MEDICAL SERVICES

PROVIDED ON BEHALF OF THE DEPARTMENT FOR WORK AND PENSIONS

Training & Development

Mental Health Support Scenarios

Mentor's Notes

MED-MHSS~001

Version: 4 Final

10 December 2014

Foreword

This training has been produced as part of a training programme for Health Care Professionals approved by the Department for Work and Pensions Chief Medical Adviser to carry out benefit assessment work.

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

This training must be read with the understanding that, as experienced practitioners, the Health Care Professionals will have detailed knowledge of the principles and practice of relevant diagnostic techniques and therefore such information is not contained in this training module.

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

Thus, although the training module 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 Health Care Professionals.

Office of the Chief Medical Adviser

December 2014

Document control

Superseded documents

Version history

Version	Date	Comments
4 Final	10th December 2014	Signed off by MAT and CMMS
4b Draft	1st December 2014	Updated following review by Medical Advisory Team
4a Draft	17th November 2014	Updated for consistency with Update to Standard 1b/2014
3 Final	26th March 2014	Signed off by HWD and CMMS

Changes since last version

General formatting and amendment of layout throughout document

Section 1.1 – question 3 – more information added to discussion points for self harm/suicidal tendency

Section 2 – more information added in the scenario on behavioural / anger issues

Section 3 - additional information added in scenario on self harm/suicidal tendency

Section 5.1 – additional information added to discussion points of the case

Section 8 – more detail added to scenario to be more consistent with significant restriction in personal action, rather than severe

Section 8.1 – reference to update to standard on substantial risk added

Section 9 – scenario amended to suggest a more stable condition, with admission being 5 rather than 2 years ago and less intensive specialist input

Section 9.1 – additional points added for mentor on change of scenario which might suggest application of substantial risk

Section 10 – scenario amended to allow more consistency in descriptor choice

Section 10.1 – descriptor choice and mentor notes amended for more consistency

Next steps – link to NICE pathways updated

Outstanding issues and omissions

Updates to Standards incorporated

Issue control

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Contents

Introduction

The Health Care Professional (HCP) new entrant training courses consider the assessment of mental health conditions from the disability analyst's perspective, including review of mental health conditions commonly seen, application of the mental state examination, review of levels of disability and indicators of severe mental health problems. During this training HCPs undertake self directed learning of relevant reading including the *EBM Mental Health Problems – Key Points and Analytical Guidance* and the *Mental Illness, Current Therapeutics and Management* documents.

These scenarios are designed to help consolidate the HCP's learning and provide a basis for discussion with an experienced HCP. New Entrant HCPs should complete these scenarios within the first 4 weeks post training. Established HCPs may also find them useful in order to keep abreast with legislative changes.

Ideally it should be a Mental Function Champion (MFC) who delivers this consolidation of training. If a MFC is not available then it should be an HCP with experience in assessing mental health cases (the HCP delivering this training will be referred to as the mentor in the remainder of the document).

This document contains the information on the Discussion and Practice Case Scenarios, together with Guidance Notes on each case for the mentor. A separate document – *Mental Health Support Scenarios for HCPs* – contains the Discussion and Practice Case Scenarios only which is to be used by the HCPs undertaking the consolidation of mental health training.

The first section contains scenarios for discussion. It is designed as a one to one discussion exercise between the HCP and the mentor.

The second section contains practice case scenarios. These are to be used to complete an ESA 85 report on the LiMA training server. The HCP will have to choose an appropriate outcome (descriptors, support group or exceptional circumstances) and justify their opinion in the Personalised Summary Statement (PSS). The case will then be reviewed by the mentor and discussed with the HCP. The mentor should ensure that local unit log-ons and training NiNos are available for the practice case scenarios.

Further guidance is provided in each section.

Section One - Cases for Discussion

This section contains cases for discussion between the HCP and the mentor.

Each case contains a scenario to be read by the HCP. There are several initial questions to be completed by the HCP and the answers discussed with the mentor.

Guidance notes are provided for the mentor following each case with the significant points which need to be discussed with the HCP highlighted.

These cases are designed to highlight important points and guidelines when dealing with claimants with mental health conditions.

The role of the Mental Function Champion should be highlighted throughout the case discussions.

Each case should take approximately 30 minutes.

1. Discussion Case One

Name: Mr John Carden

Age: 33 years old

Med 3: Schizophrenia

ESA 50: not returned

History at assessment:

Diagnosed with Schizophrenia about 10 years ago. He is under the care of a psychiatrist and CPN both of whom see him at home. He sees his CPN twice weekly. There is no history of self harm. Last hospitalisation was 8 years ago (sectioned under the mental health act).

On depot medication fortnightly.

Lives alone in a one bed roomed flat.

He spends almost all of the time in his flat. He has no routine, he sleeps and gets up when he feels like it. He says there is no need to change clothes and wash as he is not going out. His CPN will prompt him on the days he visits to get washed and change his clothes. He spends days watching TV. He is able to get to the local shop for groceries. He eats mostly snack food.

He is not in contact with his family. He has no friends that he is in contact with. He does not like having to speak to people.

Mental State Examination (MSE) Findings:

Unkempt, wearing dirty clothes

Poor rapport, poor eye contact, flat affect, appeared timid

Spoke very little, required prompting, speech bizarre at times

No insight

Questions:

1. What are your initial thoughts about this case?
2. Are there any key indicators of concern in the history and mental state examination findings?
3. What further information might be asked for in the history?
4. What areas should be probed in claimants with schizophrenia?
5. Are there any other mental state examination findings that should be assessed?
6. What is the suggested outcome in this case?

1.1 Mentor Guidance Notes for Discussion Case One

This is a claimant with a severe mental illness who presents unwell with multiple indicators of significant mental health problems (key indicators). It is designed to allow a discussion around severe mental illness and the presence of key indicators of concern within an assessment.

1. **What are your initial thoughts about this case?**
   - Claimant has a Severe Mental Illness (this is an important point)
   - Consider Support Group or mental health risk NFD

Briefly discuss the clinical features of Schizophrenia (positive and negative features). Include the importance of the severe functional effects that the negative features of schizophrenia can cause.

2. **Are there any key indicators of concern in the history and mental state examination findings?**
   - Under psychiatrist and CPN
   - Sees CPN twice weekly
   - Depot medication
   - Seen at home by psychiatrist and CPN
   - Self neglecting
   - Lack of social contact
   - MSE findings (unkempt, poor rapport, poor eye contact, flat affect, spoke very little, required prompting, speech bizarre at times, no insight)

Discuss with the HCP the meaning of key indicators of concern (essentially an alarm bell) and what their presence in a case might mean. Ensure the HCP knows what constitutes indicators of concern.

Discuss with the HCP the identification of fertile areas for further investigation in the history and typical day. Ensure the HCP fully appreciates that the history, including condition history and typical day should be tailored to the specifics problems indicated by the claimant or noted by the HCP during the assessment.

3. **What further information might be asked for in the history?**
   - Other indicators of concern - Is claimant under a Care Programme Approach (CPA), involvement of home treatment or early intervention teams, history of substance misuse?
   - Self harm/suicidal thoughts – it is not enough to enquire about past history of self

harm/suicidal tendency, the HCP has to ensure there are no current thoughts/plans /intent for self harm/suicide

- Any side effects of medication - which could lead to non compliance with treatment
- Presence of other medical conditions – physical or mental health

4. What areas of the history should be probed in claimants with schizophrenia?

- Daily functioning: on surface may appear to be fine but when probed further it may be revealed that the claimant is not actually functioning that well
- Personal action: getting up, washing, dressing, cooking, housework, shopping
- Socialising: seeing family and friends
- Getting about: leaving house, how often, where do they go, etc
- Coping with change: dislike of disruption to routine- especially in some individuals with more active psychosis
- Behaviour: interaction with others, conflict with others, inappropriate behaviour due to psychosis, aggressive behaviour

Remind the HCP that they need to have enough evidence to support their opinion. It is important to ask about the activities where they think the claimant may be struggling.

5. Are there any other Mental State Examination findings that should be assessed?

- Abnormal thought processes and content or abnormal perceptions (including delusions and hallucinations)

  Check the HCP understands the definition of delusions and hallucinations:

  Delusions: unchanging fixed beliefs that are held on inadequate grounds, are not affected by rational argument, persist in spite of contrary evidence and cannot be explained by culture or religion.

  Hallucinations: a perception experienced in the absence of an external stimulus to the corresponding sense organ. It is experienced as a true perception and seems to come from outside the head.

  Ask how HCP would check if they are present?
- Ask HCP their understanding of insight and how to assess this
- Importance of exploring past or current history of self harm and suicidal thoughts / plans / intent

6. What is the appropriate outcome in this case?

- Functional Support Group – Personal Action
- It is more appropriate to place in a functional Support Group where this is appropriate, rather than mental risk SG, as with a functional SG the HCP is able to curtail the assessment to minimise distress to claimant

2. Discussion Case Two

Name: Mr Jedi Jackson

Age: 28 years old

Med 3: Depression

ESA 50: has written “I have depression and I have trouble controlling my behaviour”.

Learning tasks – no problem

Awareness of hazard – has written “I don’t do any cooking.”

