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Mental Health Protocols: Key Points and Analytical Guidance

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Foreword

This guidance has been produced as part of a Continuing Medical Education programme for practitioners approved by the Department for Work and Pensions Chief Medical Adviser to carry out medical assessments.

All practitioners undertaking medical assessments must be registered practitioners who in addition, have undergone training in disability assessment medicine. The training includes theory training in a classroom setting, supervised practical training, and a demonstration of understanding as assessed by quality audit.

This guidance must be read with the understanding that, as experienced disability analysts, the practitioner will have detailed knowledge of the principles and practice of diagnostic techniques and therefore such information is not contained in this guidance.

In addition, the guidance is not a stand-alone document, and forms only a part of the training and written documentation that a practitioner receives. As disability assessment is a practical occupation, much of the training also involves verbal information and coaching.

Thus, although the guidance may be of interest to non-medical readers, it must be remembered that some of the information may not be readily understood without background medical knowledge and an awareness of the other training given to disability analysts.

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Part A – Key Points

Introduction

These evidence based protocols are the result of extensive research by Atos Healthcare. They contain key points on the aetiology, diagnosis, treatment, prognosis, and main disabling features of the mental health conditions that are most commonly encountered in the field of Disability Assessment Medicine.

These key points are intended to be particularly useful as a quick reference guide. The full text of the protocols is available on CD and on SharePoint.

The key points that are presented in this section are complemented by the other parts of this module, which incorporate original analytical guidance and advice on the most relevant assessment techniques.

1. Depression

1.1 Definition

- **Unipolar mood disorders** are characterised by recurrent episodes of depression without intervening episodes of mania or hypomania.
- Historically mood disorders were often referred to as affective disorders. The term 'affective' has been replaced with 'mood' in both international classification systems of mental disorders.
- The concept of mixed anxiety and depression is now recognised as a clinical entity.

1.2 Aetiology

- Adverse life events, especially those characterised by loss increase the risk of a major depressive episode for a period of 2-3 months following the event.

1.3 Diagnosis

- The diagnosis of a mild depressive episode requires at least two of the three core symptoms, plus two of the seven other symptoms for a period of more than 2 weeks.
- Diagnosis of a major depressive episode requires six of the ten symptoms listed below.

Core symptoms are:

1. Depressed mood
2. Loss of interest and enjoyment
3. Loss of energy, fatigue

Other symptoms are:

4. Poor self confidence and self esteem
5. Ideas of guilt and unworthiness
6. Ideas or acts of self harm or suicide
7. Poor concentration, attention and indecisiveness
8. Psychomotor agitation or retardation
9. Disturbed sleep
10. Disturbed appetite

- In major depression with psychotic features, hallucinations and/or delusions may occur, the content being consistent with the depressive mood.
- **Somatic** (or endogenous) depression is characterised by physical symptoms such as early waking, psychomotor retardation or agitation, marked loss of appetite, weight loss and loss of libido.
- Mood disorders are commonly co-morbid with other psychiatric disorders.

1.4 Treatment

- Antidepressants and cognitive behaviour therapy are equally effective in treating mild to moderate depression. In severe depression, anti depressant drugs are more effective.
- Patients prefer talking therapies: counselling, cognitive behaviour therapy, group therapy, brief focal psychotherapy and family or marital therapy.
- Most available antidepressants are equally effective if given at an adequate dose for a sufficient period.
- Antidepressant treatment should be continued for 6 months following remission.
- In those with onset of a major depressive episode after 50 years of age, or with three previous episodes of depression, it is recommended that antidepressant medication be continued indefinitely.
- Electroconvulsive therapy is reserved for cases of resistant depression unresponsive to pharmacotherapy, especially those with psychotic or marked biological symptoms.

1.5 Prognosis

- Co-morbidity is associated with a longer duration of the depressive episode, more psychiatric morbidity and more social and occupational impairment.
- About 70% with moderate to severe illness begin to respond to treatment within 6 weeks; without treatment, the majority can expect to recover eventually, although the natural course tends to be about 1-2 years.
- 12-20% of patients with unipolar depression develop chronic depression: they remain symptomatic 2 years after the onset of the initial depressive episode.
- The lifetime risk of suicide is as high as 15% in those with severe illness.

1.6 Suicide and Deliberate Self Harm (DSH)

1.6.1 Prevalence

- Suicide accounts for about 1% of all deaths every year.
- 70% of young suicides in the UK had been diagnosed with a psychiatric disorder, commonly depressive disorders (55%), followed by personality disorders (29%).
- The male suicide rate is 2 – 4 times higher than the female rate.
- DSH is more common in women than men.
- The highest rates of DSH occur in the 15 – 35 age group.

1.6.2 Diagnosis

- There is no evidence that asking about suicidal thoughts increases the risk of subsequent suicide.

- Risk factors for suicide following DSH include: a high level of suicidal intent, having another psychiatric disorder, a history of previous suicide attempts, social isolation, being aged over 45, being unemployed or retired, and suffering from a chronic painful illness.

2. Anxiety Disorders

2.1 Definition

- Anxiety is a normal phenomenon that occurs in response to stress, and at optimal levels, it can be beneficial.
- Anxiety occurs when an individual believes that the demands of the situation are greater than their ability to cope with it. The bodily (somatic) effects seen in anxiety are caused by activation of the autonomic nervous system, resulting in release of adrenalin: “the fight or flight reaction.”
- **Pathological anxiety** is an unpleasant emotional state characterised by fearfulness and distressing physical symptoms. It is disproportionate to the severity of the stress, continues after the stressor has gone, or occurs in the absence of any external stressor.

2.2 Generalised Anxiety Disorder

- GAD is generalised, excessive anxiety, persistent for more than 6 months.
- Thyrotoxicosis is the commonest physical cause of anxiety.
- Co-morbidity with other mental health problems is common, and is associated with increased disability. 10% of patients with GAD become dependent on drugs or alcohol.
- Other unfavourable prognostic features include:
  - Personality Disorder.
  - Derealisation and Depersonalisation.
  - Poor quality of relationships.
  - Long duration of illness.
- GAD is a chronic condition. Spontaneous remissions are rare, and relapses are common.
- About 40% of patients will experience full remission after 5 years.
- Having achieved improvement, 33% of patients will suffer a relapse in the next 3 years.

2.3 Panic Disorder

- Panic disorder is recurrent, acute, **unprovoked**, periods of intense fear (panic attacks).
- **The cardinal feature of panic disorder is fear of dying, going mad or losing control.** During a panic attack, the patient experiences such severe fear that they have to 'flee', regardless of the consequences. The episode resolves after a few minutes.
- Panic disorder occurs in 1 or 2% of the general population.
- With treatment, up to half of patients with panic disorder may be symptom-free after 3 years.

