

Health Assessment Service

Personal Independence Payment

Health assessment report

Claimant details

Name	[REDACTED]
National Insurance number	[REDACTED]
Date of birth	[REDACTED]
Benefit type	Personal Independence Payment
Date report was completed	26 March 2024
Name of Healthcare Professional	[REDACTED]

Health assessment

Select the type of assessment

Type of assessment	Telephone
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Date of assessment	21/03/2024
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Additional attendees

Attendee 1

Name: Assessed alone

Relationship to claimant: N/A

Evidence

All further medical evidence submitted prior to the 21/03/2024 have been reviewed and considered. The following documents have been used when assessing and justifying the current level of functional restrictions:

AR1 15/12/2023
PA4 25/01/2023
UC85 22/01/2024 LCWRA risk
Non clinical x4
UC85 12/05/2021
PIP HP action log 14/12/2022
Specialist letter Attention deficit hyperactivity disorder (ADHD) clinic 05/06/2023 - needs to be reassessed
Patient access medical record - last entry 29/11/2023
Discharge letter 08/02/2023 Bilateral mastectomy and nipple grafts
Letter from psychiatry 07/11/2020
Mental health referral 18/04/2023
Letter from personality disorder service 12/08/2020
Letter from rheumatology 27/02/2023 meets criteria for Ehlers-Danlos
Discharge letter to CRISIS home treatment team 02/05/2023 took an overdose
GP medical printout 18/12/2023 multiple overdoses listed and last one 15/12/2023
Letter from psychiatrist 24/02/2021

All evidence read and considered even if not listed in this section.

No further evidence presented during the assessment.

Identity confirmed using the following:

Full name – [REDACTED]

Date of birth [REDACTED]

NINO - [REDACTED]

Name of benefit - PIP

The following abbreviations may be included within the report: HCP (Healthcare Professional),

Functional History (FH), History of conditions (HOC), Social and occupational History (SOH), Informal Observations (IO), Mental state examinations (MSE), Further evidence (FE), Community psychiatric nurse (CPN), Overwhelming psychological distress (OPD), Cognitive Behavioural Therapy (CBT), Occupational therapist (OT), Post traumatic stress disorder (PTSD), Emotional unstable personality disorder (EUPD) and CAMHS (child and adolescent mental health services). Medication and treatment/therapy (MT), attention deficit hyperactivity disorder (ADHD) and community mental health team (CMHT).

History of condition

The scope of the assessment was explained to the claimant and the claimant gave verbal consent to proceed.

Emotionally unstable personality disorder (EUPD), avoidant personality disorder (AVPD) anxiety, depression, psychotic episodes and schizoaffective disorder. He had a voluntary stay in a mental health unit in April 2023. He feels that he may also have a diagnosis of bipolar disorder or non-organic psychosis. Any further diagnosis is ongoing, he is under the care of the CMHT and sees a therapist weekly online and sees a psychiatrist every 4 months. He has recently moved to this team. He has been under various mental health teams since the age of 14 and this has been almost consistent since the age of 14. His problems started earlier than this but he first saw the MHT team at 14. He has been flagged to CRISIS recently and they have advised that he is seen more by the MHT. Previously, he was an inpatient in hospital for his mental health in Summer 2022 for 2 days whilst in Sweden. He is in receipt of multiple medications for this, has been for a long time, there have been no changes on the medication for several months.

Day to day he experiences symptoms of suicidal harm thoughts and self harm urges. Low mood, empty and hollow with low motivation. Fear of abandonment which makes his suicidal ideation worse. Emotional flashback situations, experiences with thoughts and memories, violent in nature or not pleasant. He suffers with intrusive thoughts all of the time and this becomes worse when he is not focused on something, he loses track of time, recent and long

term (he has to keep a planner as a result). He has disassociation daily and avoidance anxiety - does not see people enough as a result. He will lash out when he is upset and distressed - this is verbally on a daily basis, to anyone who is nearby. This is due to reactive volatile moods. He suffers with psychotic elements - has background talking which is distracting but not intrusive. He has a fear of public spaces, suffers with impulsive behaviour - when he is upset or manic, occurring most days. He suffers with sleep issues and states that he gets lost when he goes out anywhere. There is variability within the day but he has no good days in general. His symptoms can become worse due to his joint pains.

With his intrusive thoughts - these are violent in nature or violent loops of intrusion where they can also tell him to harm himself. This results in him not being able to function, struggles to focus and becomes distressed and upset where he struggles to communicate with people. He is experiencing these symptoms weekly but is unclear how often.

He has a low level of disassociation all of the time. Twice a week, this becomes more severe where his partner needs to support him to bring him out of the phase and that he does not harm himself.

His symptoms have gotten worse over the years.