Initiating personal action – has written “I can’t be bothered with day to day stuff. My wife nags me to do things, otherwise they wouldn’t get done.”

Coping with change – no problem

Getting about – no problem

Coping with social situations – has written “I have no interest in socialising.”

Behaving appropriately – has written “I get so angry that I have problems dealing with people. I’m always arguing with my wife. I punched my neighbour after he complained about my dog barking.”

History at assessment:

Diagnosed with depression about 12 months ago by GP. He was referred for counselling which he thought was rubbish and not helpful at all. Started on citalopram about 6 months ago. He thinks there has been some slight improvement since starting medication. He feels low and angry that he is unable to find work.

He lives with his wife and young son (2 years old) in a house. He was fired from his last job 18 months ago after he was caught stealing from the company and has not been able to find work since.

Main symptoms from depression are feeling low, mood swings and anger.

He wakes when his wife gets up to look after their son. Often he will stay in bed for a few hours watching the TV in the bedroom. He doesn’t have anything to get up for. His wife mostly looks after their son but he will look after him when his wife goes out shopping or when she goes out to meet her friends. He gets washed and dressed most days. He often feels like he can’t be bothered but knows it annoys his wife if he stays in his pyjamas all day.

Sometimes he will go to the job centre to look for work, but after so long without a job he now feels ‘what is the point’. His mood feels low during the day. He argues a lot with his wife, this has increased over the last 6 months. He often feels angry; angry that he doesn’t have a job, angry that they are struggling to pay the bills, angry that his wife keeps nagging him. He has never hit his wife, but he has shoved her a couple of times during a few of their really bad arguments. The neighbours complained to the police during their last argument a few weeks ago. He doesn’t know why, they were just yelling at each other as usual.

He will spend most of the day at home. He can't afford to do much else. He has an x-box console which he plays games on. It keeps his mind occupied. Sometimes he will watch TV, but there is a lot of rubbish on daytime TV and he finds it a bit boring.

He sees his friends occasionally. He sometimes meets them in the pub for a drink. It's good to get out of the house and away from his wife who seems to spend the whole day complaining.

There is no computer in the house but he does have a mobile phone which he uses to keep in touch with friends and family.

He has a dog. He will walk it most days although some days he can't be bothered. It does bark at times and the neighbours have complained. He can't see what the problem is, dogs are supposed to bark! He got into a fight with one of the neighbours after they reported him to the council about a month ago. He punched the neighbour and was cautioned by the police. The fact that the neighbour complained still makes him feel really angry, so he is avoiding this neighbour as he feels he might punch him again for getting him in trouble with the police. It is only this one particular neighbour that he seems to keep having problems with. He has never got into any arguments or fights with any strangers or with any of his friends.

Mental State Examination Findings:

Appears well, normal build, normal complexion, does not look tired, appears kempt, wearing casual clothing

Normal facial expression, good rapport, normal eye contact, coped at interview, does not appear anxious, not hostile or irritable

Normal amount, rate, volume and content of speech

No thoughts of self harm

Did not require any prompting, general memory and concentration adequate

Good insight

Questions:

1. What are your initial thoughts about this case?
2. Is there any other information that should be sought in the history?
3. What descriptors do you think would apply for appropriateness of behaviour?
4. What pieces of evidence support your descriptor choice?

2.1 Mentor Guidance Notes for Discussion Case Two

This is a claimant with mild depression and anger management issues. There are no significant mental health issues. It is designed to allow discussion of assessment of anger and behavioural issues in claimants. It may be helpful to have a copy of the Revised WCA handbook (either hard copy or on SharePoint) at hand.

1. **What are your initial thoughts about this case?**
   - Depression appears mild
   - Claimant has anger management issues not necessarily related to his mental health condition, he feels frustrated at being out of work, however there is evidence he can control his behaviour
2. **Is there any other information that should be sought in the history?**
   - History of drug and alcohol misuse (cocaine use can cause similar behaviour and alcohol can fuel arguments & fights)
3. **What descriptor do you think might apply for the appropriateness of behaviour activity?**
   - 'None of the above apply'
   - If HCP has applied any other descriptors, explore what evidence has been used and discuss
4. **What evidence that supports 'none of the above apply' descriptor?**
   - Mental health condition is mild
   - Can look after a small child safely
   - He is aware of his anger problems and takes steps to avoid confrontations
   - Normal MSE findings with normal insight

Further questions to ask HCP:

What is the scope for the Appropriateness of Behaviour descriptor?

- There has to be evidence of a disorder of mental function (present in this case but it is mild)
- What behaviour is considered unreasonable in an average workplace? (likely to be more than just verbal aggression alone)
- There must be evidence that the claimant is unable to control their behaviour
- Problems with behaviour are directed against a variety of individuals and not towards a particular individual only

What are fertile areas in the history for evidence of appropriateness of behaviour?

- Previous occupational history
- Shopping
- Childcare
- Parents evenings at school
- Relationships with neighbours
- Ability to cope at appointments: GP/ hospital etc
- Ability to cope with bills and on the phone
- Dealing with finances and bills at the post office
- Appointments with people in authority such as the bank manager / social worker / benefits personnel

What kind of information/evidence might support the claimant having problems with appropriateness of behaviour?

- Significant condition with associated lack of insight eg brain injuries, dementia, psychosis, learning disabilities
- Abnormal MSE findings – poor insight, poor rapport, evidence of a thought disorder, cognitive impairment, hostility, irritability, aggressive manner towards HCP or other staff

3. Discussion Case Three

Name: Mr Jason Cleaver

Age: 35 years old

Med 3: Anxiety

113: Mild depression and Anxiety. Not seen often at practice, last was over a year ago. Has been under the psychiatrist. Has improved. Recently discharged from CMHT care.

Letter from psychiatrist: Dated 6 months previously. Contains the following: "Jason has long standing depression and anxiety. Whilst under the care of the CMHT his condition has improved, he is able to socialise in the community and he describes his anxiety as improved. He has been discharged back to the care of his GP."

ESA 50: Completed by claimant's mother - has written "I have severe depression and anxiety. I can not live by myself and I require a carer."

Learning tasks – has written "I have difficulty learning any new task. My mother has to help me."

Awareness of hazard – has written "My mental state is such that I am unable to cook. My mother does all the cooking."

Initiating personal action – has written "I need prompting to get dressed and washed. I don't do any personal action at all."

Coping with change – has written "I can not cope with any change, my mother has to look after my daily affairs."

Getting about – has written "I do not leave the house by myself."

Coping with social situations – has written "I do not socialise. I stay in my room. I only see my family."

Behaving appropriately – has written "I have episodes when I get very angry and I yell at my family. These episodes are very distressing for my family to deal with."

History at assessment:

Attended for the assessment with his mother, who was very keen to speak on her son's behalf. She said it was because he would not give the full picture of his disability, and as she was her son's carer, she would be able to provide a much more accurate overview. With explanation and reassurance to both the claimant and his mother, the claimant was able to give most of the history himself.

Medication: venlafaxine 225mg daily, propranolol 40 mg daily, mirtazepine 45mg daily.

He was diagnosed with anxiety and depression as a teenager. It has been much worse over the last 5 or 6 years. Before that he was living independently in a flat and working as an architectural draughtsman. He had to stop work after his anxiety worsened to the point that he was having panic attacks at work. He was finding it difficult to go out, so moved back home with his parents so that they could assist him.

Mother says he is still under the care of the psychiatrist, they have an open appointment so can return at any time.

He sleeps poorly and usually lies awake worrying. Feels un-refreshed in the morning when he wakes. Wakes at different times. He will get dressed and washed most days. Says he is able to do this on his own. He will sometimes join his parents for breakfast downstairs but often his mother will bring him breakfast in his room.

Has a TV in his room which he has on for background noise. Doesn't really pay attention to it. He is not interested in any of the programmes on TV. He does have a games console which he uses during the day to play games, although not every day.

He was able to go to the psychiatrist by taxi by himself, but he could not travel by public transport. Currently he does not leave the house and actually spends most of the time in his bedroom. He feels unwell and anxious all the time and does not want to see anyone. He has not seen any friends for the last 3 months. Except for appointments, he last left the house 3 months ago when he went to the supermarket with his mother.

He will sort out his usual bills and appointments but if he receives anything new or an appointment is changed at the last minute, then he lets his mother deal with these as he does not feel up to dealing with any stress at present. She wants him to go back to see the psychiatrist but he does not feel well enough to make the trip to the hospital to see him. He has been to his GP 4 weeks ago, with his mother, but although he managed to keep his appointment, he did not like the fact that it was a locum doctor who saw him, as he does not feel comfortable with strangers.

Mental State Examination Findings:

Appears unwell, overweight, very pale complexion, looks tired, appears kempt, wearing casual clothing

Reduced facial expression, poor rapport, poor eye contact, significant difficulty coping at interview, appeared anxious, fiddling constantly

Reduced amount of speech, spoke quietly, content of speech normal

Occasional thoughts of self harm, would never act on it because of the effects on his parents. No active plans or intent. Has never actually self harmed or made any suicide attempts.