2.4 Agoraphobia

- Excessive fear of a situation, which leads to avoidance of that situation, is called "phobia."
- **The degree of avoidance is a useful measure of severity.**
- Patients suffer severe anxiety in anticipation of going out, particularly if they are unaccompanied. This may result in a restriction of activities such as going to the shops, being in crowded places, using public transport or travelling in lifts (claustrophobia).
- Agoraphobics often feel worse the further they are away from home. Symptoms tend to escalate gradually over time. In the extreme the patient may become housebound, being unable even to open the front door or only able to go into the back (not front) garden.
- In an effort to overcome agoraphobia, the patient may develop alcohol or drug dependency.
- Depression may result from the restriction in lifestyle and social isolation.
- Agoraphobia occurs in about 1.5% of the general population.
- Untreated, agoraphobia typically runs a chronic course.
- 20% of patients with agoraphobia eventually achieve spontaneous remission.
- **90% of patients with agoraphobia will experience significant improvement with treatment.**

2.5 Social Phobia

- Most people admit to social discomfort while under public scrutiny, but social phobia is an excessive fear that a performance or social interaction will be inadequate, embarrassing or humiliating.
- The patient has insight that their fear is excessive and unreasonable.
- Alcohol is often used in an effort to control the anxiety.
- During an assessment**,** social phobics may appear relaxed. Physical symptoms (blushing, inability to speak, shaking or vomiting) may only become apparent when they are placed in the stressful social situation.
- About a third of patients will enjoy a complete remission during long-term follow-up.

2.6 Specific (isolated) Phobias

- A specific phobia is the persistent inappropriate fear of a specific object or situation.
- **The degree of avoidance is a useful measure of severity.**
- The degree of disability depends on the ease with which the phobic object can be avoided.
- In general, specific phobias are less handicapping than other types of phobias.
- Behaviour therapy is the most effective treatment. Drugs are of little use.
- Exposure treatment can achieve long-term cure in about half of patients with specific phobias.

2.7 Treatments for Anxiety Disorders

- Psychological treatments aim to teach the skills needed to cope with the physical and cognitive aspects of anxiety. They are at least as effective as drug treatments. Overall, with psychological treatments, about half of patients regain normal functioning.
- When combined, drug and psychological treatments have a synergistic effect on the long-term outcome of anxiety disorders. Psychological treatments seem to be particularly effective at preventing relapse when drug treatment is eventually withdrawn.

2.8 Main Disabling Effects

- It is important to distinguish common anxiety conditions that have no long-term disabling effects from those that cause persistent disability. “Trait anxiety” (a lifelong personality characteristic) and “stress reactions” (a self-limiting effect of life events) do not cause significant long-term disability.

3. Alcohol Related Disorders

3.1 Introduction

3.1.1 Definition of Harmful Alcohol Consumption

- Alcohol consumption damaging to the psychological, physical or social well being of the individual.

3.1.2 Key Features of Alcohol Dependence

- Increased tolerance – larger doses are required.
- Withdrawal symptoms.
- Cravings.
- Obtaining the next drink becomes the most important part of a person's life.
- The pattern of consumption (timing, place and substance) becomes rigid.

3.2 Quantifying Alcohol Intake

- The recommended safe limits of weekly alcohol intake are 21 units for men and 14 units for women, with at least 2 drink free days.
- Health is seriously at risk when weekly alcohol intake reaches 35 units for men and 21 units for women.
- A unit of alcohol (10ml) is approximately equivalent to: a small glass of wine, a pub single measure of spirits or half a pint of ordinary strength beer.

3.3 Consequences of Excess Alcohol Consumption

- 80% of patients referred for treatment of alcohol abuse have physical complications, including Wernicke - Korsakoff Syndrome, peripheral neuropathy, cirrhosis, gastritis, pancreatitis, oesophageal varices, macrocytic anaemia, cardiomyopathy and gout.
- Alcoholic cirrhosis is associated with a 5-year survival of 48% if drinking continues, and 77% if it stops.
- 40% of alcohol abusers presenting for treatment have depression.

3.4 Diagnosis

- Many heavy drinkers do not seek help.
- A high index of suspicion is required, especially in claimants with medical or psychiatric conditions often associated with alcohol.
- Screening questionnaires have been developed to identify patients who may be at risk from their pattern of alcohol consumption.
- A detailed picture of a typical day gives a good indication of how alcohol affects the claimant's life.

3.5 Treatment of Alcoholic Dependence

- Approximately 70% of all patients achieve a reduction in the number of days of drinking and improved health status within 6 months.
- The majority of patients have at least one relapse during the first year following treatment.

3.6 Prognosis

- Alcohol causes about 33,000 deaths per annum in England and Wales.
- A third of patients manage to recover without professional intervention.
- The onset of chronic complications of alcohol predicts a poor prognosis.

3.7 WCA Considerations

- The mental health assessment should always be applied when assessing claimants with alcohol related disability.
- The most important discriminating factor in assessing the impact of alcohol excess on a claimant is to determine whether they are dependent on alcohol.

4. Substance Use Disorders

4.1 Description

- Intoxication is defined as a transient syndrome due to recent substance ingestion that produces clinically significant psychological and physical impairment.
- Abuse and harmful use are used to define maladaptive patterns of substance use that impair health.
- Dependence is diagnosed in the presence of well-defined criteria.
- Tolerance develops after repeated misuse of a drug.
- Withdrawal state is drug-specific.

4.2 Aetiology

- Important factors are vulnerable personality, adverse social and environmental factors, and easy availability of drugs.
- Approximately 10% of people who experiment with drugs will develop problems with them in the longer term.

4.3 Prevalence

- Difficult to estimate as drug misuse often goes undetected.
- Prisoners tend to show the highest rate of illicit drug use and drug dependence.

4.4 Diagnosis

- Self-neglect may be evident on observation.
- Physical signs can include needle tracks, thrombosis of veins and subcutaneous abscesses.
- Cognitive impairment, altered mood and psychotic symptoms can all feature.

4.5 Treatment

- Can be provided through specialist inpatient or outpatient units, or general practitioners.
- Most cases will be offered individual counselling.
- For most drugs, including opioids, detoxification can be accomplished on an outpatient basis.
- Use of a replacement drug may reduce harmful practices, and facilitate retention in a treatment programme.
- A number of different health professionals may be involved in the rehabilitation process.

4.6 Prognosis

- Drug misuse carries a very high morbidity.
- Drug dependence cannot be cured completely; it can only be effectively controlled.
- Craving and relapses are not the exception, but the rule. A very small dose of the drug, years after the last dose can produce intense craving.
- In those who are dependent on heroin, the mortality at 10 years is 10-15%, with a tendency to natural remission in the survivors, the overall abstinence in the same group being 50%.
- Craving in abstinent individuals is caused by the presence, not the absence of the drug.

4.7 Main Disabling Effects

- Drug users in employment have a high absenteeism rate and a higher incidence of accidents.
- Employment rates for drug dependent individuals are very low.
- The disability arising from drug use is highly variable.
- Effects on the mental state can include altered mood or behaviour, poor concentration and self- neglect. The ability to interact with other people may be impaired.
- The mental and physical effects may be of such severity that advising support group criteria are met can be considered.

