagued with devastating symptoms from the initial episode until the day they die.

Taken in the round, the understanding of what constitutes a mental health problem/illness is very poorly understood by the population at large. In support of my contention one need only look at the execution in China of Akmal Shaikh just over a year ago. Various comments reported in the UK press completely failed to grasp the nature of BAD and its effects on an individual - especially when in the manic phase - charging that he must have known what he was doing as his behaviour was not that of a mentally ill person, and that he was therefore, ipso facto, responsible for his actions. The essence of the reporting clearly expressed the view that for a person to qualify as mentally ill requires them to be identifiably unstable, and be seen to demonstrate some form of erratic or bizarre behaviour. Therein lies the primary problem in assessing the needs of the individual, and in turn, determining what are the limits of a “normal life” that can realistically be hoped for.

Therefore, there is no universal answer to Q1 in respect of BAD. Rather, the history of the individual will provide the greatest insight into the realistic prospects for the future. In the case of my wife, her medical history over the past 17 years reveals that her BAD experience can be classified as “mixed”, with “rapid cycling” a significant feature between summer 2006 and summer 2010. For [REDACTED] the best we can hope for is that the frequency of manic episodes will decrease, and that the gap between episodes will correspondingly increase. To achieve this requires: a strict approach to what is and what isn't an advisable activity; the removal of any element of obligation; the time-of-day the activity is planned for (anything that involves being out of the home after 8pm, or staying up late talking with friends after 9pm is contra indicated); in bed by 10pm, and at least 9 hours sleep every night. Within those confines during the periods between episodes, [REDACTED] & I lead a quiet but content life.

But as [REDACTED] has frequently said to me “I have to watch myself like a hawk during the quiet

times for signs of an upswing in mood". However, the problem with this approach is that as an upswing begins, the very watchfulness of which [redacted] speaks evaporates. And as I have realised, if we don't catch the upswing within 48 hours of the first symptoms, the manic episode can not be stopped, only its severity ameliorated, and the following two to three months are varying degrees of hell for both of us. During an episode, I need to be on hand 24/7 to contain potentially dangerous behaviours, a well known aspect of the condition. What DLA means for us is that, taken in combination with [redacted]'s Incapacity Benefit and my small occupational pension, we can have what we classify as a relatively normal life (ie - we can eat, pay the essential bills we all have to pay, and have access to a car to get around - there is no room for holidays or luxuries), and I can be on hand at all times.

[NB - the recent reduction of episodes from an average of four per year over the previous 4 years can be attributed, I believe, to being able to look-out for [redacted] 24/7 since managing to sell my Guest House business at the end of January 2010, and effectively retiring]

Question 3. From [redacted] perspective - diagnosed as BAD type 1, with dysphoric mania and rapid cycling - the primary costs are those associated with being unable to carry out any work (paid or unpaid) and yet still eat, keep a roof over her head, and have access to a carer pretty much 24/7.

Question 4. There is no easy answer to this question in the general case. What I can say, in relation to our personal circumstances, is that with [redacted] unable to carry out any form of work, the combination of IB and the higher level of DLA provide sufficient income - when taken with my occupational pension plus carer's allowance - to meet the costs of the basic essentials.

Question 5. As stated earlier, BAD is a wide spectrum disorder and therefore each case is different, and consequently the level of support can vary significantly. However, as recognised by an entry on the DWP website under the page heading "BAD - Prognosis and Duration of disabling effects", I believe individuals who fit any of the criteria listed on that page should qualify for the new ESA benefit, and DLA benefit of right. To that end, I believe an individual's GP should be the first port of call as they are in the best position to offer an accurate assessment of the individual's capabilities and long term prognosis - especially when measured against the exclusion criteria referred to above. Where an individual with a mental disability is not automatically exempted from a face-to-face assessment, I am deeply concerned that a nurse practitioner or doctor, unknown to the claimant, will be unable to bring to bear the degree of subtlety required when reconciling a claimant's personal circumstances with respect to the pre-defined checklist of capabilities central to the process. From [redacted] point of view facing an unknown medical practitioner, whose only interest is in determining her possible entitlement to a welfare benefit, would result in one of three outcomes: an upswing into mania; a complete denial of the process and a refusal/inability to attend the assessment; attendance with cognitive function impaired, and behaviour unpredictable. It is in this distinction - physical versus mental disability - that a greater degree of awareness is required. Those claimants whose disability can realistically escalate to psychosis, or has done so in the past, must be shown a high degree of sensitivity when being assessed - preferably without any direct contact with the claimant unless agreed between the DWP and the individual's GP as absolutely necessary.