Did not require any prompting, general memory and concentration adequate

Normal cognitive assessment

Adequate insight

Questions:

1. What are your initial thoughts about this case?
2. What descriptors do you think might apply in the Mental Function Assessment?
3. What pieces of evidence support each of your descriptor choices?

3.1 Mentor Guidance Notes for Discussion Case Three

This is a claimant where there is inconsistency between the medical evidence on file and the evidence obtained at assessment. It is complicated by an over-protective mother. However the evidence from the typical day is supported by the abnormal mental state examination findings and overall there is likely to be significant disability.

1. What are your initial thoughts about this case?

- Conflicting evidence from GP/psychiatrist and evidence at assessment
- High level of disability on the Typical Day
- High level of medication
- Abnormal MSE findings
- Likely to have significant disability

2. What descriptors do you think might apply in the Mental Function Assessment?

- Learning: None of the above apply
- Hazard awareness: None of the above apply
- Personal action: None of the above apply
- Coping with change: CC(c) cannot cope with minor unplanned change
- Getting about: GA(b) unable to get to a familiar place alone
- Socialising: CS(c) engagement in social contact with unfamiliar people precluded majority of the time
- Appropriateness of behaviour: None of the above apply

3. What pieces of evidence support each of your descriptor choices?

- Discuss with the HCP which pieces of evidence support each of their descriptor choices (especially if the HCP's descriptor choices are different from the above)

Further questions to ask HCP:

What if the medication was citalopram 20mg and the MSE findings were normal, how might that affect the descriptor choices?

Further probing of the claimant's history would be necessary. The HCP would need to logically reason the inconsistent evidence (the FME, MSE, level of medication are all consistent with low level of disability, only the Typical Day History is consistent with high level of disability).

It may be possible to apply and justify 'none of the above apply', discuss with HCP.

Ask the HCP to take a few minutes to write a PSS for this case and review.

4. Discussion Case Four

Name: Ms Helen Chin

Age: 32 years old

Med 3: Depression

ESA 50: Has written "I see my GP for my medical conditions."

Learning tasks – has written "It depends how I am feeling."

Awareness of hazard – has written "When I am very depressed I can't be bothered."

Initiating personal action – has written "When I am very depressed I can't be bothered."

Coping with change – has written "I hate going out and doing things when I am very depressed."

Getting about – has written "I hate going out and doing things when I am very depressed."

Coping with social situations – has written "I don't like to talk to people especially when I am very depressed."

Behaving appropriately – has written "Friends and family say I am snappy especially when I feel very low."

History at assessment:

Attended assessment alone.

She was diagnosed with anxiety and depression 3 years ago following the break up of a relationship. She was referred to the Community Mental Health Team (CMHT) two years ago after she took an overdose and was admitted to hospital for 3 days. She overdosed on Paracetamol and Diazepam with a 750 ml bottle of Vodka. Her cousin found her unconscious. He happened to come home early from work that day. She was in contact with CMHT up until a year ago when she was discharged from their care.

She thinks she is better now, but she still gets bouts of low mood and anxiety. She sees the GP every 2 months. She says GP is thinking about referring her for CBT. Currently taking citalopram 40 mg daily.

She usually has initial insomnia at night, and eventually gets to sleep about 1 am. She wakes up about 9 am despite feeling tired and un-refreshed. She does not feel like washing and dressing, but usually gets around to doing so daily most weeks. About every 6-8 weeks her mood gets lower and she does not want to wash and dress. She tries to clean the house most of the time except for those periods when mood gets very low. She goes to the local shops for groceries. She avoids going into town as she gets too anxious when it is crowded. During the day she usually tries to watch TV. She follows the chat shows and likes to watch Coronation Street. She spends the evening at home with her cousin. They watch TV together. He encourages her to get out and about and would take her to the cinema once a month.

Mental State Examination Findings:

Looks tired

Casually dressed

Fiddling with her fingers

Reduced eye contact

Adequate concentration and general memory

Speech - normal content, normal rate and volume

Questions:

1. What are your initial thoughts on this case?
2. Are there any key indicators of concern in the history?
3. What further information might be asked for in the history?
4. Are there any other Mental State Examination findings that should be assessed?

4.1 Mentor Guidance Notes for Discussion Case Four

This is a claimant with depression that has improved after a significant self harm attempt a couple of years ago. It is designed to allow discussion around levels of severity of depression and self harm issues.

After discussing the initial case you will change the scenario slightly to reflect a greater level of disability and risk (see below)

1. **What are your initial thoughts on this case?**
   - She still has features of depression but of variable severity. More probing in history is necessary to clarify the extent

2. **Are there any key indicators of concern in the history?**
   - She has a previous history of self harm (two years ago)
   - Contact with CMHT (1 year ago)
   - Not clear if she still has any current / recent self harm / suicidal thoughts
   - Why is the GP thinking about referring to CBT?

3. **What further information might be asked for in the history?**
   - More details on current symptoms
   - Discuss any current or recent self harm / suicidal thoughts
   - Address variability more. Clarify how long the periods of lower mood last
   - Enquire further about activities of daily living such as cooking and eating, getting about and interacting with others

4. **Are there any other Mental State Examination findings that should be assessed?**
   - General appearance – any signs of neglect
   - Rapport
   - Other indicators of anxiety such as sweating
   - Behaviour – irritability?
   - Cognition – orientation and memory
   - Insight
   - Self harm / suicidal thoughts or actions – plans, nature, intent and frequency

   It may be useful to discuss the diagnostic features of depression and indicators of severity (see Mental Illness document) at this point.

Change the scenario

Discuss with the HCP

- Last admission for self harm 9 months ago
- Still seeing CMHT, the CPN visits at home every two weeks. Has a CPA
- CRISIS team contact 5 months ago as felt suicidal
- Dresses most days of the week, but prompted about twice a week by cousin and sister. Sister moved in to help keep eye on her. She has self harm thoughts every few weeks. Feels hopeless and not sure if she wants to live. Sister now supervises medication

Ask the HCP what their thoughts on this updated scenario are and how the outcome may differ from the original scenario?

There are more key indicators of concern:

- Recent history of self harm and ongoing thoughts
- Hopelessness
- Higher levels of input
- CPA in place

Risk needs to be considered in the second scenario. Although the information is limited with the second scenario, an outcome of applying the mental risk Support Group should be discussed.

Ask about prognosis: at least 6 -12 months would be appropriate. If time allows – discuss prognosis in such cases.

5. Discussion Case Five

Name: Mr Quentin Reeve

Age: 34 years old

Med 3: Drug addiction

ESA 50: Has written “I am depressed a lot and don’t I want to do anything. I hate forms and my sister is helping me fill this one out. I kicked the drugs but the alcohol is my comfort. I tried detoxification for alcohol and it has not worked yet. When I have the strength I may try again. My sister and counsellor keep nagging me to try again.”

Learning tasks – has written “I hate reading; I can’t be bothered to learn anything new.”

Awareness of hazard – has written “My sister and mother cook for me; I would burn the house down as I do not concentrate on things.”

Initiating personal action – has written “Most of time I can’t be bothered to get up and get washed and dressed. My sister and mother nag me to do things.”

Coping with change – has written “I hate change. Don’t bother to go anywhere.”

Getting about – has written “I prefer to stay at home. My mum and sister nag me and take me out.”

Coping with social situations – has written “I was a crack head and I don’t like people, they make me scared. I am paranoid. I only trust my sister and mother.”

Behaving appropriately – has written “I try to keep to myself. Some days I get irritable with my sister when she nags me.”

History at assessment:

Greeted in side room at MEC as he had told the receptionist that he was too anxious to stay in waiting room.

Sister present at assessment.

He gave up heroin and crack and is trying to cut down his alcohol intake now. He attends alcohol services for individual counselling every two weeks. The counselling started 6 months ago. He tried cannabis four years ago but stopped after only a few weeks. He has had one hospitalisation four years ago, when he was hearing things and had thoughts people were trying to poison his food. He now describes feeling paranoid around people and panics when outside the house. Two years ago he stopped drinking for a few months and GP started him on an antidepressant. The antidepressant was stopped after 6 months as he had started to drink again. He says the GP will treat the anxiety and depression, but told him he needs to be clean from drugs and excessive alcohol first. He is still drinking alcohol every day but is trying to cut down the amount he drinks.

Lives with mother and sister. He sleeps poorly as things are always on his mind. Drinking alcohol helps him sleep. He gets up at different times. His sister and mother encourage him to get up as he often feels tired and low. His appetite is poor. He spends most of the day in his room drinking lager or out in the garden alone having a cigarette. Every few days he goes to the local shop alone to buy alcohol and cigarettes.

He knows the shop keeper from childhood. His mother helps him to get ready and takes him to the appointments with the counsellor. He doesn't think he would go otherwise. He missed his grandmother's funeral 4 months ago as he was too anxious to travel to her town 15 miles away. He finds alcohol calms him down and makes him feel less anxious. When he is not able to have a drink he gets irritable.

Mental State Examination Findings:

Looks tired

Thin

Well kempt, casually dressed

Restless, fiddling with his fingers

Avoided eye contact

Speech - normal content, normal rate

Faint smell of alcohol

Questions:

1. What are your initial thoughts on this case?
2. Are there any key indicators of concern in the history?
3. What further information might be asked for in the history?
4. What areas should be probed in claimants with drug and alcohol misuse?
5. Are there any other Mental State Examination findings that should be assessed?