He last attempted suicide one month ago - he went to A&E at the time after an overdose of sleeping tablets. Prior to this was in December 2023 with an overdose. He normally attempts every 3-4 months on average and has a long history of overdosing. He suffers with suicidal ideation daily, there are always passing thoughts but does have plans to overdosing, or walking into traffic - this can be 3 times a week. He only has his prescriptions for 1 week at a time due to his history of overdosing. He has protective factors of his partner but this does not stop him from attempting suicide if he is able to. He has a history of self harm, last did this 2 days where he cut his arm. This is caused by when he is upset, he wants to kill himself but he can't. He has thoughts of self harming weekly and normally does this monthly and has a long history of this. His GP and mental health team are aware.

Gender Identity Dysphoria. He had in February 2023 a Bilateral mastectomy (breasts removed) and nipple grafts. He is under a specialist for this, takes a hormone for this, he has requested more surgery and is awaiting approval. There were no problems with his surgery. Pronouns are He/him. He sees the specialist ad hoc. He has seen them twice in the last 6 months. He does not like being out in public as a result of his dysphoria as this makes him feel anxious in himself.

Autism and ADHD - he has had recent diagnosis of autism and ADHD after an assessment but feels that he has had symptoms for a long time. He had a Special education needs coordinator (SENCO) lead at school weekly and an occupational therapist - had computer use and extra time in exams. He is not sure if he had an educational healthcare plan (EHCP). He was also allowed to wear ear plugs in school. He is going to meet with an Occupational therapist (OT) in the future to establish what support he can have for the future. He finds it hard to interact with people, especially new people, does not understand what is going on and finds this anxiety inducing. He is not able to maintain relationships. He struggles to be in noisy environments and finds this overwhelming. He feels that he has had these symptoms a lot longer than what they have been diagnosed. He struggles with sensory issues - loud noises, wet hands, high necks, being touched, strong smells. These are made worse by going outside. His symptoms are not variable unless he is outside and overall since secondary school they have not worsened.

Allergies (since 9 months old). Was not officially diagnosed until he was 9 years old. He is under the care of his GP and takes an anti- histamine. This relates to his asthma, was under a specialist for this as a child in conjunction with his asthma but no longer sees a specialist for both, there has been a good improvement. This is well controlled with medication but in winter he gets Cold urticaria (skin reacts to cold) and he is unable to do anything about this however will stay indoors most of the time due to his anxiety. There are no other plans for treatment. He reports no effects to his daily function.

Asthma (since 9 months old). Was not officially diagnosed until he was 9 years old. He suffered with asthma attacks and hospital admissions until the age of 19. He is under the care of his GP now, takes asthma medication which is largely effective and has only needed to take once course of steroids in the large year at the beginning of a chest infection. Day to day is breathless more easily than other people but not much more so and feels that this is well controlled now. His last asthma attack was over a year ago.

Migraines - they started as a teenager and has worsened in his 20's. He was under a neurologist, they changed his medication and discharged him. His migraines have improved over time but does have migraines every 2 weeks approximately, lasting from 2 hours to 2 days, where he is not able to do very much. Normally he does not have an aura.

Hypermobility syndrome (Ehlers-Danlos or EDS) This was diagnosed in 2022/2023 by a rheumatologist. He had physiotherapy which did not help. Has been referred to the pain clinic, he has an assessment some time in April 2024. Has daily joint pain from doing things - affecting his wrist and hands (caused by using his computer). When he goes for walks, he will not be able to do anything else for the rest of the day due to lower limb joint pains. He has tried over the counter pain relief but these have not worked. He is awaiting pain clinic review. He has attended A&E for this pain in 2022 as the joint pain was very bad. The pain has worsened over time. He has also been told that the fatigue symptoms that he experiences are as a result of his EDS by his rheumatologist. He has bad days where he is not able to leave the house due to fatigue - at least one day a week. He does suffer fatigue daily and takes supplements for this.

Sight loss (occasional) - this may be due to migraine or this could be related to his EDS, this has been checked in A&E after he went there with vision loss when he had no migraine. He suffers with partial sight loss (1/3 of the time when he has migraines). His vision is blurry and he cannot distinguish shapes. He has not been referred to an eye specialist and there are no other plans for treatment.

Dizziness and fainting - he has been experiencing this since he was a teenager but this has worsened over time. This can occur when he changes position or when he stands. His rheumatologist told him that it could be related to his EDS. He has had cardiology tests which came back normal. There are no other plans for treatment and takes no medication for this. He has not attended A&E as a result of his fainting. He feels dizzy when he stands up, this is some days in the week but not most days. He last felt dizzy a few days ago getting a plate from a cupboard. He last fainted some time ago, over 6 months ago. He feels that everything zooms quickly, is dizzy and then faints. He states that this does not occur very often and was vague about other details of fainting.

Vocal cord dysfunction. He was diagnosed in 2016 by specialist and has had no surgery. He is no longer under a specialist and there are no further plans for treatment. Sometimes his breathing can be affected as a result of this (main symptom). He states that he cannot run as a result of this and reports no other symptoms. His symptoms have stayed the same over time, he reports that his vocal cord dysfunction was only evident during asthma attacks.

No other medical problems reported during the assessment.