Question 6. From the perspective of a BAD claimant, the primary requirement is freedom from the sort of stresses that the rest of us find irksome, but are nonetheless, manageable. The problem is not one of neurosis - that is, a failure to implement adequate life coping skills that can be remedied by appropriate training and support through something like CBT. The reaction to stress by [redacted] is entirely biochemical, and if allowed to go unchecked will require the administration of psychotropic drugs; and if they fail, psychosis and enforced hospitalisation.

Question 7. Once again, from a BAD perspective, one's GP is the best arbiter of a claimant's condition and whether a fundamental shift in the patient's condition has occurred, and is likely to be maintained, such that a re-evaluation of a benefit claim is required. However, once again I would bring to your attention the DWP website page "BAD - Prognosis and Duration of disabling effects" which, in my opinion, correctly identifies these individuals whose award should be indefinite, and not subject to the constant fear of benefit withdrawal.

Question 9. For [REDACTED] the completion of the DLA application form was a very stressful experience, not least because she was terrified that an unknown medical assessor would be prodding and poking around in her head. It took me nearly 2 years to get [REDACTED] to even consider filling in the forms, and I only convinced her to sign the form when I told her that the final say lay with her GP, and not some anonymous assessor. This problem will most probably be found with those with a mental disability because of their desire to avoid stressful situations and avoid conflict. Inevitably, this will limit applications by such individuals. It will take an external 3rd party (including a potential claimant's partner) to ensure that those most in need do submit a claim.

One would imagine, if not expect, that a potential claimant's family would be best placed to assume this role. Regrettably, my experience is that immediate family can be more of a hindrance than a help – and this is all linked in the with huge lack of awareness amongst the public of just what mental illness is, how it manifests itself, and how it is treated/managed. I've watched two of [REDACTED]'s sisters berate her for not taking her medication, and offering no real emotional support. The greater need was to find a way to disengage from [REDACTED]. Her condition was beyond their understanding, and her recalcitrance at taking her medication was not open to what they viewed as a wholly reasonable "command & control" approach. Because of this, they felt completely vindicated when they disengaged from [REDACTED] and left her unsupported.

To simplify the application process - whilst at the same time ensuring that those who need and are entitled to DLA, and therefore likely to succeed with a claim - the responsibility for initiating the process needs to be delegated to the putative claimant's GP, or local CPN, in conjunction with the claimant's partner (where present).

Question 10. For those with a serious mental disability, the best person in a position to offer a clear assessment of a claimant is their partner/carer and GP. Backup, where it is thought necessary, can be sought from the claimant's psychiatrist and/or CPN, provided they are currently involved with the claimant. I would be less convinced that other family members (or friends), who do not have direct responsibility for caring for the claimant, would have sufficient insight to know their state of mind and true abilities. After [REDACTED] had recovered from her most catastrophic breakdown in 1996, family and friends alike were convinced she would return to work, and simply pick-up where she had left off. None had the insight to recognise that it was the very work she had been doing, and the terrible demands that it had placed on her, that precipitated each breakdown and had eventually led to her hypersensitivity to stress of any kind.

Question 11 & 12. For an individual with a serious mental disability, the key to understanding how to categorise their claim to benefit, and the nature and frequency of review, is their history: the diagnosis; the nature – chronic or acute; the frequency of relapses; the length of each episode and its severity; the availability and efficacy of medication; their degree of family support, (and to a very much lesser extent, external support via a CPN or similar).