5. Schizophrenia

5.1 Definition

- The typical course of schizophrenia is acute episodes of hallucinations, delusions and florid disorganisation of thought; superimposed on a persistent disorder of the initiation and organisation of thought and behaviour.

5.2 Clinical Features

- Schizophrenic symptoms can be seen as an:
  - Excess or distortion of normal function = **positive symptoms** or
  - A decrease or loss of normal function = **negative symptoms**.

Positive Symptoms	**Negative Symptoms**
• Formal Thought Disorder	• Poverty of thought and speech
• Disorganised behaviour	• Impaired volition
• Inappropriate affect	• Blunt affect and anhedonia
• Delusions	• Social withdrawal
• Hallucinations	• Impaired attention

- In chronic schizophrenia, the symptoms appear to segregate into three core syndromes.
  a) Negative symptoms appear to cluster together as part of a syndrome: **psychomotor poverty**.
  b) Positive symptoms fall into two separate clusters, **reality distortion** and **disorganisation.**
- Psychiatric co-morbidity is common particularly substance misuse, anxiety and depression.
- The clinical course of schizophrenia shows significant variability in mode of onset, degree of symptom persistence and long-term outcome.
- The acute phase is characterised by dysphoria, irritability, obsessional thoughts, poor concentration and sleep disturbance; followed by the development of delusions and hallucinations and a rapid deterioration in occupational and social functioning.
- Lack of insight, auditory hallucinations and ideas of reference are the most frequent acute symptoms.

5.3 Treatment

- Drugs are used for treatment of acute episodes and the prevention of relapse.
- Psychosocial interventions are used to prevent relapse and disability.
- Typical antipsychotic drugs are more effective in treating the positive symptoms of schizophrenia, but have side effects that are themselves disabling. The atypical antipsychotics are effective in reducing positive symptoms, may be more effective in reducing negative symptoms and have a better side effect profile.
- Patients who have had several psychotic episodes usually require life-long maintenance antipsychotic medication.
- Psychosocial managements that have been shown to be useful in schizophrenia include: supportive psychotherapy, cognitive behaviour therapy, family intervention and social skills training.

5.4 Prognosis

- **The clinical course becomes established within the first five years.**

There may be elements of symptomatic recovery and recovery of social functioning.

- In most cases the course follows one of four broad patterns:
  - Complete Remission (22%). Though there are no predictors of this.
  - Episodic Remittent (35%).
  - Episodic with stable deficit (8%).
  - Episodic with progressive deficit (35%).
- Death rates of people with schizophrenia are at least twice as high as the general population.
- The leading cause of death amongst schizophrenic patients is suicide. The lifetime risk of suicide in schizophrenic patients has been estimated as 10%.

5.5 Main Disabling Effects

- The disabling effects are due to a range of abnormalities in psychological functioning, such as poor attention and concentration; and failure to recognise, and act on, social or affective cues.
- Disability may also arise as a side effect of the treatment of schizophrenia such as the abnormalities of motor function secondary to antipsychotic medication.
- Persisting moderate to severe disability is present in 40% of males and 25% of females.
- Supported Employment Programmes have been shown to be effective in increasing the rates of competitive employment. Studies do not report adverse clinical outcomes following the change to supported employment programmes, and indeed there have been improvements in non-vocational outcomes reported.
- Analytical Guidance 13.6 details review considerations and intervals.

6. Bipolar Disorders

6.1 Description

- These are severe mental health conditions characterised by marked mood recurrences of mania or hypomania
- Whether manic or hypomanic episodes occur they are usually separated by periods of depression.
- Swings of mood are pathological and recurrent.

6.2 Diagnosis

- Mood swings usually include episodes of depression.
- In hypomania, the clinical features are less marked than in mania and psychotic features are not seen.
- In mania, there may self-neglect, with features such as poor personal hygiene. Inattention to nutritional needs may lead to dehydration. Sustained physical overactivity and aggressive or violent behaviour may ensue.
- Physical appearance may be unusual and speech and thought processes abnormal.
- Lack of insight may mean relevant features are not reported.
- 60% of bipolar patients have psychotic symptoms at some time.
- Co-morbidity with other mental health conditions is common.

6.3 Treatment

- Most sufferers are likely to have been in contact with specialist mental health services.
- Management of acute mania/hypomania is best undertaken in hospital with the use of medication aimed at reducing physical and mental overactivity.
- Atypical antipsychotics are the drugs of choice and may be combined with a mood stabiliser.
- Longer-term management is aimed at preventing relapse or recurrence.
- Lithium remains the prophylactic drug most used, partly due to experience but alternatives may be favoured based on their side effect profile.
- Poor compliance with treatment is a major issue, particularly for those on lithium.

6.4 Prognosis

- The average manic episode lasts 6 months (treated or untreated) with recovery the usual outcome.
- 90% of patients who have had a manic episode will have a manic or depressive recurrence.

- 50% of bipolar patients attempt suicide at some point.
- Less than 20% of bipolar patients are able to achieve a 5-year period of clinical stability.
- The long-term functional prognosis is that high levels of mental health disability are likely.

6.5 Main Disabling Effects

- Disabling mood swings are likely to persist between relapses.
- All aspects of daily life can be severely disrupted.
- Motivation, concentration and cognitive ability may be reduced.
- Long term psychosocial functioning is poor in up to 60% of patients.
- Some claimants with bipolar disorder may fulfil the criteria for substantial risk.

7. Obsessive Compulsive Disorder

7.1 Definition

- OCD has the characteristics of an anxiety disorder. The anxiety is generated by either thoughts or behaviours, to which the sufferer responds by anxiety relieving rituals.
- Obsessions are recurrent **thoughts**, ideas, or impulses, which are experienced as unwanted and distressing.
- Common obsessions include; contamination, pathological doubt, somatic concerns and the need for symmetry.
- Compulsions are repetitive, purposeful and intentional **behaviours**, which are performed in response to an obsession.
- Common compulsions include checking, washing, counting and arranging objects symmetrically.

7.2 Diagnosis

- OCD sufferers are distressed by their condition, whereas people with obsessive personality disorder are not.
- Depression and anxiety are commonly co-morbid with OCD.

7.3 Treatment

- Behavioural therapy and drug treatments are both effective in treating OCD.
- The combination of pharmacological treatment with behavioural therapy is likely to give the best chance of achieving a good response.
- First line drug treatments for OCD are the Selective Serotonin Reuptake Inhibitors (SSRIs).
- Discontinuation of drug treatment is associated with relapse rates of 80-90%.

7.4 Prognosis

- If symptoms of OCD have been present for over 1 year then spontaneous recovery is unusual.
- Relapses in OCD may be precipitated by adverse life events.

7.5 Main Disabling Effects

- Obsessions and compulsions may result in restricted social functioning and social isolation.
- Obsessional thoughts interfere with concentration on study and work.
- Co-morbid depression may worsen the disabling effects of OCD.