Current medication or treatment

Fexofenadine 180 mg once daily for allergy
Montelukast 10 mg once daily to aid breathing
Lamotrigine 75 mg twice daily - mood stabiliser
Topiramate 25 mg once x2 in the morning and x1 at night for migraine
Aripiprazole 30 mg once daily as an anti psychotic
Testogel (testosterone) 16.2 mg/g gel x2 pumps daily (hormone)
Salamol 100 mcg 1-2 puffs as required for asthma
Symbicort 400/12 x1 puff twice daily for asthma
Folic acid 5 mg once daily as a supplement

Bupropion 150 mg once daily for major depression - was taking this for a year but stopped as it was taken off the market but has now restarted this more recently.
Concerta 36 mg once daily for ADHD (started in January 2024)

Side effects: tremors from his anti psychotic

Efficacy: He is not sure if the medication is effective but feels that he is worse if he does not take his medication.

Therapies: He has been referred to OT.

Social and occupational history

Accommodation: He lives in a ground floor 2 storey flat. He lives with his partner and two flat mates. He has a shower over the bath.

Aids and adaptation: None and he does not use any aids. He has looked into getting finger splints for his EDS,

Education: He is doing an evening university degree, 1 night in person at Batchelors level. The university is supportive, has an ergonomic chair, extra time in exams - they are online only, has automatic extensions and has leniency in attendance. He reports that he is unable to attend most nights, misses more classes than he attends and is then able to pick the coursework up online. He attended university in the past and had to drop out due to his mental health.

Work: He has been a tutor in the past but did struggle due to his mental health and feeling overwhelmed due to his autism.

Driving: He has not learned to drive, he does feel that he could not learn now due to his mental health currently.

How else do they get around: He has a taxi allowance from DSA and uses this for when he attends university. He struggles to use public transport by himself and always needs someone to go with him as he is overwhelmed.

Pets: He has two cats which his partner looks after.

Caring responsibilities: None.

Hobbies/pastimes: He watches TV in his spare time and builds up his energy to attend appointments. He

will use his laptop also for university work. He reports that he does not go out very much due to his anxiety.

Housework: He tries to help out a little with the housework but due to his motivation and low energy his partner does most of this.

Shopping: He does the grocery shopping with his partner. She encourages him to go and always needs to be supported by them.

Who completed the questionnaire: He did this with his partner, cannot recall who did the writing.

Any formal or informal support received: Just his partner currently.

How do they spend their day, any difference at the weekends? There are parks and a canal walk nearby in which he can go for a short 20 minute walk for with his partner and he does enjoy this.

Preparing food

Functional history for preparing food

He struggles all of the time due to his motivation. On his good days, he will cook whilst supported by his partner due to his disassociation and intrusive thoughts as well as his suicidal and self harm ideation. He has tried to cut himself in the past whilst he has been helping in the kitchen. His good days are not very often, maybe 1-3 days a week on average.

He struggles in general to stand for longer periods of time or if he is actively doing things in the kitchen, he would need to rest and sit down due to his EDS causing pain and fatigue. He has no other physical restrictions in the kitchen. This is all of the time.

How well can the claimant cook food?

(1e) Needs supervision or assistance to either prepare or cook a simple meal

What is the reason for this answer?

PA4 - prompting advised
AR1 - reports problems remembering to cook and eat.

HOC and MT shows a diagnosis of EUPD, AVPD, anxiety, depression, psychosis, schizoaffective disorder, intrusive thoughts (With his intrusive thoughts - these are sexual and violent in nature or violent loops of intrusion where they can also tell him to harm himself. This results in him not being able to function, struggles to focus and becomes distressed), ongoing self harm and suicidal ideation (has protective factors of his partner but this does not prevent him from self harming or attempting suicide), has disassociation (With his intrusive thoughts - these are sexual and violent in nature or violent loops of intrusion where they can also tell him to harm himself. This results in him not being able to function, struggles to focus and becomes distressed), has active psychosis (has background talking which is distracting), is under the care of CMHT, has weekly therapy and is under a psychiatrist. He takes major anti depressants, anti psychotic medication and mood stabilisers. He has a recent diagnosis of ADHD and Autism, has been referred to an OT and take medication for ADHD.

SOH shows that he has given up work due to his mental health issues. Whilst he is at University, this is just one night a week and he does not attend most nights, has automatic extensions and has leniency in attendance.

GP medical printout 18/12/2023 shows multiple overdoses listed and last one was 15/12/2023 which is likely to show volatility in his mood.

MSE showed he was anxious during the assessment, had rapid speech and was clearly uncomfortable with the assessment.

This is overall medically consistent with the reported restriction in the FH.

It is likely that he needs supervision or assistance to either prepare or cook a simple meal on the majority of days, to ensure safety, timeliness, that it is done to an acceptable standard and repeatedly.