A simple form with straightforward assessment criteria is desirable from an administrative point of view, as well as providing the holy grail of a consistent and objective process. However, I can not stress enough that each potential BAD claimant is unique. The DWP site already contains details of

those conditions that entitle a claimant to an indefinite award, but this information should be supplemented by details of the individual's circumstances and history, as detailed above, by the family GP. Should an interview be thought necessary, I believe familiarity with those undertaking the assessment is the only realistic option. Placing a claimant in, what to them, would be a very stressful and intimidating situation is counter-productive, and unlikely to yield meaningful results that, in turn, may very well be open to appeal at a later date.

From my personal perspective I would like to offer the following. For somebody like [REDACTED] facing the completion of a questionnaire, followed by the possibility of an interview with an unknown assessor, the consequential events are quite straightforward to predict: (1) she will want to hide, and may even want to abandon defending her claim; (2) her sleep pattern will become disrupted; (3) in all likelihood there will be an upswing of her mood into agitation and anxiety; (4) I will need to complete the questionnaire; (5) I will need to persuade [REDACTED] to begin medication – primarily to allow her to sleep, but also to try and prevent the upswing inexorably developing into psychosis. If [REDACTED] is called for interview, a number of possible scenarios are then possible: (1) the level of agitation in the run-up to the interview will precipitate a psychotic episode; (2) a psychotic episode is avoided, but I will need to administer a very high level of medication each night in the run-up to the interview, the result being that [REDACTED] will be unfit to attend; (3) [REDACTED] will wake-up still medicated, and attend the interview in an unfit state to be interviewed; (4) wake-up so agitated that she will refuse to attend the interview; (5) attend the interview, but her state of mind will be highly unpredictable with risks both to [REDACTED]'s well-being and those around her.

Question 13. Once again, I can not speak for those whose disability is physical. For those whose impairment is mental, especially those whose history includes at least one psychotic episode, the probability is that a remission of symptoms that seem favourable in the medium to long term will result in the claimant automatically seeking to establish a more normal lifestyle, and hence automatically looking to move away from benefits.

Question 14. For somebody like [REDACTED], the natural inclination is to avoid anything stressful - that includes any direct involvement with any form of bureaucracy. When [REDACTED] was assessed under the "All Work Test" as unfit to work again, she was awarded Incapacity Benefit. It took six months for the award to be confirmed and for the first payment to be made. Unsurprisingly, [REDACTED] ran out of money. Her family were keeping their distance, friends were nowhere to be found (too much damage inflicted during her catastrophic final breakdown), and local CPN/NHS backup non-existent. She was reduced to cooking and eating the dandelions in her garden, desperate as she was, because keeping to herself felt a lot safer than trying to engage with the state benefit system.

Question 20. For somebody with [REDACTED]'s diagnosis or similar (ie – the vulnerable claimants) there should be a one-stop-shop that wraps up the whole benefit claiming process - preferably overseen by close family (if willing to be involved), and/or community medical support staff (eg – a CPN or similar).

Question 22. It is my contention that a claimant presenting with limits to their physical function is not comparable with another claimant whose limited function, though potentially variable, primarily affects their cognitive and intellectual abilities and presents, when at its most acute phase, the very real risk of self-harm, harm to those around them, or suicide.

Bipolar Affective Disorder is not well understood at the primary care level. According to the web publication "The GP" at GPonline.com "GPs typically see three cases of bipolar disorder during their career, but 85 per cent of treatment for these conditions is in primary care."^[1] Worse still, because of the enormously wide spectrum that BAD exhibits, diagnosis without a significant event (eg – psychotic breakdown) can be problematic and lengthy.^[2] Even with a diagnosis, the use of prophylactic care is mixed both in terms of what is offered, and what will work. Lithium is one of most favoured treatments for BAD, but how many GPs know that it is commonly ineffective in cases of dysphoric mania and/or rapid cycling, as are the other well known medications drawn from the anti-convulsant range of medications including Depakote.^{[3][4]}

Personal experience of the primary care on offer to [REDACTED] would support the viewpoint that the quality of treatment on offer in England is variable, and often poor. Before I met [REDACTED] she received primary care through her GP in [REDACTED] where she lived, and had previously worked as a Family Law solicitor. Her GP had been with from before her initial breakdown in 1993, until we married in December 1997. He understood her particular illness, and was very sympathetic to her problem, and yet could not foresee or prevent her subsequent breakdowns. Once married, [REDACTED] joined me at my home in [REDACTED] and remained asymptomatic until January 1999. When the upswing began I had no idea what was happening, or that the sudden mood change was in any way related to BAD. When I did realise that this was a manifestation of BAD, I booked an appointment with my local GP.

