

Uptake of welfare benefits by psychiatric patients

Mike Slade, Paul McCrone and Graham Thornicroft

The British benefit system provides for disabled people. However, disincentives within the existing system reduce uptake of benefit entitlements. The link between mental illness and poverty is now well known. If welfare benefits are essential for mentally ill people to function effectively in the community, then changes may be necessary to the current system. These changes include increasing the availability of accessible literature and information from both health and social services sources, further training for mental health staff, and the automatic evaluation of benefit entitlement by the Department of Social Security.

To enjoy life in the community requires money, and the welfare benefits system is the main source of income for many people in Britain. The system is based on the belief that people should receive all benefits for which they are eligible, and that nobody should receive a benefit to which they are not entitled. In this paper we examine the extent to which benefits uptake equates with entitlement for people with mental illness.

Current British benefits system

Responsibility for the provision of welfare benefits in Britain rests with the Benefits Agency, part of the Department of Social Security (DSS). The types and amounts of welfare benefit that an individual can receive are dependent upon income, employment status, disability status, accommodation types, co-habitees, and number of dependants. Uptake may also be influenced by administrative factors. There are no British welfare benefits that relate specifically to people with mental illness. Benefits that are targeted at people with disabilities include Disability Living Allowance, Disability Working Allowance, Severe Disablement Allowance, and Incapacity Benefit (which has replaced Invalidity Benefit). Other benefits may also help people with mental illness, such as housing benefit, income support, council tax relief and child benefit. The

complexity of the system may in itself prevent people from receiving their full entitlement.

Incapacity Benefit has been the most common benefit for mentally ill people (Cobb, 1993). This entails individuals declaring themselves unfit for work. However, for people to enter into open employment they have to state that they are fit to work, and their benefit is automatically withdrawn. Therefore, there can be a financial incentive for recipients to remain on benefits and not work. Disability Working Allowance allows people to work and have their earnings 'topped-up' for a limited period. The original intention of the government was for 50,000 people to receive Disability Working Allowance, with resultant savings of £10 million (Hadjipateras & Howard, 1992). However, only 8,000 had done so by January 1993 (Cobb, 1993).

In April 1995 Incapacity Benefit replaced Invalidity Benefit and Sickness Benefit. Payments to spouses and children have been reduced under this new benefit. In addition a new assessment is required. The old benefit was given if the disability was such that there was an inability to do "work which the person can reasonably be expected to do". From April people will be assessed to see if they can do *any work at all*. In addition the assessment will be self-reported.

The stigma associated with mental illness and the language used in official advice leaflets may be a disincentive to people claiming their full benefit entitlement. To be eligible for Disability Living Allowance (a non-means tested benefit for care and mobility) a person with illness must be "...severely mentally impaired with severe behavioural problems...". To qualify for Income Support someone with mental health problems must be "Too sick or disabled to work". Some people who do not feel that this terminology applies to them may still be entitled to such benefits. Furthermore, benefits that are available to people with health problems generally focus on physical ailments rather than on mental disorders.

Uptake of benefits is low for the mentally ill

Against this backdrop, it will be no surprise that studies examining uptake of benefits among mentally ill people find that receipt of benefits is much less than entitlement. More than half the out-patients surveyed in a London study had not claimed benefits to which they were entitled, and over a third of the out- and day-patients stated that they had debts or were experiencing considerable financial strain (Linney & Boswell, 1987). Another study looked at uptake among day hospital patients in Hampshire, finding that 24% of those surveyed were eligible for non-received benefits, and over a quarter of those in receipt of benefits were eligible for another benefit (Allen & West, 1989).

Mentally ill people are among those most likely to get too low a rate of disability benefit (Hadjipateras & Howard, 1992). The refusal rate for community care grants is currently 70% (Cobb, 1993). Many people have automatic deductions made from income support for fuel bills, paying off community charge or Social Fund loans, water charges, court fines, Child Support Agency or child maintenance payments. In August 1992, 1.28 million income support claimants had some deductions made, meaning that between one-quarter and one-eighth of all claimants live on less than the government believes is the minimum needed to survive, i.e. full income support. This may increase anxiety and prolong recovery in a person with a mental illness (Cobb, 1993). For the Social Fund, no evidence was found by a York University study that those being given help were in any greater need than those who were refused (Huby & Dix, 1992). In one study 73% of welfare advisers believed that claimants were sometimes or often failing to receive their full entitlements, and 77% said that some claimants were being wrongly refused, with mental illness being highlighted as a particular cause of refusal (Hadjipateras & Howard, 1992).

Poverty and mental ill-health are associated

Studies have demonstrated a link between poverty and mental illness (Thornicroft, 1991). Poverty both causes and arises as a by-product of mental ill-health. Reduced earning power is associated with any chronic illness, and being unable to maintain a reasonable

standard of living can lead to depression or anxiety. The unemployed person may feel undervalued by society, adding to the existing stigma of having a mental illness. Furthermore, the 'poverty trap' in which people may gain only minimal extra spending resources through taking a low-paid job, or may indeed be worse off, can further contribute to a reduction in their mental health by acting as a disincentive to looking for work. An in-depth examination of these issues is beyond the scope of this paper but the scale of the association is worth noting: in a review of studies about financial needs, Stewart (1988) concludes that about two-thirds of mentally ill clients are benefits claimants.