8. Adjustment Disorders and Post-Traumatic Stress Disorder

8.1 Definition

- Post-Traumatic Stress Disorder (PTSD) and Adjustment Disorders arise because of acute severe stress or continued psychological trauma.
- A diagnosis of PTSD requires that, “the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others,” and that, “the person’s response involved intense fear, helplessness, or horror.”
- An Adjustments Disorder (AD) is a “state of subjective distress and emotional disturbance that interferes with social or occupational functioning, and which arises during a period of adaptation to an adverse life event.”
- PTSD is an anxiety-type disorder with symptoms of:
  - Re-experiencing the event.
  - Avoidance behaviour and numbing of responsiveness.
  - Persistent symptoms of increased arousal.
- PTSD can occur at any age and may affect children who have been exposed to traumatic events.

8.2 Aetiology

- Adjustment Disorder and PTSD result from the failure of the individual’s coping strategies.
- The most common cause of PTSD is road traffic accidents.

8.3 Diagnosis

- Adjustment Disorders lie on the threshold between normal behaviour and psychiatric morbidity.
- Diagnosis of PTSD is sometimes difficult, as the sufferer may be reticent in describing their symptoms to avoid recalling the traumatic event.
- Co-morbidity with other psychiatric illness is very common in PTSD.

8.4 Treatment

- Treatment of adjustment disorders focuses on psychotherapeutic and counselling interventions. The symptoms of anxiety and depression can be managed pharmacologically.
- Prevention, training and pre-selection of individuals likely to be exposed to severe stressors reduces the likelihood of development of PTSD. This is especially important in occupations such as the armed forces and the emergency services.
- Debriefing immediately following the stressful event does not prevent PTSD and may be harmful.
- Benzodiazepines in the immediate post stressor period are harmful.
- Selective Serotonin Reuptake Inhibitors (SSRIs) improve symptoms in patients with PTSD.
- Cognitive behaviour therapy is effective, especially if combined with SSRI drug therapy.

8.5 Prognosis

- 60% of cases of PTSD have a slow natural recovery time over a period of about six years; treatment accelerates recovery.
- Long-term chronicity remains about 40% with or without treatment.

8.6 Main Disabling Effects

- The disabling effects of these conditions are very variable: each case must be assessed individually.

9. Learning Disability

9.1 Introduction

- In people of working age, learning disability is the commonest disability in the UK.
- Classification of Learning Disability:

Classification	IQ	EQUIVALENT MENTAL AGE	Proportion
Mild	50 – 69	8 – 12 years	85%
Moderate	35 – 49	3 – 8 years	10%
Severe	20 – 35	1 – 3 years	3.5%
Profound	< 20	< 1 year	1.5%

9.1.1 Mild Learning Disability

This is not usually associated with abnormalities in appearance or behaviour. Language, sensory and motor abnormalities are mild or absent. Adults may have difficulty coping with stress, and may need support with complex functioning such as parenting and handling their finances. However, the majority are able to live independently in the community and manage some form of employment.

9.1.2 Moderate Learning Disability

People with moderate learning disability are rarely able to live independently, but they may learn to wash, dress and feed themselves. This group have limited but useful language skills. Help is needed with road sense and finances. Challenging behaviour is common. Moderate learning disability is often associated with epilepsy, neurological, and other physical disabilities.

9.1.3 Severe and Profound Learning Disability

This group of claimants have very limited verbal and self-care skills. Epilepsy affects 33%, incontinence 10% and inability to walk 15%. Behaviours such as self-harming or inappropriate sexual behaviour occur in up to 40% of children and 20% of adults in these categories.

9.1.4 Prevalence

- In England, it is estimated that there are 1.2 million people (2% of the population) with mild or moderate learning disability, and about 120,000 adults with severe or profound learning disability.

9.1.5 Aetiology

- There is an obvious cause for mild learning disability in about half of cases. In the remainder, combinations of social, educational and emotional deprivation are the main contributory factors.
- In severe learning disability, 80% have evidence of organic brain damage.

9.1.6 Psychiatric Co-morbidity

- 40% of those diagnosed with learning disability also have a mental illness.

9.2 Autistic Spectrum Disorders

- A group of developmental conditions that affect the way the brain processes information. People with autism are severely affected, while Asperger's syndrome describes people at the higher functioning end of the autistic spectrum.

9.3 Autism

- Autism is a lifelong developmental disability that affects the way a person communicates and relates to people around them. An autistic person experiences a confusing mass of events, people, places, sounds and sights without order or meaning.
- The range of intellectual ability extends from severe learning disability to above average IQ.

9.3.1 Core Clinical Features

- Autism is usually apparent by the age of 3 years.
- Abnormal social interaction: There is poor grasp of non-verbal social cues and avoidance of eye contact, so people with autism may appear aloof and indifferent.
- Impaired language and communication skills.
- A "rigid routine," interests and activities that have a preoccupation with dates or numbers, and a stereotyped behaviour pattern such as hand flapping, nodding or rocking.
- About 10% of children with autistic spectrum disorders have a special skill at a much higher level than the rest of their abilities - for example, music, art, numerical calculations or jigsaw puzzles.

9.3.2 Prognosis

- Autism typically runs a steady lifelong course.
- Although some autistic adults learn to adapt partially to their disability, only 11% gain jobs on the open market, and only 15% achieve independent living.

9.4 Asperger's Syndrome

- People with Asperger's syndrome can speak fluently, but they may not understand the reactions of listeners.
- They often develop an obsessive interest in memorising facts about a special subject.
- Any unexpected happening or change in the routine can upset them.
- Children with Asperger's syndrome usually have normal or above average intelligence, and they attend mainstream school.

9.5 Down's Syndrome

- The vast majority of cases of Down's syndrome are caused by trisomy 21.
- Down's syndrome is associated with a typical facial appearance and short stature.
- 85% have moderate or severe learning disability.
- Physical health problems are associated with Down's syndrome:
  - Congenital heart disease – 40%.
  - Visual and hearing impairment – 50%.
  - Hypothyroidism – 30%.
  - Oesophageal and duodenal atresia.
  - Cognitive decline and dementia (similar to Alzheimer's disease) occurs 30-40 years earlier than in the general population, and affects 25% of people with Down's syndrome.
- Life expectancy is approximately 50 years.

9.6 Fragile X Syndrome

- Fragile X syndrome is the second commonest cause of moderate and severe learning disability after Down's syndrome, accounting for 20 - 30% of learning disabilities.
- A milder form affects girls, who may have normal intelligence.
- Fragile X syndrome is associated with a typical appearance, including an elongated face, large ears and blue eyes. Other features include flat feet, macro-orchidism and hyper-flexible joints.
- The degree of learning disability is similar to that in Down's syndrome.
- The majority of people with Fragile X syndrome need day-to-day supervision. They may work in a sheltered environment, and live at home or in supported accommodation.

9.7 Attention Deficit Hyperactivity Disorder – ADHD

- The prevalence of ADHD in the UK is about 1%.