I accompanied my wife to the GP's surgery as the upswing into a manic phase began to take hold. I was stunned by what happened next. We were met with the response "we don't do mental health care here; you will need to visit the A&E at the local hospital". With that, they washed their hands of my wife. We were then treated to a visit by a local CPN who, aware of my wife's previous diagnosis of BAD, said that people with her condition could go on to lead full and meaningful lives, and promptly left – her visit must have lasted less than 5 minutes. In desperation at the deterioration of my wife's condition, I took her to the local hospital. We were seen by a team of two people, a nurse and doctor. The doctor spoke limited English, and professed to have just arrived and be unfamiliar with her new responsibilities. At every turn the doctor asked the nurse whether her assessment of my wife's condition seemed appropriate, and what medication to prescribe. At this point I asked [REDACTED] to leave the room on some pretext and tried to get some sense out of these two healthcare professionals – none was forthcoming, so we left. On this occasion the manic episode was contained by me pleading with my GP to prescribe Valium, and by taking two weeks off work. With hindsight, a psychotic episode was avoided by my 24/7 presence and sheer dumb luck. Even so, one particular night still haunts me from that first episode. [REDACTED] was terribly anxious and agitated, and couldn't sleep. She was becoming more and more desperate, and as this was my first experience of mania, I called my GP's out of hour's service. I spoke to the on-call GP – a man I had consulted on previous occasions and thought I knew reasonably well - and pleaded for a visit. He refused to attend point blank, and hung-up.

Subsequently, our choice of GP surgery has been predicated on somebody within that practice having some degree of knowledge of mental health matters. However, they are few and far between. Our last GP proved unique in that his next door neighbour suffered from BAD, and this allowed him to observe first hand the pattern of the disability over a much longer time period than would normally be possible in a 10 minute consultation. However, we have now moved from [REDACTED]

(having sold my business) to our new home in [REDACTED], and have struggled to find a GP who admits to having any knowledge of BAD. In the end we settled on a practice that has a GP who professes to "have an interest" in mental health matters.

This fairly lengthy pre-ambule is designed to show how limited the resources within the NHS are when it comes to supporting people with mental health issues, and in the particular case of [REDACTED]. Bipolar type 1 with dysphoric mania.

Trying to reduce an assessment of [REDACTED] entitlement to ESA and DLA to a set of multiple choice questions that rely on an easily quantifiable set of capabilities and actions will not reveal the true extent of her limitations.

Whilst the following description of some of our experiences is highly personal they, nonetheless, demonstrate the inability of a checklist to adequately understand, let alone assess objectively, the real life problems that somebody with BAD, with dysphoric mania, experience.