Whilst prompting has been considered as per previous report, this is likely to be superseded by the need for supervision. It is likely that prompting alone is not adequate enough to mitigate the risk from the disassociation, psychosis, intrusive thoughts and ongoing self harm and suicidal ideation as reported in the HOC, which also shows that his symptoms

have gotten worse over the years.

Whilst memory issues have been considered as per questionnaire, limitation from this, is already covered within the scope of the advised descriptor and MSE showed no evidence of this. This requires no further exploration.

Whilst aids have been considered as per EDS, dizziness, migraine and asthma, this has been superseded by the need for supervision and requires no further explanation.

Whilst cannot prepare and cook food has been considered as per migraine, HOC shows that this is not on the majority of days and there is no FE to suggest otherwise.

Whilst eating has been considered as per questionnaire, this is not within the scope of the descriptor and is covered in Activity 2 - taking nutrition.

Whilst cannot cook a simple meal using a conventional cooker but is able to do so using a microwave due to the reported fainting in the HOC has been considered, this has been superseded by need for supervision and requires no further exploration.

Taking nutrition

Functional history for taking nutrition

He has no problems physically eating and drinking, uses standard cutlery and no aids. He has no problems swallowing and chewing food. Does forget to eat breakfast and lunch but does not need reminding to eat in the evening, doing so of his own volition.

Which of these describes how well the claimant can take nutrition?

(2a) Can take nutrition unaided

What is the reason for this answer?

PA4 - unaided.
AR1 - no information but reports in Activity 1, preparing food, has problems remembering.

HOC shows no dietary input or weight loss. There is no evidence of mental health services input specific for eating disorders.

There is no FE to support restriction in this activity. MSE showed no memory, cognitive or insight issues. Previous report showed that he was able to undertake this activity unaided.

This is medically consistent with the lack of reported restriction in the previous report.

It is likely that he can take nutrition unaided on the majority of days, to ensure safety, timeliness, that it is done to an acceptable standard and repeatedly.

Managing therapy

Functional history for managing therapy

He only has one week of medication at a time due to his suicidal and self harm ideation. His partner keeps his medication to ensure that he does not overdose and he has no problems removing the medication from the packets,

Which of these describes how well the claimant can manage therapy or monitor a health condition?

(3b) Needs to use an aid or appliance to be able to manage medication, or needs supervision, prompting or assistance to be able to manage medication, or needs supervision, prompting or assistance to be able to monitor a health condition

What is the reason for this answer?

PA4 - unaided
AR1 - problems forgetting and needs prompting.

HOC and MT shows a diagnosis of EUPD, AVPD, anxiety, depression, psychosis, schizoaffective disorder, intrusive thoughts (With his intrusive thoughts - these are sexual and violent in nature or violent loops of intrusion where they can also tell him to harm himself. This results in him not being able to function, struggles to focus and becomes distressed), ongoing self harm and suicidal ideation (has protective factors of his partner but this does not prevent him from self harming or attempting suicide), has dissociation (With his intrusive thoughts - these are sexual and violent in nature or violent loops of intrusion where they can also tell him to harm himself. This results in him not being able to function,

struggles to focus and becomes distressed), has active psychosis (has background talking which is distracting), is under the care of CMHT, has weekly therapy and is under a psychiatrist. He takes major anti depressants, anti psychotic medication and mood stabilisers. He only has these prescribed one week at a time due to previous overdosing. He has a recent diagnosis of ADHD and Autism, has been referred to an OT and take medication for ADHD. SOH shows that he has given up work due to his mental health issues. Whilst he is at University, this is just one night a week and he does not attend most nights, has automatic extensions and has leniency in attendance.

GP medical printout 18/12/2023 shows multiple overdoses listed and last one was 15/12/2023 which is likely to show volatility in his mood.

MSE showed he was anxious during the assessment, had rapid speech and was clearly uncomfortable with the assessment.

This is overall medically consistent with the reported restriction in the FH.

It is likely that he needs to use an aid or appliance to be able to manage medication, or needs supervision, prompting or assistance to be able to manage medication on the majority of days, to ensure safety, timeliness, that it is done to an acceptable standard and repeatedly.

Whilst forgetfulness has been considered as referenced in the questionnaire, this has already been covered within the scope of the descriptor and requires no further exploration.

Whilst completing the task unaided has been considered as per previous report, this is likely to be ruled out as it has been superseded by the need for supervision. This is likely to not be adequate enough to mitigate the risk from the disassociation, psychosis, intrusive thoughts and ongoing self harm and suicidal ideation as reported in the HOC, which also shows that his symptoms have gotten worse over the years.