5.1 Mentor Guidance Notes for Discussion Case Five

This claimant has a history of significant alcohol use and at least moderate depression with features of anxiety. It is designed to allow discussion of assessment of claimants with drug and alcohol misuse. With more detail, the HCP may be able to advise on a functional support group, such as personal action or coping with change, or mental risk in this case.

1. What are your initial thoughts on this case?

This claimant has a history of significant alcohol use and some features of depression and anxiety.

With further information and clarification, he may have significant restriction overall (considering areas such as personal action, going out and social engagement).

2. Are there any key indicators of concern in the history?

- Previous mental health admission, but not within the last 12 months (unclear if was under section)
- Ongoing alcohol misuse
- Alcohol services involvement
- Significant support from family

Need to probe and clarify paranoid feelings as these may be significant. Discuss assessment of paranoia (not taken at face value, needs to be probed during assessment to understand what the claimant means by the term):

- paranoia refers to feelings of distrust, suspicion or persecution that are not based in reality
- paranoid does not just mean persecutory, but also allows people to define things around them to have a special, personal significance
- paranoia leads a person to think they are being singled out in a negative way, people will often look for evidence to prove they are being singled out and refuse to see that they have an exaggerated view of their own significance
- paranoia is a mental symptom of many types of mental illness

Discuss definitions of delusions and hallucinations and how these are assessed (see case one for definitions)

3. What further information might be asked for in the history?

- Quantity of alcohol consumed per day/week
- Clarify what is meant by paranoid, description of what happens
- Probe around hallucinations noting any further episodes

- Clarify what is meant by panic
- Any other mental health symptoms: mood, motivation, concentration
- Further detail in typical day - explore motivation issues around self care activities (washing, dressing, eating etc). Get indication of *frequency* and *extent* of prompting. Ask about other domestic activities such as cleaning and shopping
- Explore behaviour and interaction with others
- Claimant well kempt today and casually dressed: sensitively explore how they prepared for today
- Ask about self harm / suicidal tendency

4. What areas should be probed in claimants with drug and alcohol use?

- Condition history
- Quantity of alcohol consumed
- If possible, estimate units
- Type of drugs used
- Frequency of drug intake
- Any specific symptoms and how long these last
- Any withdrawal symptoms
- Clarify things such as blackouts if mentioned: What does the claimant mean? Is it a drunken stupor?
- Last alcohol / drug detoxification
- Explore current treatment, any further plans for detoxification, effects of treatment
- Lifestyle – Chaotic?
- Other medical conditions present – liver failure, cardiomyopathy, oesophageal varices? May need to perform an appropriate physical examination if relevant

5. Are there any other Mental State Examination findings that should be assessed?

- Rapport
- Other indicators of anxiety such as sweating
- Behaviour – irritability?
- Speech – volume
- Cognition – orientation and memory
- Insight
- Self harm / suicidal thoughts or actions
- Abnormal Thoughts and perceptions
- Level of intoxication (noted faint smell of alcohol)

Discuss how a claimant who is intoxicated at assessment and persistently uncooperative should be handled at assessment.

- Refer to the Revised WCA Handbook subsection on the uncooperative claimant
- Refer to Unacceptable Claimant Behaviour Procedure Process Guide

6. Discussion Case Six

Name: Ms Jeannie Smythe

Age: 24 years old

Med 3: Mild depression

ESA 50: Has written “I have very bad depression. I am very unwell and I cannot work.”

Learning tasks – has written “I’m not able to learn any new tasks.”

Awareness of hazard – has written “I can’t cook and I have no awareness of hazard.”

Initiating personal action – has written “I don’t do any personal action, my depression is very bad.”

Coping with change – has written “I can not cope with any change.”

Getting about – has written “I do not leave the house by myself.”

Coping with social situations – has written “I do not socialise at all. My depression is very bad.”

Behaving appropriately – has written “I have episodes of inappropriate behaviour.”

History at assessment:

Diagnosed with depression after the breakdown of a relationship 6 months ago. It is managed by her GP. No referral to secondary services. She is waiting to start a course of counselling.

Not on any medication.

Last worked 3 months ago as a florist’s assistant, was laid off because the business was in financial difficulties.

Lives alone in a 1 bedroom flat.

She sleeps poorly, she lies awake feeling sad. She will then wake late in the morning. She will often lie in bed until late morning. She does not get dressed or washed.

She doesn’t do any housework or cooking. She doesn’t like to go shopping, she can’t be bothered. She doesn’t see anyone, and spends all day in her flat alone. She does not go out to socialise. She has to be accompanied if she leaves the flat.

She has a mobile phone but doesn’t use it.

She can’t cope with any change, and she often yells and screams at people as she has no patience at the moment.

Mental State Examination Findings:

Appears well, overweight, normal complexion, does not look tired, appears kempt, wearing casual clothing

Normal facial expression, good rapport, normal eye contact, coped at interview, does not appear anxious

Normal amount, rate volume and content of speech

No thoughts of self harm

Did not require any prompting, general memory and concentration adequate

Good insight

Questions:

1. What are your initial thoughts about the case?
2. What further information from the typical day would be useful?

6.1 Mentor Guidance Notes for Discussion Case Six

This is a case where there is significant inconsistency between the history given at assessment and the Med 3/clinical history/MSE findings. It is designed to help HCPs develop further questioning / probing skills and logical reasoning of these inconsistencies to provide a robust justification.

1. **What are your initial thoughts about the case?**
    - Significant inconsistency within the evidence presented
    - Evidence suggesting mild disability: Med 3, clinical history and normal MSE findings
    - Evidence suggesting significant / severe disability: Typical Day History

2. **Ask the HCP how they might resolve it** – Typical Day history needs to be probed in greater depth. Discuss the need for asking probing questions at times.

It might be useful to role-play this with the mentor acting as the claimant, revealing the further information only if sufficiently probing questions are asked.

Further information:

Stays in bed late watching TV most mornings, but if she does have to get up for something specific, she will get up and make it to the appointment. Lies in bed because she has nothing else to get up for. When she gets up, she generally does get dressed and she has a shower most days. She does not like being dirty. Although she doesn't feel like cleaning the house she still does the housework. It is only a small flat and doesn't take her very long per week. She does not like to have a dirty kitchen or bathroom.

She doesn't like going to the supermarket as there are too many people there. So she does most of her shopping at the local shops. Sometimes she will go to the supermarket in the evenings, when there are less people, as things are cheaper in the supermarket. She goes shopping alone. None of her family or friends live close by.

She spends the day watching TV or reading. She goes to the library in the town centre once a fortnight to get some books. She has a computer at home and uses the internet to keep in touch with friends and family. She has a pet rabbit and some goldfish. She doesn't see her friends that often, none of them live close by. She keeps in touch via Facebook and perhaps once or twice a month will catch up for a coffee or a film. She manages her own household affairs. She has had a couple of episodes where she has got frustrated with poor customer service and ended up yelling at people. She knows she shouldn't but her illness seems to have made her less patient than before.

Now ask HCP for level of disability and suggested descriptors:

- No significant functional restriction with 'None of the above apply' descriptors for all mental function categories

If there is time, ask the HCP to spend a few minutes writing a PSS and review.

Section Two - Practice Scenarios

These practice scenarios are designed to be completed using LiMA on the training server. Local training NiNos should be used.

The whole case report should be completed and then the case discussed with the mentor.

An hour is allocated for each case, including discussion. Therefore the HCP is advised to enter only minimal essential information in the history section, along with the MSE findings and to concentrate on choosing an appropriate outcome and justifying this by completing the PSS. The case should be finished in about 45 minutes to allow 15 minutes for discussion. The mentor may need to prompt to ensure these timings are followed. The review and discussion of each case is important and designed to consolidate learning and should not be skipped.

There are 5 cases, 3 compulsory and 2 optional. Three cases should be completed in a session.

Guidance notes for the mentor are provided for each case. For each case there will be some relevant points about the case to be brought out in the ensuing discussion. Suggested outcomes and a suggested PSS are provided for each case. It should be an opportunity for HCPs to discuss and consolidate learning around levels of evidence required to support descriptor choices as well as appropriate justification of opinion.

7. Practice Scenario One

Name: Mr John Taggart

Age: 27 years old

Med 3: Bipolar Disorder

113: Bipolar disorder for 5 years. Under regular psychiatric review. Stable on medication. No recent hospitalisation. No active psychotic features. No self harm tendency.

None of the boxes suggesting any functional restrictions were ticked with comment: "Has been stable for past few years, lives with family but able to function well for most of the time"

Able to attend for assessment using public transport or taxi

No history of threatening or violent behaviour

Additional comment: "Would benefit from supported or voluntary work"

ESA 50: He has written "I am bipolar and I see my CPN and Psychiatrist often. I am not as bad as I was five years ago when I was hospitalised."

All physical function descriptors – no problem

Learning tasks – has written "It depends how I am feeling."

Awareness of hazard – has written "When I am very depressed I can't be bothered. When I am manic, anything goes."

Initiating personal action – has written "I do manage but when I am very depressed I can't be bothered."