9.7.1 Core Clinical Features

- **Inattention**
  Easily distractible, forgetful, difficulty sustaining tasks such as play, learning and work.
- **Overactivity**
  Fidgety, reckless, socially disinhibited, inappropriately active, talking excessively.
- **Impulsivity**
  Interrupts and intrudes, unable to “wait their turn”.

9.7.2 Treatment

- Ritalin (methylphenidate) is an amphetamine-like stimulant. It has the paradoxical effects of decreasing activity level and improving attention.
- Medication produces a short-lived improvement after each dose, but it is not a permanent cure.

9.7.3 Prognosis

- By the second decade, impulsivity and inattention tend to improve, even without medication.
- The learning difficulties caused by ADHD in childhood have long-term consequences. About 60% of adults continue to experience disability.

9.8 Education

- Children with learning disability are usually educated within mainstream schools.
- The Equality Act 2010 protects employees with learning disability.

10. Eating Disorders

10.1 Description

- The three most common eating disorders are anorexia nervosa, bulimia nervosa and obesity.
- These are now recognised to be both disabling and relatively common.
- There is considerable overlap between anorexia and bulimia.
- There is usually no underlying psychological causative factor in obesity.

10.2 Diagnosis

- Anorexia is characterised by distorted body image, fear of fatness and deliberate weight loss to BMI of 17.5 or less.
- In anorexia, medical complications occur commonly and can be disabling or life threatening.
- Bulimia is characterised by episodes of binge eating, fear of fatness and self-induced vomiting.
- Obesity is diagnosed when the BMI exceeds 30, and severe obesity when BMI >40.

10.3 Treatment

- The majority of anorectic patients can be managed as outpatients. Hospital admission may be necessary if the weight falls to a dangerous level.
- Psychological measures to treat anorexia include cognitive, behavioural or family therapy.
- Treatment for bulimia follows the same general principles. In-patient treatment is rarely necessary and the management is usually easier than for anorexia.
- Patients with bulimia should not be given tranquillisers because of a high propensity for addiction.

10.4 Prognosis

- In anorexia, 65% have a good outcome and maintain a normal weight.
- Mortality in anorexia is up to 5% over 4-5 years, and as high as 10% in the long term.
- Two-thirds of deaths are due to the effects of starvation, and one-third to suicide.
- In bulimia, two thirds have a continued preoccupation with weight and eating, and about one third maintain a healthy and regular eating pattern.
- Obesity roughly doubles mortality risk.

10.5 Main Disabling Effects

- In anorexia, physical function is usually well preserved, but medical complications are common and may give rise to symptoms such as fatigue.
- In bulimia, the likelihood of physical incapacity increases with frequent bingeing and purging due to electrolyte imbalance and other complications.
- Psychological problems are common in anorexia and bulimia.
- Low mood is particularly common at low weights in anorexia.
- Unless the BMI is over 40, obesity is unlikely to produce significant impairment.

11. Personality Disorders

11.1 Definition

- The point at which personality problems become personality disorders is generally taken as the point at which the personality disturbance results in impaired relationships and reduced social and occupational functioning.
- The categorical approach to the classification of personality disorder assumes the existence of distinct types of **personality disorder** with distinctive features. In reality, few patients fit neatly into any single category and individuals with severe personality disorder may satisfy the criteria in all categories. An alternative dimensional approach has been proposed which is gaining popularity, although it is not yet standard clinical practice.
- The Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM-IV), groups the different disorders into three clusters:

Cluster A	The odd and eccentric group	• Paranoid Personality Disorder • Schizoid Personality Disorder • Schizotypal Personality Disorder
Cluster B	The flamboyant or dramatic group	• Anti-Social Personality Disorder • Borderline • Histrionic • Narcissistic
Cluster C	The anxious and fearful group	• Avoidant • Dependent • Obsessive compulsive

11.2 Prevalence

- In Britain, the prevalence of personality disorder has been estimated as:
  - 2% to 13% in the general population.
  - 32% in primary care patients.
  - 30-40% amongst psychiatric outpatients.
  - 40-70% of psychiatric inpatients.

11.3 Diagnosis

- Personality disorder is often a diagnosis of exclusion.
- The patient's own account of the disorder may be unreliable due to the disorder itself or the patient's self-assessment of personality may be distorted by mood disorders.
- Most people diagnosed with a personality disorder are not dangerous. Danger (to self and others) is most often associated with a dissocial disorder.
- People diagnosed as borderline or paranoid personality disorder may be at higher risk of self-harm and/or suicide.
- Personality disorders are commonly co-morbid with other psychiatric illnesses.
- Dissocial personality disorder is included in the Mental Health Act 1983, and if thought to be treatable, can be the basis for compulsory admission to hospital.

11.4 Treatment

- There is not much research evidence to support the treatment of personality disorder with drugs.
- Aggressive behaviour has been shown to respond to carbamazepine therapy, depot anti-psychotic drugs have been reported to benefit patients who self-harm, and SSRIs have been used in patients with borderline personality disorders.
- Psychosocial treatments aim to provide insight for patients, allowing them to understand their emotions and to find more appropriate coping mechanisms.

11.5 Prognosis

- Personality disorders are lifelong conditions.
- There is a high incidence of death by violence and suicide.
- Obsessional personality disorders are at a high risk of progression to an actual Obsessive Compulsive Disorder, or to depression.
- Paranoid and schizotypal disorders may progress to schizophrenia, but schizoid disorder does not.
- Borderline personality disorder carries a relatively favourable prognosis with clinical recovery in over 50%.

11.6 Main Disabling Effects

- As there is such an overlap between the different disorders, it is unlikely that claimants will fall exactly into neatly defined categories. It is important for the examining doctor to assess the claimant’s actual functional capabilities and not to assume that particular difficulties exist purely based on the diagnosis.

12. Organic Disorders

12.1 Delirium & Dementia

12.1.1 Description

- These are due to some demonstrable abnormality of brain structure or function.
- Cognition, behaviour or emotions may be affected.

12.1.2 Aetiology

- Delirium is more common in those who have reduced cerebral reserve.
- Dementia has many causes but in the elderly, the commonest are vascular and degenerative causes. Alzheimer's disease accounts for half of all cases. Lewy body dementia, 20% of cases.

12.1.3 Prevalence

- In the community, 5% of over 65s have dementia.
- As the ageing population increases the number of people with dementia will rise significantly.

12.1.4 Diagnosis

- In dementia, the usual mode of presentation is poor memory.
- Vascular dementia shows a stepwise progression.
- In Lewy body dementia, cognitive impairment fluctuates. Vivid visual hallucinations, Parkinsonism and frequent falls may feature.
- AIDS dementia complex is usually a later feature of AIDS, occurring in 30% of cases.
- Prion diseases remain extremely rare in the UK.
- In recent years, a separate entity called mild cognitive impairment (MCI) has been recognised.

12.1.5 Treatment

- In delirium, the underlying cause is treated.
- In Alzheimer's disease acetyl cholinesterase inhibitors can slow the rate of deterioration in mild or moderately affected individuals.

