



Disability Living Allowance Advisory Board

NEWS & UPDATE

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Topics for Future Issues

- ◆ ADHD
- ◆ Autistic Spectrum Disorders
- ◆ DCD (Developmental Co-ordination Disorder/Dyspraxia)
- ◆ MS
- ◆ The Effects of Chemotherapy and Radiotherapy

If DM's have any questions on these issues, please contact us.

DLAAB NEWS AND UPDATE

Hello Everyone,

Welcome to this late spring/early summer issue of the DLAAB Up-date and News. As you know we do try to address the issues which are causing some difficulties for decision-makers and Mental health problems is one of those areas which is constantly requested. So I hope that the article here will address some of your concerns.

Diabetes is often in the news these days too so we thought that some up-to-date information would also be helpful.

We have a lot of ideas for future editions of this up-date but we do want to hear from you so that we can target the areas of concern. We look forward to hearing from you, meanwhile please enjoy this issue.

Anne Spaight
Chair DLAAB

DLA – DEVELOPING A FRAMEWORK OF APPROACH TO MENTAL HEALTH DISORDERS.

Dr Richard Lucas.

INTRODUCTION.

The writer of this article was appointed to the DLAAB in 1994, as the first psychiatric consultant member to the Board. After ten years service, coming up to retirement from the Board, the author reviews the development of awareness of the needs of those with mental health problems over the last decade. An overall framework of approach is suggested that may be of practical help to Decision Makers in their everyday work. The topics of depression, anxiety and panic attacks are taken as illustrative examples.

The point that DLA was increasingly being awarded to those suffering from mental illness as well as the physically disabled, and the needs arising from those with psychiatric disorders had to be incorporated within the new structure when DLA was introduced in 1992. It was made clear upon the introduction of the lower rate of the mobility component that agoraphobics could qualify for the new component.

The number of DLA claims in the area of mental health has grown considerably since the early days, so that now mental health (552,000) and arthritis (480,000) are the two main categories for recipients of DLA benefits, and together represent 43% of all cases (Department for Work and Pensions, 2002).

Recently a new milestone has arisen in the differentiation of assessment of those with mental illness from those with severe physical illness, leading to a Government amendment to the Social Security (Disability Living Allowance) Regulations 1991 relating to lower rate mobility and this has become known as the Dualeh Regulations (Lucas, 2003).

DEPRESSION, ANXIETY AND PANIC ATTACKS.

These are topics that Decision Makers often request to be included as agenda items on day teaching events. It is understandable as they are complex areas. While each case needs individual consideration in relation to entitlement for benefits, having an overall framework of classification is helpful, in arriving at the decision as to whether there is evidence of an underlying mental illness to account for the presenting symptoms (Gelder et al, 2001).

Anxiety disorders are states in which the most striking features are mental and physical symptoms of anxiety in the absence of any organic brain disease. Anxiety states can be generalised with fearful anticipation, worrying thoughts, hypersensitivity to noise, poor concentration, autonomic arousal i.e. hyperventilation, gastro-intestinal upsets, palpitations, urinary frequency, headaches, and disturbed sleep with night terrors.

Anxiety can be also be a prominent feature of depression and may be found in schizophrenia, dementia and substance abuse. We all get anxious at times, but a persistent anxiety state would lead to a diagnosis of a generalised anxiety disorder. In spite of the distressing symptoms, usually a person with a general anxiety state can manage and therefore is unlikely to meet the criteria for entitlement to DLA. Treatment is by psychological treatments such as relaxation therapy, counselling, CBT(cognitive behavioural therapy), psychotherapy or a short period of anxiolytic medication. **Only those few with chronic anxiety states are likely to be under the care of the psychiatric service.**

As well as generalised anxiety states, there are anxiety states occurring in specific situations, known as phobic disorders. There may be situational phobias e.g. flying phobia, or animal phobias e.g. to spiders.

These phobias if incapacitating can be successfully treated by behaviour therapy and may not meet the criteria for DLA. Social phobia is characterised by an avoidance of social situations and is generally treated by psychological therapies. The tendency is to avoid social events not a fear of going out on unfamiliar routes, and so the claimant is unlikely to meet the criteria for entitlement to LRM on these grounds alone.

In contrast many cases of agoraphobia are likely to meet the criteria for entitlement to LRM. Typically the condition begins in the mid twenties but others may start in the thirties. It is more common in women. It may start with a sudden panic attack and feeling faint while out in a crowded store or waiting for public transport. They then start to avoid going distances from the home, and avoid crowds and confined spaces. They can get bouts of depression during which their symptoms may become more intense.