Washing and bathing

Functional history for washing and bathing	He needs to be prompted to wash and bathe daily otherwise he would not bother due to his depression.
	He states that he does not really have any issues with using the bath, does not use any aids and has no assistance. He can reach to wash himself and reports no restriction however he states that he can become dizzy when standing from the bath.
Which of these describes how well the claimant can wash and bathe?	(4c) Needs supervision or prompting to be able to wash or bathe
What is the reason for this answer?	<p>PA4 - prompting advised AR1 - does not shower unless prompted.</p> <p>HOC and MT shows a diagnosis of EUPD, AVPD, anxiety, depression, psychosis, schizoaffective disorder, intrusive thoughts has disassociation, has active psychosis (has background talking which is distracting), is under the care of CMHT, has weekly therapy and is under a psychiatrist. He takes major anti depressants, anti psychotic medication and mood stabilisers. He has a recent diagnosis of ADHD and Autism, has been referred to an OT and take medication for ADHD.</p> <p>SOH shows that he has given up work due to his mental health issues. Whilst he is at University, this is just one night a week and he does not attend most nights, has automatic extensions and has leniency in attendance.</p> <p>There is multiple FE to support him being under mental health services.</p> <p>MSE showed he was anxious during the assessment, had rapid speech and was clearly uncomfortable with the assessment.</p> <p>This is consistent with the reported restriction in the previous report.</p> <p>This is overall medically consistent with the reported restriction in the FH and questionnaire.</p> <p>It is likely that he needs supervision or prompting to be able to wash or bathe on the majority of days, to ensure safety, timeliness, that it is done to an acceptable standard and repeatedly.</p> <p>Whilst aids have been considered as per EDS,</p>

dizziness and asthma, this has been superseded by the need for prompting and requires no further explanation.

Whilst supervision has been considered due to reported memory issues and fainting, these are already covered within the scope of the descriptor and require no further exploration.

Whilst a higher descriptor has been considered due to migraine, HOC shows that he does not experience migraines on the majority of days.

Managing toilet needs

Functional history for managing toilet needs	He has no problems in going to the toilet, he can stand and clean himself, does not use any incontinence pads and reports no incontinence issues. He uses no aids to stand and states that he has no issues.
Which of these describes how well the claimant can manage toilet needs?	(5a) Can manage toilet needs or incontinence unaided
What is the reason for this answer?	<p>PA4 - unaided AR1 - no issues listed (blank)</p> <p>HOC shows that he is not under specialist care and takes any medication for his dizziness nor fainting. He does not experience migraines on the majority of days. He was only able to recall one episode of fainting in 6 months ago - there is no further treatment planned for this and he takes no medication for this. Whilst he has been referred to the pain clinic for his EDS, he is not currently in receipt of any pain relief. He reports that his asthma is now stable.</p> <p>Whilst there is no FE confirming EDS diagnosis, there is none to confirm significant restriction in this activity with regards to being able to stand from the toilet and clean themselves nor any continence issues.</p> <p>IO showed no expression of pain during the assessment. There was no evidence of wheeze or breathlessness during the assessment. He did not sound tired during the assessment.</p>

There is no restriction noted in their previous report nor is there any physical restriction advised in the other descriptors.
This is medically consistent with the lack of restriction reported in the FH and questionnaire.

It is likely that he can manage toilet needs or incontinence unaided on the majority of days, to ensure safety, timeliness, that it is done to an acceptable standard and repeatedly.

Dressing and undressing

Functional history for dressing and undressing	<p>He generally not change his clothes unless he has been told or prompted to do so as he does not have the motivation or energy as he does not care for himself.</p> <p>When he does get dressed and undressed, he is able to do this himself physically, uses no aids or loose fit clothing and reports that in general he does not have to sit down to do so.</p>
Which of these describes how well the claimant can dress and undress?	(6c) Needs either prompting to be able to dress, undress or determine appropriate circumstances for remaining clothed, or needs prompting or assistance to be able to select appropriate clothing
What is the reason for this answer?	<p>PA4 - prompting advised. AR1 - needs prompting, often will not change clothes.</p> <p>HOC and MT shows a diagnosis of EUPD, AVPD, anxiety, depression, psychosis, schizoaffective disorder, intrusive thoughts has disassociation, has active psychosis (has background talking which is distracting), is under the care of CMHT, has weekly therapy and is under a psychiatrist. He takes major anti depressants, anti psychotic medication and mood stabilisers. He has a recent diagnosis of ADHD and Autism, has been referred to an OT and take medication for ADHD.</p> <p>SOH shows that he has given up work due to his mental health issues. Whilst he is at University, this is just one night a week and he does not attend most nights, has automatic extensions and has leniency in attendance.</p>

There is multiple FE to support him being under mental health services.

MSE showed he was anxious during the assessment, had rapid speech and was clearly uncomfortable with the assessment.

This is consistent with the reported restriction in the previous report.

This is overall medically consistent with the reported restriction in the FH and questionnaire.

It is likely that he needs either prompting to be able to dress, undress or determine appropriate circumstances for remaining clothed, or needs prompting or assistance to be able to select appropriate clothing on the majority of days, to ensure safety, timeliness, that it is done to an acceptable standard and repeatedly.

Whilst aids have been considered as per EDS, migraine, dizziness and asthma, this has been superseded by the need for prompting and requires no further explanation.