1. At 4am one morning, at the height of an episode, [REDACTED] woke in an agitated state. Before I could get my bearings, she had fled the house and was running up the road. I chased after her, and eventually caught her up some 300 yards later. Given her state of mind, she wouldn't let me approach - [REDACTED] finds close personal contact confining and threatening in such circumstances. [REDACTED] was very distressed, and felt her mind was racing out of control. In a bid to deflect the mental anguish she beat both forearms against a nearby wooden fence, and only stopped when the pain was too great to bear.
2. [REDACTED] & I were in [REDACTED] visiting her younger sister and family. The problem was that [REDACTED] was in the middle of a dysphoric episode, which was also the reason for being there in the first place - home was too confining, and she needed to get away. However, no matter where we might be, [REDACTED] will begin to feel hemmed in by her surroundings. Predictably the level of irritability and anxiety started to grow. In such circumstances I can not allow [REDACTED] to go out on her own, especially in the car - driving recklessly is a major concern. To ease the tension in the house I agreed to take [REDACTED] into the city centre and walk around the shops with her. However, once in the city centre, parking was a problem. [REDACTED] just wanted to get out of the car, and became extremely agitated when I wouldn't stop in the middle of the carriageway to let her out. Eventually we came to a set of traffic lights and I had to stop - [REDACTED] took off before I could do anything. I parked on double yellow lines on a side street, and set about finding her. When I did, she was confrontational and ready for a full blown argument. Imagine the scene; a woman is being aggressive towards a man who is trying to persuade her to return to his car. The stares of an uncomprehending public are now on us. I know I can not reach out to her, let alone seek to take hold of her arm for fear of the response of those around us, let alone [REDACTED]. What am I to do - tell the assembled onlookers that my wife is in the middle of a dysphoric mania episode, and is in danger of hurting herself? Who do you think they would sympathise with, let alone, believe? What one has to realise is that mania does not make a person stupid. [REDACTED] was the foremost family solicitor of her generation in [REDACTED] when practising, and had been selected to serve on [REDACTED] at the tender age of 36. The bottom line is that [REDACTED] has a formidable intelligence and the capacity to take-on any and all comers in a debate - a manic episode, before it degenerates into psychosis, makes her abilities all the more formidable. I knew I was beaten, and had to let her walk away and gamble that being allowed some space would allow the rage to subside. I waited in the car for half an hour, and then went looking for her, but without success. I returned to her sister's house and hoped she would return unharmed. As it is, [REDACTED] is a city that is very familiar to [REDACTED] and after she had walked off, had calmed down reasonably quickly. She had hailed a taxi, and arrived home shortly after

me. Her sister was very worried when I came home without her, and when [redacted] arrived home her sister was not backward in telling her off for her perceived bad behaviour – but this approach completely misses the point, as do so many people when trying to understand the actions of those in [redacted] position. Though [redacted] behaviour may seem reminiscent of a strop 6 year old, and therefore in need of a response suited to such a situation, the reality is that her sister, reacting as she did, reignited the rage and was the worst thing she could have done. I have come to realise that giving [redacted] enough space to reflect on what has happened, and avoiding judgemental behaviour, usually brings its own realisation of the risks and problems created during such an event. Too often, family and close friends don't understand who or what they are dealing with, and can often make a situation a lot worse – either by exacerbating the problem, or by their absence.

3. In August 2010, [redacted] was experiencing her second episode of the year. At approximately 9pm one evening I could tell [redacted] was becoming more and more agitated. In such circumstances I have to be very careful when recommending the use of Valium to take the edge off the anxiety – frequently it ends up in a shouting match about me trying to drug her into unconsciousness. The agitation continued to build as [redacted] paced around the house, angered by any item not in its allotted space, or deemed no longer suited to its purpose. Liberally scattered between these observations were highly pejorative and inflammatory remarks about me as a man, as a husband, as a carer – all barbed the way only a spouse can. My job was to be there following her around – listening to every word and ready to respond in a calm and collected manner; taking each verbal onslaught on the chin without a scintilla of reaction, and trying to talk in a way that would allow [redacted] to know she was being heard but not patronised. By midnight, I had persuaded [redacted] to take her due dose of Seroquel – but it was having absolutely no effect. The pressure built until finally at 2.30am the dam burst, and [redacted] collapsed onto the bed in our spare room. She was racked with sobs of such pain, and cried at how merciless her affliction is, knowing that this would be with her for the rest of her life, with no parole for good behaviour. At that moment I knew that [redacted] was feeling suicidal, and all I could do was hold her and agree that the BAD would never leave her alone, but that I would be there for her no matter what. I held her tightly and after about half an hour the sobs began to subside. I was able to take her back to our bedroom and gave her one more Seroquel tablet. I continued to hold her tightly until finally a combination of exhaustion and medication saw her fall asleep. Without somebody present, I feel confident in predicting [redacted] would have attempted suicide.
4. Since that last episode, we have decided to change the regimen and continue with a very low maintenance dose of Seroquel, instead of coming off the medication all together, as has normally been the case. The hope is that [redacted] will get her minimum safe level of sleep, and break the rapid cycling that had been a feature of our lives together over the previous 4 years. The risk inherent in this new strategy is that [redacted] will feel medicated – and regrettably, so it has proven to be. [redacted] mood is very flat, she has little motivation to do anything, and we have not been terribly active outside the home in all that time. However, in November we were invited to a christening, and [redacted] agreed to go. On the morning in question [redacted] woke at 6am; she was calm, but nonetheless nonplussed as she had taken medication the night before. We put it down to a sense of anticipation, and nervousness at being out in public. That night we increased the level of Seroquel slightly to ensure a good night's sleep, but the following morning she awoke after about 6 hours, and went and sat in our sitting room until I awoke. The day passed without incident, and we went to bed as normal, taking the same level of medication as the night before. The following morning [redacted] was up early again, and was bustling around the house when I emerged. I asked how she was feeling and we both knew instantly what the question really meant. [redacted] was immediately defensive, and I knew her mood was lifting.