Treatment is by behavioural approaches of encouragement to return to face the situations that they have been avoiding and cognitive therapy for panic attacks. Antidepressant medication may also be given.

Most patients will improve with therapy but few lose the symptoms completely following treatment and relapse is common. However, it can also become a chronic disorder, and agoraphobia lasting for one year, tends to change little in the next 5 years.

Agoraphobia can also be a prominent symptom of a depressive disorder, in this case the prognosis is usually better, as when the depression lifts with medication, the agoraphobia also lifts.

Panic attacks can occur in generalized anxiety disorders, phobic disorders (usually agoraphobia), in depressive disorders and acute organic disorders. Typical symptoms include shortness of breath, choking sensation, palpitations, chest pain, sweating, shaking, dizziness, faintness, nausea, abdominal discomfort, and fears of dying or going crazy. The tendency to hyperventilate when panicking may contribute to many of the symptoms and learning to breath more regularly at such times can prove helpful.

Treatment would address any personal or social problems that might contribute to the panic attacks. Also focus would occur to any associated disorder i.e. agoraphobia or depression. Cognitive therapy, antidepressants or benzodiazepines may be used and where necessary withdrawn slowly to prevent withdrawal symptoms.

Depressive disorders are common conditions with some 3% of the population seeking help for this condition at any one time.

Classification tends to be divided into mild, moderate and severe depression, depending on the severity of the symptoms. The majority of mild cases will be mild and treated by the GP. Only the more severe cases, where DLA considerations may arise, will have been referred by the GP to the specialist psychiatric services for management.

Depression can present clinically with many differing symptoms. Depressive episodes are typically treated with antidepressant medication. Very severe episodes would require hospital admission. **Antidepressant medication** is divided into three groups. The older, tricyclic antidepressants are noradrenaline re-uptake inhibitors. They include Amitriptyline, Imipramine, Prothiaden and Lofepramine. The newer SSRIs (selective Serotonin uptake inhibitors) include Cipramil, Seroxat, Prozac and Lustral. Some antidepressants combine the properties of both the two groups these are Venlafaxine and Mirtazapine.

Manic episodes are treated with major tranquillisers, such as Chlorpromazine, Haloperidol and Amisulpride and mood stabilisers (e.g. Lithium, Carbamazepine and Valproate). The mood stabilisers are given to try to reduce the frequency and severity of relapses in recurrent bipolar disorders.

PUTTING THEORY INTO PRACTICE.

The customer described in the following example would be unlikely to meet the criteria for entitlement. A 35-year-old man with a history of alcohol and drug abuse reports that he is in a fearful state all the time. He feels depressed, has panic attacks, cannot look after his own needs at home and is too frightened to go out unless he is accompanied. His girl friend confirms that this is the case and that she has to look after him. He reports having continual suicidal feelings, has previously taken an overdose and cut himself, and needs someone with him all the time to prevent this from happening. His partner also writes that this is the case.

Drug misuse per se is unlikely to give rise to DLA entitlement, unless it has caused organic brain damage, and the person can seek help with treatment through the district drug and alcohol service. An applicant and his partner claiming that he is in a disabling state of fearfulness is not indicative of a formal psychiatric disorder, such as agoraphobia with panic attacks, or a major depressive episode. For this to be the case, one would expect the patient to have been referred by the GP to the local community health team and the consultant psychiatrist or community mental health nurse or psychiatric social worker involved. It

would not be advisable for the DM to rely solely on the information provided in the claim pack in such a case.

Expressed suicidal feelings do not necessarily indicate a requirement for supervision, but have to be considered in the context of the overall presenting picture. It is not possible to prevent anyone from taking an overdose or self-harming. Clinically speaking, every time a patient is seen with a severe depressive episode, a risk assessment is made as to whether they can be safely managed in the community, or admission is warranted.

An example where entitlement may be appropriate would be a fifty-year old woman with a two-year history of unremitting depression. She needs to be looked after by her daughter, who cooks and does the housework. She is not able to attend outpatient appointments unless accompanied. Attempts are being made to involve her in going by transport to a community day centre. She sees the consultant psychiatrist for outpatient monitoring of her antidepressant medication and has a community support worker.

With regard to prognosis for unipolar depressive disorders

The average length of a depressive episode is about six months, 25% of patients have episodes of more than a year.

- ◆ About 10-20% develop a chronic unremitting course.
- ◆ About 80% of cases with major depression will have further episodes.
- ◆ Over a 25-year follow up, on average patients may experience five further episodes.
- ◆ About one third of patients do not achieve complete remission between episodes.
- ◆ About 25% of patients with unipolar depression achieve a period of five years clinical stability with good social and occupational functioning (Gelder et al, 2001).