Whilst a higher descriptor has been considered, HOC shows that whilst he has been referred to the pain clinic for his EDS, he is not currently in receipt of any pain relief. He does not report having migraines on the majority of days. He reports that his asthma is now stable. Whilst there is FE confirming EDS diagnosis, there is none to confirm significant restriction in this activity with regards to being able to dress and undress themselves from a physical perspective. IO showed no expression of pain during the assessment. There was no evidence of wheeze or breathlessness during the assessment. He did not sound tired during the assessment. This is medically consistent with the lack of reported physical restriction in the FH.

Communicating verbally

Functional history for communicating verbally

He does occasionally experience periods where he is unable to speak due to high periods of distress. This will occur a couple of times a month lasting for a few hours at a time. Otherwise he reports no problems with being able to communicate - talking and

Which of these describes how well the claimant can communicate verbally?	<p>understanding what has been said. He uses no hearing aids.</p> <p>(7a) Can express and understand verbal information unaided</p>
What is the reason for this answer?	<p>PA4 - unaided. AR1 - avoids people, will not speak to them if he does not know them unless prompted.</p>
	<p>HOC reports no speech or hearing issues on the majority of days. His vocal cord dysfunction occurs when he has an asthma attack and he has not had one for over a year.</p>
	<p>There is no FE to support the need for communication support.</p>
	<p>SOH shows that he is able to attend university part time and there is no evidence of communication support.</p>
	<p>MSE showed that despite being assessed alone, no significant communication issues were noted nor were there any memory, insight or cognition issues observed.</p>
	<p>The reported speech issues due to distress as reported on the FH are not on the majority of days. This is overall medically consistent with no restriction noted in the previous report.</p>
	<p>It is likely that he can express and understand verbal information unaided on the majority of days, to ensure safety, timeliness, that it is done to an acceptable standard and repeatedly.</p>
	<p>Avoiding people as reported in the questionnaire, is not within the scope of the descriptor and is covered in Activity 8 - engaging face to face.</p>

Reading and understanding signs, symbols and words

Functional history for reading and understanding signs, symbols and words	<p>He has no problems reading and understanding what he has read in areas such as appointment letters. He does read at University but struggles with his concentration for longer pieces of text. He does wear prescription reading glasses.</p>
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Which of these describes how well the claimant can read and understand signs, symbols and words?

What is the reason for this answer?

(8a) Can read and understand basic and complex written information either unaided or using spectacles or contact lenses

PA4 - unaided
AR1 - reports no issues (blank)

HOC reports that he only experiences sight loss, one third of the time when he has migraines and he does not experience migraines on the majority of days. There is no FE to support the need for reading support.

SOH shows that he is able to attend university part time and there is no evidence of communication support in addition to additional time for exams. MSE showed that despite being assessed alone, no significant issues were noted with their memory, insight or cognition.

There is no restriction noted in his questionnaire or previous report.

This is overall medically consistent with no significant restriction noted in the FH within the scope of the descriptor, with him being able to read appointment letters.

It is likely that he can read and understand basic and complex written information either unaided or using spectacles or contact lenses on the majority of days, to ensure safety, timeliness, that it is done to an acceptable standard and repeatedly.

Engaging face to face

Functional history for engaging face to face

When he is at university, he does not engage with the other students nor the lecturer and rarely attends classes. He struggles to engage with people in appointments and when he is in any social situation, his partner has to calm him down with techniques that they have learned with him. He becomes overwhelmed, can lash out verbally, will not speak, will leave and not come back. His intrusive thoughts heighten and he may become more disassociated

Which of these describes how well the claimant can engage face to face?

What is the reason for this answer?

nor become more suicidal with ideation if his partner was not there to support.

(9c) Needs social support to be able to engage with other people

PA4 - prompting advised.

AR1 - struggles to engage and speak with people.

Needs at least one person that they know to stay with them.

HOC and MT shows a diagnosis of EUPD, AVPD, anxiety, depression, psychosis, schizoaffective disorder, intrusive thoughts has disassociation (this is daily. He will lash out when he is upset and distressed - this is verbally on a daily basis, to anyone who is nearby. This is due to reactive volatile moods. He has a fear of public places, suffers with impulsive behaviour - when he is upset or manic, occurring most days), has active psychosis (has background talking which is distracting), is under the care of CMHT, has weekly therapy and is under a psychiatrist. He takes major anti depressants, anti psychotic medication and mood stabilisers. He has a recent diagnosis of ADHD and Autism, has been referred to an OT and take medication for ADHD. SOH shows that he has given up work due to his mental health issues. Whilst he is at University, this is just one night a week and he does not attend most nights, has automatic extensions and has leniency in attendance.

There is multiple FE to support him being under mental health services.

MSE showed he was anxious during the assessment, had rapid speech and was clearly uncomfortable with the assessment.

This is overall medically consistent with the reported restriction in the FH and questionnaire.

It is likely that he needs supervision or prompting to be able to wash or bathe on the majority of days, to ensure safety, timeliness, that it is done to an acceptable standard and repeatedly.