The day continued apace, and I followed behind. At bedtime I brought [REDACTED] her medication, only I had increased the dosage. The atmosphere went very cold, and the mood very hostile. However, being together for 13 years, and knowing that we accept that it is my responsibility to administer the medication, [REDACTED] relented and took the tablets. Within 3 days the mood level had dipped, and I lowered the dosage level – but not before some harsh words were spoken. A person with BAD is instructed to be watchful of their mood level, and to take action when it begins to noticeably change. But what happens when somebody who is feeling flat suddenly finds the sky is bluer, the air sweeter, and the world full of possibilities? The natural restraint that is there when mood levels are flat disappears in a flash when the possibilities seem limitless. We caught and stopped this episode before it started because I could be with [REDACTED] without let or hindrance, 24/7. Without my early retirement in January 2010, my fear is that this episode would not have been caught, and the seemingly endless cycle of episodes would have continued. This has demonstrated to both of us is how close to the surface the risk of an episode is, and that it takes both of us to be ever vigilant if the warning signs are not to be missed.

What I have tried to demonstrate here is an understanding of how a multiple choice checklist, completed by an assessor who does not know the individual or their history, and who knows little of BAD and its variants & complications, will not uncover the true nature of the claimants condition and its concomitant disabling affects.

To quote from the DWP website: "For any individual the aims of treatment are to alleviate the severe effects of the manic or depressive phase, to stabilise mood between episodes and to lengthen the intervals free of disabling symptoms. Describing the mood as stabilised does not necessarily mean that the mood is normal, or that the condition should be regarded as cured. 90% of people who have an episode of mania will go on to have a recurrence of mania or depression. Episodes of mania or hypo mania may respond relatively quickly to treatment, but the long-term disabling effects are due to the recurrent nature of the illness and the lack of effective treatment, in particular of the depressive episodes."^[5]

At the conclusion of [REDACTED] last assessment by ATOS, even though an interview was not thought necessary, the assessor concluded: "I advise that the functional incapacity would be expected to improve significantly in 18 months". Such a finding is, in my opinion, completely at odds with another entry on the DWP website. The page entitled "Prognosis and Duration of disabling effects"^[6] clearly shows somebody with [REDACTED] level of disability should be entitled to an "indefinite award" (ie – there will be no miracle cure, or significant change in her circumstances, for the rest of her natural life).

[REDACTED] lives with the fear that she will be hauled in for interview, and from the experiences of those she knows through Facebook who similarly claim IB/ESA and have been re-assessed, subjected to a very unpleasant and possibly hostile interview by a complete stranger who has no understanding of her condition, and who will ultimately invalidate her claim. For somebody in [REDACTED] situation I find this intolerable. The best [REDACTED] can hope for is a degree of peace, and I believe that is the least the DWP and its agents should afford her.

- [1] <http://www.gponline.com/Clinical/article/649897/Management-bipolar-disorders/>:
- [2] <http://www.recoverywirral.com/?p=1776&instance=tml-1&action=lostpassword>
- [3] http://www.mentalhealth.com/mag1/p51-bpcf.html#Head_3
- [4] http://findarticles.com/p/articles/mi_m0689/is_3_52/ai_99254320/
- [5] <http://www.dwp.gov.uk/publications/specialist-guides/medical-conditions/a-z-of-medical-conditions/bipolar/course-variants-bipolar.shtml>
- [6] <http://www.dwp.gov.uk/publications/specialist-guides/medical-conditions/a-z-of-medical-conditions/bipolar/prognosis-and-duration/>