Coping with change – No problem

Getting about – No problem

Coping with social situations – has written "When I am very depressed I don't want to talk."

Behaving appropriately – has written "When I am manic I get very excited."

Information from Assessment:

Clinical History

It started 5 years ago when he was at university studying computer science. He was admitted to a psychiatric unit for 3 months. He did not go back to university. Three years ago he had delusional thoughts, he thought he was a new superhero and he could stop speeding motorists by flying from a pedestrian bridge over the motorway. He was sectioned and admitted to the psychiatric unit for three weeks.

He now sees the CPN every 6 weeks and the psychiatrist every 3 months, but he can see the psychiatrist more often if the CPN thinks he needs to be seen.

The psychiatrist usually reviews his medication at each visit. He has regular blood tests every 3 months. His describes his mood as a bit low most of the time with occasional days when it gets even lower. He also gets periods where his mood lifts to the extent that he becomes very active with him not wanting to sleep much. These episodes of excess activity may occur about 2 times a year and can last between 3-7 days. He was told by his psychiatrist that he may get these episodes from time to time and these are hypomanic episodes. The psychiatrist advised him not to stop the medication because he is feeling energised. He has learned to look out for these episodes and tries to keep taking his medication. The last hypomanic episode was three months ago and lasted about 7 days. His family usually realise when these episodes are in progress as he becomes more talkative, impatient and at times irritable. They alert the CPN to ensure he is supported during these episodes. The family are very supportive. He had CBT 2 years ago. He has no current thoughts of self harm/suicide.

The last time he had such thoughts was around the time of admission 3 years ago.

Medication

Lithium 250 mg twice daily

Olanzapine 10 mg once daily

Side effects

Reports weight gain and feeling tired.

Social and Occupational History

Lives with parents and sister. His sister, Jane, gave him a lift and was present during the assessment.

He last worked 5 years ago as a part time shop assistant while at university. He never returned to work after the first hospital admission.

Typical Day History

He usually sleeps well except for the periods when he becomes more active. He goes to bed about 11 pm and gets up around 9 am. When he is having an active episode he can stay up until 3 am but still gets up at his normal time. During these periods he would spend hours and hours on the computer surfing the internet or writing multiple computer programmes none of which he ever finishes. He gets irritated and a bit snappy with his sister if she disturbs him during these writing sessions.

He usually manages to get washed and dressed when he is feeling low. On the odd day every few weeks he will stay in bed without getting washed or dressed. On these days he would only get up to go to the toilet, have a snack and take his medication. The family usually leave him alone on these days. He gets back to his usual self after a day or two.

After the other family members leave for work, he takes the dog for a walk in the local park. He then spends the rest of the day watching TV or using the computer. He likes

chat shows and movies. He selects movies from the on demand TV service. Most days he spends about 1- 2 hours on the computer. He plays computer games as well as Sudoku puzzles online and chats with two of his friends from school days. They both live in Edinburgh now and run a small IT firm. There is an occasional day every few weeks when he cannot manage to chat to them as he feels low and cannot be bothered. Apart from those friends in Edinburgh, he has lost contact with his other friends.

He learned to cook before going to University and now manages simple meals most of the time except for those days when he is feeling very low. Sometimes he helps his sister plan and prepare a more elaborate meal for the family. His older brother, kids and wife visit for these meals. His sister is attending catering school and wants to be a chef. He reports no recent kitchen accidents. He may go to the supermarket with his sister when they have a big meal planned. Otherwise, he goes to the local shop about once or twice a week alone to get bread and milk etc.

He previously played the lottery but stopped 3 years ago, when he was unwell. At that time he was sure it was his turn to win and spent a lot of money on tickets. He had multiple problems with excessive spending at that time but this is now under control. He manages his own finances mainly through internet banking.

He previously liked driving and was his sister's 'taxi' before she learnt to drive. However, since his first hospitalisation he rarely drives as he finds it too stressful. He last drove 7 months ago when went to the local garden centre with his mum to collect some items. She is an avid gardener and has a greenhouse with orchids and exotic plants. He catches the bus on his own into town once or twice a week. He visits charity shops to see if he can find second hand computer games.

He usually spends the evenings with his mum, dad and sister. They encourage him to keep active and would chat with him about their day at work or college. After chatting and watching TV, he goes to bed.

Mental State Examination

Casually dressed, well kempt, looks well

Slightly reduced eye contact, normal facial expression

Not restless or irritable

Adequate rapport, adequate concentration, general memory and recall adequate

Speech normal rate, volume and content

No thought or perception disturbance

No self harm thoughts

Normal insight

7.1 Mentor Guidance Notes for Practice Scenario One

This is a claimant with bipolar disorder, who is relatively stable. It is an opportunity to consolidate learning around clinical features and treatment of bipolar disorder along with a need to assess variability and whether it is appropriate to apply the mental risk NFD (exceptional circumstances).

The case is designed so that there is insufficient evidence to support the application of the risk NFD.

The 113 confirms stability, with no evidence to suggest that substantial risk would apply.

Careful review of justification of the non application of the risk NFD is required. It is not sufficient to say there is no evidence that the claimant is at risk. His diagnosis and medication could be considered key indicators of concern, but there is insufficient other evidence to suggest he is at risk.

Suggested Outcome:

None of the scoring descriptors apply and all areas should be: 'None of the above apply'

None of the Support Groups or Exceptional Circumstances apply in this case

Sample PSS:

Mr Taggart has bipolar disorder and is currently under the care of the psychiatrist. He has had no recent psychiatric admissions or thoughts of self harm. He has episodes of feeling very low on the odd day every few weeks. He also has episodes of hypomania about twice per year lasting up to a week. However, the majority of time, despite some ongoing low mood, he is able to manage a number of activities unaided including his own medication, self care and interaction with his family.

With the exception of slightly reduced eye contact, the mental state examination was normal which is consistent with the history.

Significant restriction of mental function is unlikely.

Remind the HCP they can call and discuss any mental health case they are unsure about with the MFC.

8. Practice Scenario Two

Name: Mrs Jayne Cresswell

Age: 45 years old

Med 3: Depression

ESA 50: Has written “I have been diagnosed with depression. It affects every part of my life. Everything is a struggle currently.”

All physical function descriptors – no problem

Learning tasks – no problem

Awareness of hazard – has written “I don’t have the energy or concentration to cook or drive.”

Initiating personal action – has written “I struggle with my motivation, it’s hard to find the energy to do anything. “

Coping with change – no problem

Getting about – no problem

Coping with social situations – has written “I have no interest in seeing either friends or family.”

Behaving appropriately – no problem

Information from Assessment:

Clinical History

She attended with her husband who provided the majority of the history.

She was diagnosed with depression about 12 months ago. She has a history of depression, first diagnosed when she was 20. She was admitted to hospital for 2 months after a serious suicide attempt at that time. She has had episodes of depression intermittently since that time. The last was about 5 years ago. This current episode was precipitated by the death of her grandmother who she had been very close to.

She was diagnosed by her GP and commenced her on citalopram. There was no initial improvement and she was referred to the CMHT. Her medication has been increased and changed several times over the last 10 months. There has been some gradual improvement but she has significant ongoing symptoms. She currently sees a CPN every fortnight and the psychiatrist every month. Her main symptoms are low mood, fatigue and feelings of hopelessness, with poor sleep and poor concentration.

She has occasional thoughts of self harm. No active plans (when she was first

diagnosed she had thoughts of self harm and was formulating plans around collecting tablets, it has improved with treatment)

Medication

Venlafaxine 150mg daily

Fluoxetine 60 mg

Social and Occupational History

She attended the Medical Examination Centre with her husband, who was present during the assessment and provided most of the history.

They live in a semi detached house and have no children.

Typical Day History

She sleeps poorly. She has difficulty getting to sleep, as she keeps worrying about things. She then wakes early (4-5 am). She remains in bed in the morning, as she does not wake refreshed. She lacks the energy to get up and get going in the morning. Her husband has been very supportive. Initially he took time off work to look after her when she was really unwell at the beginning of this episode. He often needs to prompt her to get out of bed, although this has improved recently. She may manage this on her own a couple times a week now. He will bring her a cup of tea and some toast in bed. She doesn't have much of an appetite and has lost about a stone in weight since she became unwell.

On the days that she does get out of bed without prompting, she generally has a shower and gets dressed, but on the other days her husband needs to chivvy her along about these things. She just feels so tired.

Her sister lives near by and often comes to spend the day with her, whilst her husband is at work. It is something her husband has arranged, she doesn't really feel like seeing anyone including family, but she accepts they are doing it to try to help her.

She used to be an avid reader but does not have the concentration to read currently. She might flick through a few magazines that her sister brings around but she doesn't take anything in. Sometimes the TV is on but she has no interest in watching any programmes. Her sister likes to watch daytime TV, but whilst she is sitting there with her sister, she is not following the programmes. She feels low all the time and is often tearful during the day. She can't see how things will improve and feels everything is hopeless. She has occasional thoughts of self harm, but would not act on them currently as she could not do that to her husband.

Her sister or her husband will take her out for a drive a few times a week. She will go but has no interest in these outings. They go to places she has not been before but she can't remember the place names. She never goes out on her own as she always feels too tired and she does not like talking to strangers. She has stopped going shopping and her sister or husband does this now.