12.1.6 Prognosis

- In delirium, this is dependent on the underlying cause.

- The mean life expectancy, from diagnosis, in Alzheimer's disease is 7 years.
- Vascular dementia has a shorter life expectancy at 4 to 5 years.
- The prognosis in AIDS dementia complex is very poor.

12.1.7 Main Disabling Effects

- In the majority of cases, the disabling effects of cognitive impairment are very significant.
- More than 30% of those with MCI have difficulty with tasks of daily living such as using the telephone.
- With regard to the WCA, cases of dementia are likely to fulfil support group criteria depending upon the degree of cognitive impairment.

12.2 Head Injury

12.2.1 Description

- The after-effects and residual disability from head injury can be significant.
- Long-term effects may include epilepsy, impaired cognition and psychiatric syndromes.

12.2.2 Aetiology

- The commonest cause is road traffic accidents.

12.2.3 Prevalence

- About 20% of all head injuries will need admission to the hospital and 2-3% of those admitted will prove fatal.

12.2.4 Diagnosis

- The duration of unconsciousness and amnesia are proportional to the severity of the injury.

12.2.5 Treatment

- Initial recovery may be rapid, but some functions may take a very long time to recover.
- Recovery is not only due to anatomical reorganisation but also due to behavioural compensation and functional adaptation.

12.2.6 Main Disabling Effects

- Focal neurological deficits may never recover.

- Cognitive deficits resolve within 3 months in most individuals who have a minor brain injury.
- Moderate to severe brain injury leads to persistent cognitive and behavioural problems.
- With regard to the WCA, severely affected individuals are likely to fulfil support group criteria depending upon the degree of cognitive impairment.
- Mental health assessment may show reduced concentration and memory. The ability to learn new tasks may be affected. Anxiety, fatigue, behavioural problems and difficulty communicating may all feature.

12.3 Cognitive Impairment due to Prescribed Medication

- The mental health assessment of the WCA should be applied whenever a claimant is taking any medication that impairs cognitive function to a degree that causes mental disablement.

13. Analytical Guidance

13.1 Introduction

The tables in this section provide guidance concerning the mental health conditions that are most commonly encountered when working in the field of Disability Assessment Medicine.

ESA approved HCPs should always consider “risk” advice on the basis of a severe mental illness in those situations where they find evidence of features that are described in the tables under the heading of “Severe Disability Likely”.

13.2 Depressive Disorders

Severe Disability Likely	History	Attempted suicide in the last 6 months. Psychiatric hospital admission in the last year. Treated with ECT in the last year. Attending psychiatric day hospital. Living in supported accommodation.
	MH Assessment	Unkempt appearance. Poverty of speech. Psychomotor retardation. Severe mood disturbance. Psychotic symptoms. Active suicidal thoughts.
Significant Disability Likely	History	Attending with a CPN, social worker or support worker. Co-morbidity with drug or alcohol abuse or another psychiatric illness. Death of a partner, spouse or first-degree relative in the last 6 months. Numerous recurrent depressive episodes or chronic depression. Attending psychiatric outpatient clinic. Under the supervision of a CPN. Taking a course of antidepressants. Taking lithium treatment. Receiving a course of psychotherapy.
	MH Assessment	Loss of appetite. Loss of weight. Early morning waking. Diurnal variation of mood. Anhedonia. Downcast gaze and poor eye contact. Hopelessness. Unreasonable guilt. Impaired concentration and memory. Avoids social interaction.
Significant Disability Unlikely	History	Not receiving antidepressant or psychological treatment.
	MH Assessment	No biological symptoms of depression. Able to continue with their usual interests and hobbies. Enjoys social contact with friends and family.
Prognosis		• An individual acute episode of depression is likely to respond to treatment. • However, in the longer term, further depressive episodes are common. • Depression may present to the Disability Analyst as chronic and intractable. 12-20% of subjects with unipolar depression develop chronic depression, and remain fully symptomatic in the longer term.
Suggested review periods for ESA		• For an acute episode of depression, a review after 6 or 12 months will usually be appropriate. • A severe acute episode of depression that warrants support group advice should be reviewed in 12 months or longer. • Chronic depression that is not responding to treatment should be reviewed in no less than 18 months. The most severe and intractable cases should be reviewed in 2 years or “the longer term” according to the age of the claimant, and duration of the illness.

13.3 Anxiety

Severe Disability Likely	History	Housebound due to severe disabling anxiety disorder e.g. visited by GP or psychiatrist at home.
	MH Assessment	Attending with CPN, social worker or support worker. Severe and persistent symptoms of anxiety leading to social isolation.
Significant Disability Likely	History	Taking antidepressant treatment. Taking buspirone. Taking propranolol specifically for anxiety symptoms. Taking benzodiazepines most days for relief of anxiety symptoms. (Not for sleep). Under the care of a psychiatrist or the community mental health team. Receiving psychological therapy. Co-morbidity with drug or alcohol abuse or another psychiatric illness.
	MH Assessment	Avoidant behaviour: Only leaves home when it is unlikely that there are many people about, does not answer the phone or the door, and avoids social interaction. Reliant on friends and family to accompany them outside the house. No social life.
Significant Disability Unlikely	History	Specific phobias. Trait anxiety. Short-term “stress reactions.”
	MH Assessment	Claimant living independently. Claimant enjoys contact with family and friends. No loss of interests or hobbies. Can travel unfamiliar routes unaccompanied on public transport.
Prognosis		**The length of history and type of treatment help to predict prognosis:** • Cognitive behaviour therapy is an effective treatment for most anxiety disorders. • Drug treatments typically last about 6 months. • A long history of disabling anxiety and previous unsuccessful treatment are associated with a poor prognosis.
Suggested review periods for ESA		**Considerations pertaining to length of history:** • Acute problems should be reviewed after 6 months. • Years of intractable anxiety should be reviewed after no less than 18 months. **Considerations pertaining to type of treatment:** • Claimants starting psychological treatment should be reviewed in 12 months. • Simple phobias and panic may respond quickly, so review after 6 or 12 months may be appropriate.