One needs to be clear in one's mind that one is referring to moderate to severe episodes of depressive disorder, with the clinical features as described above. This needs to be distinguished from reactive more neurotic depressive moods to stress, where the patient might see their GP only rather than referral to the specialist service, and where the low mood is shorter in duration.

With regard to bipolar disorder

- ◆ The age of onset is typically around age twenty (late onset may be precipitated by organic brain disease).
- ◆ The average length of a manic episode is six months.
- ◆ 90% of patients with mania will experience further episodes of mood disturbance.

- ◆ Over a twenty-five year follow-up, bipolar patients will experience, on average, about 10 further episodes.
- ◆ The interval between episodes may become shorter with age and number of episodes.
- ◆ Only 20% of bipolar disorders achieve a period of five years clinical stability with good social and occupational performance.

Patients are sometimes categorised into bipolar I and bipolar II disorders.

- ◆ Bipolar I have severe manic episodes.
- ◆ Bipolar II disorders have primarily marked depressive episodes, but only very mild hypomanic episodes.

Category II patients have a better prognosis, whilst rapidly recycling patients have a worse prognosis (Gelder et al, 2001).

However, in clinical parlance, often the term hypomania is used to describe quite severely disturbed states of mind, with reserving the term mania only for very extreme states.

Despite the general statistics on prognosis for unipolar and bipolar affective disorders, in relation to DLA entitlements, each case will require individual assessment.

Background information sought from the specialist mental health service, the consultant psychiatrist, community mental health nurse or psychiatric social worker may help the Decision Makers in their deliberations.

References used in the preparation of this article can be obtained from the DLAAB Secretariat.

The Board thanks Dr Richard Lucas for his valuable contributions over his years of membership. His services to the Board were recognised by the award of an O.B.E. in the New Years Honours list 2003. We wish him continued success.

The rising prevalence of diabetes is likely to lead to more claims relating to the condition. Here are some frequently asked questions with responses.

FAQ'S DIABETES

Dr. David Cohen

Q What is the modern treatment of insulin dependent diabetes in young people?

A Most people will now be taking four insulin injections a day using a pen injector. They will also be testing their own blood sugar once or twice a day.

Q Who can best tell me about the care needs of a person with insulin dependent diabetes?

A Most people with diabetes on insulin cope well with their illness. The time needed for injections and blood tests is only a few minutes a day. Even if a parent needs to supervise a child this would barely be in excess of the normal supervision needed (maybe five minutes three times daily). A few people have serious difficulties because of unstable diabetes and need closer supervision. These people will almost always be known to a diabetes specialist nurse who will have much better knowledge of the day-to-day needs than a doctor. They should be the first source of further evidence if needed.

Q The claim pack says that a 16-year-old boy needs close supervision four times a day for his diabetes and watching over at night in case he goes hypo. Is this usual?

A Most children and adolescents cope well with their diabetes and can do so by themselves. It is natural for parents to be anxious and sometimes over-protective of their children. A diabetes specialist nurse is the best person to give advice if a particular person's needs seem above average.

DLAAB NEWS

MEETINGS WITH OUTSIDE ORGANISATIONS

The Board meets regularly with outside organisations. At these meetings Board Members with relevant skills, expertise or interest have discussions with representatives of various groups.

The Board invites specific groups and also welcomes approaches from any group who feels it would benefit from meeting the Board.

We use the News and Update as a means of directly informing DM's of changes that are new or brought to the Board's attention. This is in addition to the information already available in the Disability Handbook.

Updates to the Disability Handbook are being made via ICT where appropriate. Meeting with the Board gives access to representatives of outside organisations to inform us of issues needing clarification.

Since the last issue of Update the Board have met with:

- ◆ **The Dyscovery Trust**
- ◆ **Beat The Benzo's**
- ◆ **The Charcot Marie Tooth Association**

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THE REMIT

The Board has three main functions:

- To give advice to the Secretary of State on matters referred by him/her.
- To give advice to Department of Work and Pensions Medical Services doctors on cases referred for expert advice.
- To present an Annual Report on its activities over the year to the Secretary of State.

INVITATION TO DM'S

If you have any specific questions or general queries please contact us via the Secretariat.

We wish to use the News & Update as a forum for discussion.

HEALTH WARNING

Please note- the articles contained in this news- sheet are written for the benefit of Decision Makers, to help them with their job.

The articles are **not to be quoted** in any decision or communication with members of the public or their representatives.

GETTING IN TOUCH

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