Her husband does the housework, cooking and running of the household currently. If it

was left to her it wouldn't get done. She will tidy up a bit on her better days and may do the dishes, however she avoids anything to complex. Also she is too distracted in the kitchen, there were a couple of incidents where she left something boiling on the stove and wandered away. It set the smoke detector off on both occasions. Her husband and sister frequently ensure she does not use the cooker but she usually manages to make herself a cup of tea or some toast. She has also stopped driving because her husband does not allow her to, she thinks she could still drive but lacks motivation to do so, however her husband indicated that the last time she drove, she went the wrong way down a one way street and nearly crashed into another car. Since then he has not really allowed her to drive.

She has not used the computer at home since she became unwell. She does have a mobile phone and her husband will call to talk to her a few times during the day. She used to ignore it, but now she does answer it, as she knows her husband worries if she does not answer. She does not like it when someone knocks on the door unexpectedly, but she will still see who it is and just send them away if she does not know who they are.

She has stopped seeing her friends as she just does not feel up to it. It is too tiring and she has no interest in seeing anyone.

Mental State Examination

Appears unwell, thin, pale complexion, looks tired, appears kempt, wearing casual clothing

Reduced facial expression, poor rapport, poor eye contact, has psychomotor retardation

Spoke very little, spoke quietly, content of speech normal

Occasional thoughts of self harm, no active plans

Needed frequent prompting, appears distracted, concentration poor, general memory adequate

Had some difficulty coping with assessment and often looked to husband for reassurance, she let him do most of the talking and only answered some direct questions herself

Limited insight

8.1 Mentor Guidance Notes for Practice Scenario Two

This claimant has severe depression and there is sufficient evidence contained within the scenario to apply the mental risk SG. The case is designed to allow discussion around the clinical features of depression, indicators of severity of depression, and the risk NFD/SG

Ask the HCP if they think the claimant has a severe mental illness. The answer should be yes.

Review the case once the HCP has completed it. Check the MSE findings have been entered correctly. Check the descriptor choices and overall outcome.

Suggested Outcome

Mental Health Descriptors:

Learning: LT(d) None of the above apply

Hazard awareness: AH(b) Frequently require supervision

Personal action: IA(b) Cannot initiate personal action for the majority of the time

Coping with change: CC(d) None of the above apply

Getting about: GA(b) Unable to get to a familiar place alone

Socialising: CS(c) Unable to engage with unfamiliar person for majority of the time

Appropriateness of behaviour: IB(d) None of the above apply

Exceptional circumstances

This would be curtailed as the claimant would have scored over the threshold

Support Group

The Mental Risk SG should have been applied in this case

If different descriptors are chosen, go through each one discussing what evidence supports that descriptor choice, it may also be useful to review the scope of each descriptor.

Look to see whether the mental risk SG has been applied. Discuss the indicators in this case that would make application of the risk SG appropriate?

- Background of significant mental health problems (suicide attempt and hospitalisation, albeit a long time ago – not enough on it's own but consider in combination with other factors)

- Level of input – under CMHT with input from CPN and psychiatrist

- Medication regime, on second line treatment for depression
- Attended the MEC with her husband, could not have come by herself
- Did not cope that well during the assessment, in fact she was quite withdrawn, with poor eye contact and poor rapport and most of the history was provided by the husband
- Appears significantly depressed at assessment

Discuss that it is not one isolated piece of evidence in this case that suggests the risk SG is appropriate to apply, rather it is the overall combination of several factors.

Discuss that Risk NFD can still be applied when a claimant is below threshold and that Risk SG may be applied to claimants regardless of whether they are below or above threshold.

Remind HCPs that when assessing the risk NFD/SG in mental health cases, it is not just about the risk of suicide. Risk of deterioration in mental health if they are found fit for work or work related activity must also be considered. Remind HCPs on the Update to Standard on substantial risk in claimants with a mental health problem. HCPs have to consider what will be the impact of the WFI (Work focussed interview) process on the claimant. Ensure the HCP understands what the WFI process entails.

Other things that could be considered when considering risk (but which are not present in this case) are:

- Suicide risk or recent history of significant suicide attempts
- Recent hospitalisation (voluntary/under section)
- Need for home visits by GP, care workers or Atos
- Living circumstances, living alone, unsupported
- Occupational history (repeated job failures, length of time since they have worked)
- Substance misuse
- Co-existing physical or mental health conditions
- Co-existing social/family problems – separation/divorce, bereavement, court procedures, etc

Sample PSS

Mrs Cresswell has depression and she is being treated with significant anti-depressent medication. She is receiving intensive support from the CMHT. She continues to have significant depressive symptoms and is requiring a lot of support from her family to help her function on a day to day basis. She has had some accidents at home due to poor concentration, and often needs prompting for self care although she does manage independently on some days. She does not go out alone and does not like talking to people other than close friends and family. Mental state examination was consistent with significant depression and anxiety. She is likely to have substantial functional restrictions with hazard awareness, personal action, going out and social interaction, although not with learning tasks, coping with change and behaviour. However she also has suicidal thoughts, intensive mental health input and support from family, and it is likely that there would be a substantial risk to her mental health if she was found capable of work or work related activity.

Remind the HCP they can call and discuss any mental health case they are unsure about with the MFC.

9. Practice Scenario Three

Name: Mr David Ford

Age: 23 years old

Med 3: Psychosis

113: Psychosis, seen by psychiatrist. On medication. Not seen recently.

ESA 50: He has written "I have been diagnosed with psychosis. I used to hear voices at times. My medication helps."

All physical function descriptors – no problem

Learning tasks – has written "It depends how I am feeling."

Awareness of hazard – no problem

Initiating personal action – has written "Sometimes I cannot be bothered."

Coping with change – has written "I don't like changes."

Getting about – has written "Sometimes I can't be bothered to go out."

Coping with social situations – has written "Sometimes I do not feel like talking."

Behaving appropriately – has written "I used to be very irritable, but this is not as bad as before. My medication helps."

Information from assessment:

Clinical History

The condition started about 5 years ago when he was admitted to the mental health unit. He was behaving strangely at work over a few days and one afternoon he was checking behind all the televisions looking for the three people who were speaking to him. He became very disruptive and the police were called and took him to hospital. He was sectioned and remained in hospital for 4 weeks. He had been smoking a lot of cannabis prior to becoming unwell and he was diagnosed with a drug related psychosis. For the first year after his diagnosis he was seeing the CMHT almost every 1- 2 weeks. The frequency was gradually reduced and he now sees the psychiatrist every year and the CPN every 6 months. At the time of onset he was having disturbing hallucinations, with three people talking to him all about different things. These took a while to get under some control with medication. He has had CBT and his immediate family also attended family intervention. He no longer hears the voices now; he has not heard any voices for a couple of years. He was also very suspicious of people and refused to eat anywhere other than home when he first became unwell. He is less suspicious now and no longer feels everyone is out to poison him. He describes himself as paranoid of strange people and takes a while to get accustomed to anyone. He thinks his medication makes him feel quite tired. There have been no further psychiatric admissions. No current thoughts of self harm / suicide, has never really had any such thoughts.

Medication

Olanzapine 10 mg once daily – has been on same dose for a few years

Side effects

Reports weight gain and feeling tired

Social and Occupational History

Attended the assessment alone. Used the bus, journey took 20 minutes with a 10 minute walk from bus stop to Medical Examination Centre.

Lives with his cousin in a two bedroom house.

He worked as a retail assistant in an electronics store up until the hospital admission 5 years ago. He never returned to work after hospitalisation.

Typical Day History

He usually goes to bed around 11 pm and most of the time drops off to sleep almost immediately. He usually gets up between 8 and 9 am just in time to see his cousin off to work. He gets his own breakfast. He likes to prepare bacon and eggs. He takes his medication and then has a quick wash and gets dressed before sitting to watch morning TV. Occasionally (once every few months) he doesn't get washed and dressed until late afternoon just before his cousin returns.

He is currently helping his cousin paint and decorate the house. His cousin leaves small tasks for him to do during the day. The bulk of the work is being done over the weekend when his cousin is home. His cousin is glad to have him home to receive the deliveries. When he first moved in he found it difficult to even answer the door to the postman, as he thought people were coming to collect him and take him away. He now knows the postman well and chats with him. He is able to answer the door and receive the deliveries from the hardware company and he likes to pack items away in the shed. He is currently searching the internet for stereo equipment as his cousin is planning to upgrade the home cinema system.

He gets himself a sandwich for lunch. Most afternoons he reads magazines and surfs the internet. A few afternoons he would start preparing the vegetables and other ingredients for dinner. He does some general tidying up. He may go to the local shop to get any missing ingredients. While there, he may purchase credit for his mobile phone. He uses his mobile phone for emergencies and to keep in touch with his sister who lives in Wales. He visits her about three times a year. He travels alone by train for the 2 hour trip. He avoids making the trips during busy periods and holidays as he finds this more stressful.

When his cousin returns home, they chat and watch TV together. Most days at about 7 pm the cousin would start getting the main meal ready. They both stay in and watch TV. He prefers to watch comedies and dramas. He avoids watching science fiction and horrors as these make him feel distressed.