13.4 Alcohol

Severe Disability Likely	History	Severe chronic physical complications e.g. liver failure, portal hypertension, bleeding oesophageal varices, recurrent pancreatitis, cardiomyopathy and Wernicke-Korsakoff syndrome. Claimants who are habitually intoxicated and would pose a threat to themselves or others in the workplace. Claimants undergoing detoxification and rehabilitation. Poor self-care and a chaotic lifestyle.
	MH Assessment	Failure of memory, loss of intellectual ability and deterioration of personality. Claimants whose dependence on alcohol has led to extreme poverty and neglect and an inability to function socially.
	Physical signs	Signs indicative of the severe chronic physical complications of alcohol excess.
Significant Disability Likely	History	Claimants who have developed dependence on alcohol. Under the care of a specialist alcohol treatment service. Taking disulfiram or acamprosate treatment. Chronic physical consequences such as peripheral neuropathy or atrial fibrillation. Hospital referrals for investigation of alcohol related physical or mental illness. Emergency admissions for fits, delirium tremens, pancreatitis or haematemesis. Co-morbidity with another psychiatric illness. Alcohol-related social problems such as debt, divorce or homelessness. Social isolation and the avoidance of people.
	MH Assessment	Early features of cognitive impairment. **NB:** Amnesic “blackouts” due to heavy drinking are not a form of epileptic fit.
	Physical signs	Signs including unkempt appearance, the smell of alcohol on the breath, plethoric face, bloodshot conjunctivae, acne rosacea and tremor.
Significant Disability Unlikely	History	Claimants who are able to continue with their usual interests and hobbies. Enjoy social contact with friends or family.
	MH Assessment	Absence of abnormal findings on mental state examination
Prognosis		Alcohol dependence is often characterised by periods of remission and relapse. **Length of history is predictive of prognosis.**
Suggested review periods for ESA		• Those with acute problems, or a history of long remissions, should be reviewed after 6 months. • Claimants with very long histories of intractable alcoholism should be reviewed after no less than 18 months.

13.5 Substance Abuse

Severe Disability Likely	History	Chaotic and disorganised lifestyle. Poly-substance abuse and dangerous injecting habits. Compulsive drug seeking behaviour to the exclusion of all other activities. Gross self-neglect. Grossly impaired social interaction. Currently undergoing detoxification or detoxification planned in the near future. Overdoses or suicide attempts in the last six months. Suicidal ideation and low self-esteem.
	MH Assessment	Evident gross self-neglect. Co-morbidity due to associated severe mental illness. Behavioural and/or thought disorders. Attends with CPN or care worker.
Significant Disability Likely	History	Long history of drug abuse and dependence. Multiple failed detoxification attempts. Associated mental disorders such as anxiety. Intensive input and support from community psychiatric team and social services.
	MH Assessment	Some evidence of self-neglect. Poor insight and motivation. Poor social relationships. Associated mood disorders. Impaired concentration.
Significant Disability Unlikely	History	Recreational drug use only. Normal social functioning. Adequate self-care. No loss of interests or hobbies.
	MH Assessment	Well groomed with no evidence of self-neglect. Intact insight. Normal mood and concentration. Good inter-personal skills. Appropriate behaviour.
Prognosis		Drug dependence cannot be cured completely; it can only be effectively controlled. **Length of history is predictive of prognosis.**
Suggested review periods for ESA		• Acute drug related problems with a short history should be reviewed in 6-12 months. • A short term prognosis of 6-12 months may be used in claimants with good motivation, intact insight and good compliance with treatment, especially in presence of mild to moderate disability • Claimants with a very long history of drug abuse should be reviewed after no less than 18 months to 2 years. A small subset of this group may not show any significant change in the longer term.

13.6 Schizophrenia and other Psychoses

Severe Disability Likely	History	Positive symptoms such as formal thought disorder, disorganised behaviour, inappropriate affect, delusions, hallucinations. Multiple psychotic episodes.
	MH Assessment	Extrapyramidal side effects - parkinsonism, dystonia, akathisia, tardive dyskinesia Prominent negative symptoms such as flat affect, poverty of speech and social withdrawal. Poor self care. Thought disordered. Distracted appearance suggestive of active hallucinations. Residual cognitive deficit. Poor insight and compliance.
Significant Disability Likely	History	Ongoing contact with mental health services. Co morbid substance abuse. Some reduction in social functioning. Ability to self care not affected.
	MH Assessment	Some residual symptoms evident. Compliance and insight may fluctuate.
Significant Disability Unlikely	History	History of acute and transient psychotic disorders with full recovery following episodes. Discharged from follow up by mental health services.
	MH Assessment	Mental state examination normal.
Prognosis		The prognosis of schizoaffective disorders is better than schizophrenia and worse than affective disorders. Acute and transient psychotic disorders have a better prognosis than schizophrenia and schizoaffective disorders. Persistent delusional disorders are chronic, probably lifelong conditions.
Suggested review periods for ESA		• **First episode of psychosis:** are likely to satisfy LCW/LCWRA and as the mean time to remission is 42 weeks they do not merit review in less than 12 months, further follow up dependent on clinical course. • **Schizophrenia cases with no cognitive deficit following resolution of the psychosis:** review will be determined by features or conditions which determine if LCW/LCWRA is satisfied or not. • **Schizophrenia cases with residual cognitive deficit, either stable or progressive with time:** should be reviewed less frequently, review advice of 2 years or “in the longer term” is appropriate.

13.7 Bipolar Disorders

Severe Disability Likely	History	Long duration of illness with a pattern of regular relapse. No episodes of full recovery. Hospital admission in the previous 12 months. Ongoing supervision by a psychiatrist. History of suicidal ideation or behaviour. Poor compliance with treatment or follow up. History of admission under the Mental Health Act. History of unpredictable relapses. Ongoing treatment with mood stabilising or anti-psychotic medication. Significantly impaired social functioning.
	MH Assessment	Evidence of self neglect, disinhibited or unco-operative behaviour. Overt psychotic features. Labile or abnormal mood. Lack of insight.
Significant Disability Likely	History	Co-morbid substance misuse or alcohol related disorder. Difficulty sustaining attempted returns to work. Sub-optimal response to treatment. Continuing treatment with psychotropic medication.
	MH Assessment	Appearance, behaviour and mood likely to show some abnormal features. Thought, speech, insight and perceptions may be normal. Intellect and cognition unlikely to be affected.
Significant Disability Unlikely	History	In younger age group: short history, full recovery between episodes and few or no recurrences. History indicates that mental health has been normal for a sustained period of several years. Not being prescribed mood stabilising or psychotropic medication. No ongoing contact with, or supervision from, mental health services. No co-morbid conditions.
	MH Assessment	All aspects of mental state normal.
Prognosis		**Length of history is predictive of prognosis:** • Recurrent episodes of mood disturbance are common • Long duration of illness is associated with poor prognosis.
Suggested review periods for ESA		• If mental state examination is normal in all respects, a short finite period may be advised, provided other aspects of the assessment such as history support this. • Once a bipolar illness has become established, a review period of 2 years or “in the longer term” will usually be appropriate.

13.8 Obsessive Compulsive Disorder

Severe Disability Likely	History	Claimant spends so much time performing rituals, such as cleaning or checking that their social functioning is severely restricted. Obsessive ruminations may occupy the claimant to such an extent that their awareness may be affected. Past history of neurosurgery for OCD.
	MH Assessment	Compulsive slowness.
Significant Disability Likely	History	Co-morbid depression. Social interaction reduced.
	MH Assessment	Abnormal mood. Rapport difficult to establish.
Significant Disability Unlikely	History	Obsessive personality trait. Claimant living independently. Claimant enjoys contact with family and friends. No loss of interests or hobbies. Can travel unfamiliar routes unaccompanied on public transport.
	MH Assessment	Mental state examination normal.
Prognosis		• Treatment resistant cases with functional limitations are likely to have the condition long term. • Late age of onset, initial severe depression, pre treatment anxiety and the obsession having the characteristics of an overvalued idea are predictive of treatment failure.
Suggested review periods for ESA		• A review period of 6 or 12 months is usually indicated following the initiation of treatment. • In treatment resistant cases, a review period of 2 years or “in the longer term” will usually be appropriate.