Community care means "providing the right level of intervention and support to enable people to achieve maximum independence and control over their own lives" (Department of Health, 1989). When benefit entitlement or uptake is low, dependence on welfare can reduce the social opportunities open to psychiatric patients – integration into and use of community facilities requires money. This can lead to reduced self-esteem, and difficulty in forming and maintaining friendships.

How can uptake be increased?

Lack of information is suggested as a reason for low uptake (Cohen *et al.* 1993). This information should come from both health and social services staff. The respondents in the Islington People's Rights study also highlighted the attitudes they encountered at Department of Social Security offices (Linney & Boswell, 1987), which Marks (1988) suggests may be due to understaffing or social attitudes to mental illness. Training of DSS staff in dealing sensitively with mentally ill claimants and advising them of their benefit entitlements would address these issues.

A study of uptake among psychiatric day hospital patients found that 65% of those surveyed had obtained benefits information from the Department of Social Security, whereas only 4% received entitlements advice from a social worker (Allen & West, 1989). This suggests the need for more social worker provision in statutory settings, such as hospitals and day centres. A generic service programme (i.e. not specifically for mentally ill people) for older homeless people which

included entitlements advice found improved benefit uptake at three year follow-up for those with severe mental illness (Cohen *et al.*, 1993). Care managers for people with serious mental illness would be able to give better advice about entitlements if they were given specific training.

Provision of benefits information should also be a routine part of clinical work for health staff. It has been argued that the provision of benefits information should be integral to a discharge procedure and available to residents of local authority and group homes and community day centres (Marks, 1988). Psychiatrists, nurses, and other clinical staff could be encouraged to ask patients about their benefits receipt whether within the setting of an out-patient clinic or elsewhere. In addition 'benefit clinics' should be seen as integral components of community services.

A study looking at how well-informed patients are about attendance and mobility allowances recommended that doctors should carry leaflets with them on visits and write more helpful letters detailing current and future functioning (Buckle, 1986). Leaflets in GP surgeries would also help. The Citizens' Advice Bureau in Birmingham placed advice workers in GP surgeries, who offered information about entitlements (Jennings & Veitch, 1993). They found that older people, who felt uneasy about visiting welfare agencies, were more agreeable to receiving help legitimised by their doctor.

The final source of information which could be improved is that supplied by government. This could include advertisements in the media, and clearly stated political goals of increasing uptake by eligible claimants. Such an initiative would counteract claims that low uptake is encouraged by omission, for economic and ideological reasons: poor uptake reduces welfare expenditure, and may be seen as acting as an incentive to take paid employment.

Research into uptake among the mentally ill is rare. As Marcovitch (1988) has observed, although the social security budget is larger than that for health, far less research is commissioned by the DSS than the Department of Health. In compiling this review we contacted the DSS Press Office, who knew of no DSS research relating to mental illness. Our final recommendation is therefore that a research programme be initiated to establish how uptake of benefits

by mentally ill people can be maximised. This should address the reasons for low uptake, the extent to which people are making an informed choice not to apply for benefits, and how to ensure that potential claimants are aware of the benefits for which they are eligible.

In summary, we recommend that appropriate information be more easily available from both health and social services outlets. Further training for staff who routinely deal with mentally ill people could be complemented by the use of computer evaluation tools. If community care is to be a reality, then changes will be needed to ensure that vulnerable people are given the protection that welfare benefits can provide.

References

- ALLEN, D. & WEST, R. (1989) The uptake of social security benefits among psychiatric day hospital patients. *Psychiatric Bulletin*, **13**, 626-627.
- BUCKLE, J. (1986) Informing patients about attendance and mobility allowances. *British Medical Journal*, **293**, 1077-1078.
- COBB, A. (1993) *Balancing the Payments*. MIND Policy Report. London: MIND Publications.
- COHEN, C., ONSERUD, H. & MONACO, C. (1993) Outcomes for the mentally ill in a program for older homeless persons. *Hospital and Community Psychiatry*, **44**, 650-656.
- DEPARTMENT OF HEALTH (1989) *Caring for People: community care in the next decade and beyond*. London.
- HADJIPATERAS, A. & HOWARD, K. (1992) *Too Late: a national survey of claimants' and advisers' experiences following the introduction of Disability Living Allowance and Disability Working Allowance*. London: Disability Alliance and RADAR.
- HUBY, M. & DIX, G. (1992) *Evaluating the Social Fund*. London: Department of Social Security.
- JENNINGS, P. & VEITCH, T. (1993) Just what the doctor ordered. *Health Service Journal*, **103**, 30-31.
- LINNEY, J. & BOSWELL, C. (1987) *Social Security and Mental Illness*. London: Islington People's Rights.
- MARCOVITCH, H. (1988) Impact of changes in social security. *British Medical Journal*, **297**, 1282-1283.
- MARKS, B. (1988) Social security benefits for the mentally ill. *British Medical Journal*, **297**, 1148.
- STEWART, G. (1988) Maintaining people with mental disabilities in the community. In *Social Security and Community Care* (eds S. Baldwin, G. Parker & R. Walker). Avebury.
- THORNICROFT, G. (1991) Social deprivation and rates of treated mental disorder. *British Journal of Psychiatry*, **158**, 475-484.

Mike Slade, *Research Worker*; *Paul McCrone, *Lecturer in Health Economics*; and Graham Thornicroft, *Director, PRISM, Institute of Psychiatry, Denmark Hill, London SE5 8AF*

*Correspondence