Whilst prompting has been considered, this is likely to have been superseded by the need for social

support as it is unlikely that prompting alone is adequate based on the level of support required in his FH, corroborated by the multiple conditions for his mental health reported in the HOC inclusive of the treatment and symptoms as well as the more recent diagnosis of autism and ADHD. HOC also shows that his symptoms have gotten worse over the years.

Budgeting

Functional history for budgeting

He understand money and finances, tries to have a budget with his partner but is an impulse spender and his partner now has their money in an account where the money is not easily accessed and there is a process that they need to go through to ensure that it cannot be taken out when he has the impulse to spend it. He is not motivated in paying the bills as a priority. His has impulse buying habits on a monthly basis where he doesn't care of the consequences. He reported that he has no issues with dealing with smaller amounts of money and is able to make random purchases as required, is able to calculate the change and does not struggle with the changing cost of items.

Which of these describes how well the claimant can budget?

(10b) Needs prompting or assistance to be able to make complex budgeting decisions

What is the reason for this answer?

PA4 - unaided.
AR1 - is an impulse spender.

HOC and MT shows a diagnosis of EUPD, AVPD, anxiety, depression, psychosis, schizoaffective disorder, intrusive thoughts has disassociation, has active psychosis (has background talking which is distracting), is under the care of CMHT, has weekly therapy and is under a psychiatrist. He takes major anti depressants, anti psychotic medication and mood stabilisers. He has a recent diagnosis of ADHD and Autism, has been referred to an OT and take medication for ADHD.

SOH shows that he has given up work due to his mental health issues. Whilst he is at University, this is just one night a week and he does not attend most nights, has automatic extensions and has leniency in

attendance.

There is multiple FE to support him being under mental health services.

MSE showed he was anxious during the assessment, had rapid speech and was clearly uncomfortable with the assessment.

This is overall medically consistent with the reported restriction in the FH and questionnaire.

It is likely that he needs prompting or assistance to be able to make complex budgeting decisions on the majority of days, to ensure safety, timeliness, that it is done to an acceptable standard and repeatedly.

Whilst completing the task unaided has been considered as per previous report, this is likely to be ruled out as it has been superseded by the need for prompting or assistance to be able to make complex budgeting decisions. Unaided is not likely to be adequate enough to mitigate the risk of overspending or not managing his financial affairs, due to his anxiety, depression, autism, anxiety, disassociation, psychosis and intrusive thoughts as reported in the HOC, which also shows that his symptoms have gotten worse over the years.

Whilst needs prompting or assistance to be able to make simple budgeting decisions has been considered due to his Autism. this is likely ruled out as there is no evidence noted within his FH and his MSE showed that he was able to cope with the assessment alone.

Planning and following journeys

Functional history for planning and following journeys

He is only managing to go out once a fortnight by himself to the local shop when there is something he absolutely needs and feels very anxious about this. He needs to go out more for things but his partner will normally go instead due to his anxiety. He is supposed to go to University once a week in the taxi funded for him but he is unable to go most of the time due to his anxiety and has not been in 6 weeks and is not managing to attend even half of the classes.

He would spend most days at home due to his

anxiety if it were not for his partner who encourages him to go out 3-4 days a week for walks and once a week in addition to these walks, to the supermarket. He is not able to go out without his partner as it causes him to feel overwhelmed, to worsen in his intrusive thoughts, he would potentially lash out if he is upset or distressed and develop worsening self harm ideation. He would not cope with busy environments by himself and most days he would not be able to use public transport himself due to the crowds on them. His partner needs to support him with this. He can experience emotional flashbacks with situations he is not happy with, these thoughts and memories are violent in nature or not pleasant. He suffers with intrusive thoughts all of the time. He has disassociation daily and avoidance anxiety. He has background talking psychotic elements which is distracting. His fear of public places can result in impulsive behaviour.

Which of these describes how well the claimant can plan and follow journeys?

(11f) Cannot follow the route of a familiar journey without another person, an assistance dog or an orientation aid

What is the reason for this answer?

PA4 - unaided.
AR1 - gets lost easily, cannot follow a map to a new place. Can go to familiar places alone.

HOC and MT shows a diagnosis of EUPD, AVPD, anxiety, depression, psychosis, schizoaffective disorder, intrusive thoughts has disassociation (this is daily. He will lash out when he is upset and distressed - this is verbally on a daily basis, to anyone who is nearby. This is due to reactive volatile moods. He has a fear of public places, suffers with impulsive behaviour - when he is upset or manic, occurring most days), has active psychosis (has background talking which is distracting), is under the care of CMHT, has weekly therapy and is under a psychiatrist. He takes major anti depressants, anti psychotic medication and mood stabilisers. He has a recent diagnosis of ADHD and Autism, has been referred to an OT and take medication for ADHD. SOH shows that he has given up work due to his mental health issues. Whilst he is at University, this is just one night a week and he does not attend most nights, has automatic extensions and has leniency in

attendance.

There is multiple FE to support him being under mental health services.