Occasionally the cousin may go to the pub after work. On those evenings, he would make himself beans on toast or heat up left-over food using the microwave. On these evenings he may do a bit more reading or surfing the internet.

Some weekends he goes out with his cousin for a meal and a movie. They used to go to the same restaurant all the time, but over the last few months they have been trying different places. He now feels comfortable enough to place orders for himself and is enjoying going to the new restaurants. He only has a small glass of wine with the meal as he does not want the alcohol to interfere with his medication.

Mental State Examination

Alert throughout, not tired looking

Well kempt, casually dressed

Average build

No psychomotor retardation or agitation

Reduced facial expression however maintained appropriate eye contact

Adequate concentration and memory

Speech rate, volume and content normal

No self harm/suicidal ideas

No obsessions

No delusions

No hallucinations

No other abnormal thoughts or perceptions

Good insight

9.1 Mentor Guidance Notes for Practice Scenario Three

This claimant has a diagnosis of psychosis. This case can be used for a discussion around psychosis (itself not a diagnosis, rather a symptom) that can touch on the clinical features of psychosis, treatment and assessment.

Suggested Outcome

None of the scoring descriptors apply and all areas should be: 'None of the above apply'

None of the Support Groups or Exceptional Circumstances apply in this case

In the risk NFD/SG justification the HCP needs to address why the claimant is not at risk in view of the diagnosis. Key point is the hallucinations have stopped and he has insight. He is reasonably stable with the current treatment and functions on a day to day basis. It is not sufficient to say there is no evidence that indicates that the claimant is at risk (his diagnosis and medication could be considered key indicators of concern).

Develop discussion around how the situation may be different if having the claimant reported frequent disturbing hallucinations, more intensive support from mental health specialists or recent increase in dosage of medication. Discuss potential mental state findings associated with significant active psychosis symptoms including reduced concentration and appearing distracted.

Sample PSS

Mr Ford was diagnosed with drug related psychosis. His condition has improved with treatment and is reasonably controlled with medication currently. He no longer has frequent, disturbing hallucinations and has not been admitted to hospital since the original admission 5 years ago. He is able perform a number of self care activities independently, use new technology such as the internet, travel independently and interact normally with strangers when required. This is consistent with his mental state findings which were broadly normal with no psychotic features.

Remind the HCP they can call and discuss any mental health case they are unsure about with the MFC.

10. Practice Scenario Four

Name: Miss Molly Mears

Age: 20 years old

Med 3: Moderate Learning Disability

ESA50: Not returned

Information at assessment:

Clinical History

Mother explained that the ESA 50 wasn't returned as it was not received. They have recently moved. Mother advised that Molly has problems with learning tasks, hazard awareness and getting about.

She was diagnosed with Learning Disability at age 9. Attended a mainstream primary and secondary school. Had a statement of needs during secondary education, which meant she was supported by a teacher's assistant in all of her classes. Did not obtain any GCSEs on leaving school at age 16. Attended college and completed a life skills course.

Medication

On no medication

Social and Occupational History

Attended with her mother who helped Molly give the history.

Lives with her mother, in a house. Has never been employed. Did a couple of work placements in Tesco and at the local garden centre, but there was no job at the end of it. She was taught how to stack shelves in both placements.

Typical Day History

Sleeps well. Her mother wakes her up in the morning about 7 am. She gets out of bed and gets washed and dressed every day. She does not require any prompting to do this. She can get her own breakfast (cereal / toast) and a hot drink.

She helps her mother with the housework. She has the same chores each week, so she knows what to do. It took her a little while to learn what was required for each chore. Her mother had to remind her over several days until she remembered what was required. Now she is able to vacuum and do the laundry regularly (sorting clothes, setting the machine and hanging clothes to dry). She has to perform the chores on the same day of the week and in the same order as otherwise she becomes anxious and makes mistakes.

She can make simple snacks/meals she has been taught to make unaided/ unsupervised (such as beans on toast etc) but can't cook anything more complicated without help. She is not able to follow a recipe and she has had a few accidents with the cooker so her mother does not let her use it on her own. She understands the dangers of using a cooker and will not use it if she is unsupervised. However she enjoys cooking and so helps her mother when they make more complicated meals in the evening which she knows she would not be able to do on her own.

Her mother works so she spends the day either at home alone or at her grandmother's house. Her mother indicated that she prefers to avoid leaving Molly on her own for long periods of time if possible. Molly has been known to give money to anyone who asks for help, regardless of whether they are genuine or not. Her mother will drop her over to her grandmother's house as it is on the other side of town. She could not manage to get there on her own as it requires a complicated bus journey and then a 20 minute walk.

She can manage a simple bus journey (i.e. one without any changes) after being shown where to get on and off a couple of times. She used to go to college by bus by herself. She does not like travelling on the bus by herself as she is always anxious that something may happen. A few weeks ago, the bus had to pass through a different route due to road works. She did not know where she was going and became very upset. Although the bus still stopped at her usual stop, she had to call her mother to come for her as she was too distressed.

She has been taught how to start and use the computer for simple tasks. She is able to use face book to keep in touch with a few friends from college and family. Her mother had to set the account up to ensure the security settings were correct and put an icon on the desktop for her. She also has some simple games she enjoys playing. Her mother has bookmarked them, so she can find them easily. She does not use the computer for anything else.

They have a dog and a cat, which keep her company during the day when she is at home. She is able to walk the dog alone a couple of times a day around the block (she does not have to cross any roads). There is also a local park on the way where she can play 'fetch' with the dog, which she really enjoys. She always follows the same route and would not venture anywhere different as she might get lost and not be able to find her way home.

She can go to the local shops, 2 blocks away. She has to cross a quiet road, which she can manage, although she would struggle on a busy road as she tends to forget which way she has to look to cross a road when it is very busy.

She likes spending time with her grandmother. They will often go out to different places, and she enjoys these outings. She knows that her grandmother will take her to different places and she can cope with these because she is not alone. They will go to different cafés for coffee and lunch and they also go to museums sometimes. She could not go to these places alone as she would not know how to get there.

She has a mobile phone and she can use it to phone family and friends. She does not use text as she finds it a bit confusing and her reading and writing is not the best. Her contract is capped and her mother deals with the bills as she had to pay a lot of money initially before her mother sorted out the contract for her.

Mental State Examination

Appears well, normal build, normal complexion, does not look tired, appears kempt, wearing casual clothing

Normal facial expression, good rapport, normal eye contact

Slightly tense and apprehensive although her mother had prepared her for the interview and what she was to expect during the assessment

Normal amount, rate, volume and content of speech

No thoughts of self harm

Required some prompting, but general memory and concentration adequate

Good insight

Could not complete 5 rounds of serial sevens

Could not calculate change

Could remember 2 objects at registration but could not recall any of the 3 objects later in the assessment

10.1 Mentor Guidance Notes for Practice Scenario Four

This is case where the claimant has a moderate learning disability. It is designed to allow a discussion around the diagnosis of learning disability, levels of disability and cognitive examination at assessment.

Suggested Outcome

Mental Health Descriptors:

Learning: LT(c) Cannot learn anything beyond a moderately complex task

Hazard awareness: AH(c) Occasionally requires supervision

Personal action: IA(d) None of the above apply

Coping with change: CC(c) Unable to cope with minor unexpected change

Getting about: GA(c) Unable to get to an unfamiliar place without being accompanied

Socialising: CS(d) None of the above apply

Appropriateness of behaviour: IB(d) None of the above apply

None of the Physical Scoring Descriptors, Exceptional circumstances or Support Groups apply in this case

Sample PSS

Miss Mears has a learning disability. She is able to self care and learn tasks such as setting a washing machine but would be unable to manage more complex tasks. She has to follow a routine and has to be prepared for any changes as she becomes distressed with unexpected events. She requires help and supervision for more complex tasks in the kitchen and help with more complex journeys, although she does go out alone in places she is familiar with. While she is able to recognise hazards in her own daily environment (such as dangers of the cooker), she may fail to recognise a potential hazard if outside of her usual environment (such as crossing as busy street). It is likely that she will sometimes require supervision.

These findings are consistent with mental state examination findings of significant impairment of cognitive function.

Remind the HCP they can call and discuss any mental health case they are unsure about with the MFC.

11. Practice Scenario Five

Name: Ms Jenny Joseph

Age: 22 years old

Med 3: Asperger's and Anxiety

113: "Has Asperger's syndrome but has recently become very anxious. She has been referred to specialist psychological services."

ESA 50: has written "I have Asperger's and I was working before. I hate being around people as they misunderstand me."

All physical function descriptors – no problem

Learning tasks – no problem

Awareness of hazard – no problem

Initiating personal action – no problem

Coping with change – has written "I don't like changes."

Getting about – has written "depends on where I have to go and who is there."

Coping with social situations – has written "I don't like talking."

Behaving appropriately – has written "I can get irritable when I am upset or scared."