13.9 Adjustment Disorders and Post Traumatic Stress Disorder

Severe Disability Likely	History	The presence of co morbid conditions, such as major depressive disorders, alcohol related disorders, substance misuse disorders, generalised anxiety disorder and phobias may be associated with severe disability.
Significant Disability Likely	History	Persistent PTSD symptoms 6 years after the stressor Associated major depressive illness, alcohol or substance misuse, generalised anxiety disorders.
	MH Assessment	Irritability, hypervigilant behaviour, poor concentration and exaggerated startle response. Avoidant behaviour.
Significant Disability Unlikely	History	Acute stress reactions. Claimant living independently. Claimant enjoys contact with family and friends. No loss of interests or hobbies. Can travel unfamiliar routes unaccompanied on public transport.
	MH Assessment	Mental state examination normal.
Prognosis		**Length of history is predictive of prognosis:** PTSD has a slow natural recovery time over a period of about six years, after which the condition is likely to remain chronic in about 40% of cases.
Suggested review periods for ESA		• The slow recovery times indicate that two-year review periods, up to a 6-year maximum, are usually appropriate. • After a 6-year interval, those chronically disabled are likely to remain so.

13.10 Learning Disability

Severe Disability Likely	History	Co-morbid physical disability, epilepsy or mental illness.
	MH Assessment	Incapable of living independently. The need for help with some or all bodily functions. A failure to be aware of dangers, thus requiring supervision. Severe behaviour problems requiring supervision, e.g. self-harm or violence.
Significant Disability Likely	History	In receipt of an educational "Statement of Need." Attendance at a special school. Living alone, but in supported accommodation.
	MH Assessment	The claimant requires prompting to get up and get dressed in the morning. The claimant is unable to initiate and complete household tasks.
Significant Disability Unlikely	History	Dyslexia. Treated Attention Deficit Hyperactivity Disorder. (ADHD)
	MH Assessment	Claimants attending an examination centre assessment on their own. Use public transport to travel independently on an unfamiliar route. Claimants who are living independently in their own home. Claimants who can manage their own finances and do their own shopping. Claimants who are able to plan and prepare a proper meal for themselves.
Prognosis		Learning disability runs a chronic life-long course. Once an assessment has been made, it is unlikely that there will be significant change in the condition.
Suggested review periods for ESA		A review date "in the longer term" is likely to be appropriate.

13.11 Eating Disorders

Severe Disability Likely	History	Hospital inpatient treatment.
	MH Assessment	Severe co-morbid psychiatric illness.
	Physical signs	Severe weakness, requiring personal care from another person.
Significant Disability Likely	History	Frequent episodes of self-induced vomiting or purging. Abuse of laxatives or diuretics. Amphetamine abuse. Excessive exercise. Amenorrhoea. Co-morbid physical complications. Co-morbidity with drug or alcohol abuse or another psychiatric illness. Attending psychiatric day hospital.
	MH Assessment	Social isolation: little contact with family or friends.
	Physical signs	Severe weight loss: BMI < 17. Morbid obesity: BMI > 40. Underweight despite treatment. Lanugo hair. Physical weakness. Poor dental hygiene with pitting and acid erosion.
Significant Disability Unlikely		**Function is usually well preserved in claimants with eating disorders.**
Prognosis		• For anorexia nervosa, about 65% have a good outcome and maintain a normal weight, whilst 15% have a poor outcome with a persistently very low BMI. • In bulimia, the prognosis is poor in those individuals with a low BMI, and with a high frequency of purging • In severe obesity (BMI >40), increased morbidity arises from conditions such as arthritis, diabetes and coronary heart disease.
Suggested review periods for ESA		• Claimants starting treatment should be reviewed in 12 months. • Claimants who have suffered intractable problems for years should be reviewed after no less than 18 months.

13.12 Personality Disorders

Severe Disability Likely	History	Self-harm in the last 6 months. Psychiatric hospital admission in the last 6 months. Co-morbidity with drug or alcohol abuse or another psychiatric illness. Living in supported accommodation. Bizarre behaviour towards other people. Chaotic, unstructured lifestyle.
	MH Assessment	Unkempt. Living in social isolation.
Significant Disability Likely	History	Co-morbidity with drug or alcohol abuse or another psychiatric illness. Receiving psychotropic medication. Receiving psychotherapy. Attending psychiatric outpatient clinic. Attending psychiatric day hospital. Under the supervision of a CPN. Repeated episodes of self-harm. Repeated episodes of violent behaviour. Left previous employment due to excessive anxiety and inability to cope.
	MH Assessment	Unable to complete tasks in a timely manner. Claimant avoids social contact.
Significant Disability Unlikely	History	Not receiving psychiatric care or supervision. Not receiving psychotropic treatment.
	MH Assessment	Able to enjoy interests and hobbies. Enjoys social contact with friends and family. The claimant is able to do their own shopping, cooking and cleaning. Able to manage their own finances.
Prognosis		• Acute problems or crises may resolve with time or treatment. • Personality disorders are lifelong conditions, but the disabling effects may abate with the passage of time.
Suggested review periods for ESA		• Acute problems or crises should usually be reviewed after 6 months. • For personality disorders, a review between 18 months and “in the longer term” may be appropriate, depending on the severity of the associated disability.

13.13 Organic Brain Disorders

Severe Disability Likely	History	Any dementing condition. Amnesic syndrome or Korsakov's syndrome.
	MH Assessment	Significant cognitive impairment. Physical aggression.
Significant Disability Likely	History	Psychogenic fugue (loss of personal identity). Mild cognitive impairment. Head injury resulting in unconsciousness for more than 20 minutes and post traumatic amnesia for more than 1 hour.
	MH Assessment	Attention deficit / reduced concentration. Learning and memory problems. Impaired planning and problem solving. Lack of initiative, and inflexibility. Dissociation between thought and action. Impulsivity, irritability and temper outbursts. Communication problems. Socially inappropriate behaviour and disinhibition. Personality change with self-centred behaviour and egocentricity. Changes in affect (flat affect, inappropriate emotions and mood). Lack of insight.
Significant Disability Unlikely	History	Head injury resulting in unconsciousness for less than 20 minutes and post traumatic amnesia for less than 1 hour. Transient global amnesia. Independent existence and near normal or normal functioning.
	MH Assessment	All features of mental state examination normal.
Prognosis		Long history and significant disability indicate a poor prognosis.
Suggested review periods for ESA		• Conditions where a non-functional descriptor or support group has been advised are unlikely to undergo significant change. • Where there is significant disability and the condition has been present for more than 1-2 years, significant change is also unlikely.

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