MSE showed he was anxious during the assessment, had rapid speech and was clearly uncomfortable with the assessment.

This is overall medically consistent with the reported restriction in the FH.

It is likely that he cannot follow the route of a familiar journey without another person, an assistance dog or an orientation aid on the majority of days, to ensure safety, timeliness, that it is done to an acceptable standard and repeatedly.

Whilst cannot follow the route of an unfamiliar journey without another person, assistance dog or orientation aid has been considered as per questionnaire. This has is likely to have been superseded by cannot follow the route of a familiar journey without another person. FH does show that he is able to go out on the majority of days with support and encouragement from their partner, assisting him to manage his OPD symptoms, as well mitigating risk of harm to himself and others from his lashing out and impulsive behaviour. He is supposed to go to University once a week in the taxi funded for him but he is unable to go most of the time due to his anxiety and has not been in 6 weeks and is not managing to attend even half of the classes.

Whilst can plan and follow the route of a journey unaided has been considered as per previous report, this has likely to have been superseded by the need for support from another person with familiar journeys. Performing this task unaided is inadequate based on the level of support required in his FH, corroborated by the multiple conditions for his mental health reported in the HOC inclusive of the treatment and symptoms as well as the more recent diagnosis of autism and ADHD.

Moving around

Functional history for moving around

He is able to manage at a slow to normal pace to go for 20 minute walks, 3-4 days a week. He does not use any aid but will take 1-2 variable in length

breaks. In addition to these walks, at least once weekly, he is able to walk 10 minutes to the shop, will walk around the shop for 20 minutes and then walks home, this is at a slow to normal pace. He will stop for rest at the supermarket before carrying on the with the 20 minute shop, then walks home for 10 minutes carrying some of the shopping. On the other days he will mobilise around the house but would not be able to go out due to his anxiety. He did classify that he is able to walk 200 metres or more at time on the days that he does not go out for walks or to the shops despite his pain and fatigue, doing so unaided and without needing a break.

Which of these describes how well the claimant can move around?

(12a) Can stand and then move more than 200 metres, either aided or unaided

What is the reason for this answer?

PA4 - Can stand and then move more than 200 metres, either aided or unaided

AR1 - over 200 metres although reports that this will hurt.

HOC shows that he is not under specialist care and takes no medication for his dizziness nor fainting. He was only able to recall one episode of fainting 6 months ago. Whilst he has been referred to the pain clinic for his EDS, he is not currently in receipt of any pain relief and reports that he is unable to go out one day a week due to his EDS causing fatigue, which is not on the majority of days. He reports that his asthma is now stable.

Whilst there is no evidence confirming EDS diagnosis, there is none to confirm significant restriction in this activity with regards to being able to stand from the toilet and clean themselves nor any continence issues.

IO showed no expression of pain during the assessment. There was no evidence of wheeze or breathlessness during the assessment. He did not sound tired during the assessment.

There is no restriction noted in their previous report. This is medically consistent with the lack of significant restriction reported in the FH and questionnaire.

It is likely that he can stand and then move more than 200 metres, either aided or unaided on the

majority of days, to ensure safety, timeliness, that it is done to an acceptable standard and repeatedly.

Physical health	Telephone assessment.
Mental state	<p>Did sound anxious and tense during the assessment. Did not require prompting. Manner appeared normal and did not appear withdrawn. Had adequate rapport. Had adequate insight. Had adequate memory. Did cope with the assessment however was clearly uncomfortable with the assessment. His motivation was to complete the assessment so that he did not have to do it again. Speech was normal in tone and content. Volume was normal, comprehensible however was more rapid in nature. No evidence of a cognitive impairment. Engaged with the assessment process without any input. (Telephone assessment undertaken)</p>
Observations	<p>He did not express any pain during the assessment. There was no evidence of wheeze or breathlessness during the assessment. He did not sound tired during the assessment.</p>
Variability	See HOC.

Daily living qualifying period and prospective test

**Has the claimant had
the functional
restriction for at least
3 months?**

Yes

**Is the claimant likely
to have the functional
restriction in 9
months?**

Yes

Mobility qualifying period and prospective test

Has the claimant had the functional restriction for at least 3 months?

Yes

Is the claimant likely to have the functional restriction in 9 months?

Yes

Review period for PIP

When should this claim be reviewed?

3 years

Why do you recommend this review period?

He has a long history of enduring mental health issues and despite the level of input from the mental health team and the high level of medication for his mental health, his symptoms remain. Whilst a longer review has been considered due to his recent diagnosis of Autism, this a later in life diagnosis, he has already gone through the development phase of his life and it is likely that his symptoms and functional restriction are associated more with his mental health conditions. The above review period has been advised for these reasons.

It is likely that the functional restriction identified in this report will be present at the recommended point of review: Yes

Although they have not claimed under the special rules end of life provisions, in my opinion they do not meet the prescribed definition.

There is no harmful information included in this report.

Is the claimant likely to need additional support for future claim processes?

Yes