Information at assessment:

Clinical History

(Most of the history provided by mother)

She was diagnosed with autism at age three when mother noticed that she was not speaking or interacting socially like her older siblings did at the similar age. In her teens the diagnosis was changed to Asperger's syndrome. Her paediatrician told her that the main problem with her autism was the impairment of her social skills rather than her learning as she had a good IQ. She attended a main stream school. She had support from child psychology services to deal with social skills and anxiety as she was somewhat disruptive when she got very anxious at school. She later attended college and did a life skills course to further improve her social skills as well as undertaking a bookkeeping course. She was able to finish the course and obtain an administrative job in a local shop.

She lost her job 9 months ago when the business closed. Since then she has been unable to find another job. This makes her feel frustrated and low most days. Her anxiety has also worsened and she has become a bit more withdrawn since losing her job.

She gets anxious most days especially when she has to leave the house or go to new places. She gets panicky at changes. When asked to describe panic, her mother reported that Jenny gets very distressed, sweaty, trembles and short of breath. This can last for up to 10 minutes after leaving the area or situation, but also leaves her restless for the rest of the day. She often gets irritable, but not violent. Her GP became concerned about the increasing anxiety and started her on medication and referred her to a psychologist with interest in autism.

Medication

Sertraline 50 mg daily

Social and Occupational History

Attended the assessment with her mother. Got a lift with older brother.

Lives with her parents and younger brother.

Stopped working 9 months ago due to redundancy. Worked in a shop.

Typical Day History

Usually goes to bed around midnight. Usually sleeps well. Gets up on her own between 8 - 10 am. Previously she got up earlier when she was working and was able to get herself ready on her own. She was always early for work. She was able to get a job though the help of her local branch of an autism charity. Her previous manager and team leader were very understanding and had input from the specialist employment services of the charity on how to deal with autism. She worked in the cash room, counting money and was responsible for reporting cashier variances to her team leader. She never worked on the shop floor as she found interacting with the customers very stressful. Before starting the job full time she had a coach from the charity who attended work with her for six weeks. Her coach also gave tips to the manager and other employees to raise their awareness of autism. Her team leader learned some techniques and took over as her mentor when she started to work full time 3 years ago.

Now when she is sad, she sometimes does not feel like washing and dressing, but she does generally manage this independently most days. She usually does her own laundry and helps with the housework occasionally. She usually keeps her own room clean and tidy and makes sure everything remains in the exact place. The family know not to reorganise the items in the bathroom as this upsets her.

She spends most of the day in her room doing Sudoku puzzles on the computer. She keeps in touch with her team leader from work via the internet. Her team leader moved away to Bristol as she found a job there. Jenny would like to go to Bristol and visit, but she thinks the journey would be too stressful as she has never visited there before. Her coach from the charity had taught her the route to work. This was a single 10 minute bus journey. One morning the bus did not turn up due to an accident. She got very distressed and returned home. Her older brother heard about the incident and offered to drive her to work but she was so distressed, she stayed in her room at home for the entire morning. When her team leader called, her mother explained what had happened and he advised that she took the remainder of the day off.

She occasionally manages to go to the local shop alone to get bread and milk if her mother asks her to go. She does this alone as she knows the shop keeper. She never goes to the large supermarket alone. She used to go with her mother and younger brother up until 6 months ago. However, as her anxiety got worse, she would no longer make the trip there. She is able to travel to her GP surgery alone. She always keeps the appointments and gets there on time. The surgery is 10 minutes walk away. She does not speak to anyone on her way there. She knows the receptionist there and usually has no problems booking in. Two weeks ago when she visited the GP surgery, she returned home very distressed. She locked herself in her room for the rest of the day and did not even come out for supper. When her mother eventually persuaded her to chat, she told her mum that her usual receptionist was not there and a stranger was asking her lots of questions.

Her mother explained that she usually has to prepare Jenny for any interviews and unusual appointments. She had cancelled her first WCA assessment as she had 10 days to prepare and was anxious about making the half hour journey to the MEC. Mother arranged for an appointment 4 weeks later. Mother is currently preparing her for the visit to the psychologist. This specialist psychologist is in another town, 45 minutes away. The brother has already booked time off of work to give them a lift to the health centre as they doubt Jenny would tolerate the train journey.

She gets upset with her brother if he comes into her room and moves anything around. When they were much younger this was the source of major arguments and fights. Now she just gets upset and shouts at him. She likes to play games on her X box and computer. Eighteen months ago she purchased an X-box kinect sensor and two discs with dance routines. Recently her brother took the dance discs up without her permission as he had a group of friends from college over. She got very upset when she noticed both her discs were missing and had a shouting match with him the following day.

She chats with her younger brother briefly most days. Her older brother lives away from home but he visits regularly. They try to invite her out to the movies, but she always refuses as she does not like the crowds. When her younger brother brings friends over unexpectedly, she would refuse to come out of her room. She never answers the door even if she is expecting a delivery of items she may have ordered online. She does not answer the house phone even if she is home alone. She only uses her mobile phone for text messaging. Recently when she was home alone, her mother called the landline as she forgot her mobile home and wanted to ask Jenny to take the clothes out of the machine. She refused to answer the phone. Her mother eventually stopped by her brother's workplace and got him to send a text message to her about the clothes in the machine.

She does not usually attend extended family events. Three months ago her mother and father persuaded her attend her cousin's wedding reception. They tried to prepare her for the event by explaining to her about the number of people coming and how they may want to chat with her. However, she only spent 30 minutes at the reception as there were too many people there and she could not chat with anyone. Lots of relatives and other people who had not seen her for many years were coming up to her trying to chat. She was getting very anxious and seemed to be ignoring all of them. Her mother noticed how irritable and anxious she was getting and took her home.

Mental State Examination

Well kempt

Casually dressed

Average build

Avoided eye contact throughout the assessment, appeared restless and tense

Fiddling with her fingers throughout the assessment

Adequate concentration and memory

Spoke very little but volume and content normal

No self harm ideas

Appeared reluctant to enter the assessment room. Asked mum to speak for her very early on in the interview. Difficult to establish any useful rapport

Only spoke with mother in very short sentences. Appeared to ignore all questions directed towards her and blurted out “ask mum” from very early in the interview

Appeared somewhat restless, anxious and uncomfortable throughout the assessment

11.1 Mentor Guidance Notes for Practice Scenario Five

This claimant has Asperger's syndrome (the high functioning end of the autistic spectrum). She does not have a significant learning disability. However she has significant impairment of her social skills. She gets significant anxiety with changes to her routine.

Review the case once the HCP has completed it. Check the MSE findings have been entered correctly. Check the outcome and descriptor choices.

Suggested Outcome

None of the Physical Scoring Descriptors, Exceptional Circumstances (NFD) or Support Groups apply in this case

Mental Health Descriptors:

Learning: LT(d) None of the above apply

Hazard awareness: AH(d) None of the above apply

Personal action: IA(d) None of the above apply

Coping with change: CC(c) Cannot cope with minor unplanned changes

Getting about: GA(c) Unable to get to an unfamiliar place without being accompanied

Socialising: CS(c) Engagement with someone unfamiliar is not possible for the majority of the time

Appropriateness of behaviour: IB(d) None of the above apply

Look at the evidence used to support descriptor choices if any different descriptors are chosen by the HCP. The coping with social engagement activity descriptor may be debated by some suggesting CS(b) instead but in the scenario the evidence and information suggests it is likely at CS(c) level.

Sample PSS

Ms Joseph has Asperger's and significant anxiety. She has significant difficulty coping with unexpected changes in her routine and finds it very difficult to communicate with strangers. She gets irritable at times, but never violent. She is able to travel to local, familiar places to attend planned appointments. However she is unable to travel to unfamiliar places. She recently commenced medication for anxiety and is awaiting psychology input.

At interview she was anxious and had reduced rapport. This was reasonably consistent with the restrictions reported in her typical day.

Discuss

Although she has worked previously, this was with lots of support to get her ready for the working environment and at a specific place. Discuss how this may affect the prognosis. She would likely need time to find suitable employment and get support in finding such employment. A 6 months prognosis is unlikely to be adequate.

Remind the HCP they can call and discuss any mental health case they are unsure about with the MFC.

Next steps

At end of the discussion and practice scenario sessions ask the HCP if there are any areas where they are unsure and direct them to the following appropriate references.

Useful References

EBM protocols

Revised WCA Handbook

Mental Illness: Current Therapeutics and Management (Distance Learning) MED-CMEP~0085

Davies T. Craig T. (2009) ABC of Mental Health. London: Wiley-Blackwell

Dogra N. Lunn B. Cooper S. (2011) Psychiatry by Ten Teachers. London: Hodder Arnold

NICE Clinical Guidelines & Pathways:

http://pathways.nice.org.uk/

www.nice.org.uk

Quick reference and full guides available on a range of mental health conditions including:

- Anxiety
- Depression
- Bipolar Disorder
- Schizophrenia
- Autism
- Alcohol Dependence and Harmful Alcohol Use

Re-iterate the role of the MFC and that they can be contacted at any time to discuss cases.

Check the HCP is aware how to contact the MFC in their local area.

Observation form

Please photocopy this page and use it for any comments and observations on this document, its contents, or layout, or your experience of using it. If you are aware of other standards to which this document should refer, or a better standard, you are requested to indicate this on the form. Your comments will be taken into account at the next scheduled review.

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