Examples of letters for PIP Assessment

Letter 1 – With examples of daily living and mobility needs

Re: Assessment for Personal Independence Payment
Laura Christmas dob 25/12/1958
Flat 2 Elfin House, Gift Lane, London

Current medication: Clozapine 200mg and Fluoxetine 20mg

Diagnosis: Schizophrenia. Psoriasis

Ms Christmas is currently in contact with the mental health team at the above address and has been so since 2011. She has a history of contact with mental health services since 1980.

In the past she has had frequent admissions to hospital owing to relapses of her schizophrenia, during which she experiences an increase in her auditory hallucinations and her persecutory delusions. She had eight admissions during 2015 and 2016, all of which were under the Mental Health Act. Her last admission was in November 2016 for two months, when she was started on Clozapine. Since the last admission she has been adherent with her medication owing to an increased support package.

She is managed under the care programme approach (CPA) and is seen each week by her care co-ordinator (Community Psychiatric Nurse – CPN) and support worker. She has contact with a local drop-in centre and attends the several times a week. She is currently seen by a clinical psychologist for weekly cognitive behavioural therapy (CBT). She is currently in the middle of her course of CBT. She attends the clinic each month for blood tests to monitor her white cell count (this is necessary because of the Clozapine medication). She receives her medication for the clinic. Her GP treats her psoriasis and she last had an appointment with the Dermatology clinic in 2016 following a flair-up of her skin condition. She has a full CPA review every six months.

She currently lives in supported accommodation and has access to a housing support worker.

She has put on weight since starting Clozapine and experiences some drowsiness during the day.

She experiences auditory hallucinations which persist despite adequate doses of medication and adherence to the medication. Her persecutory delusions have improved since starting Clozapine but, when her auditory hallucinations increase, she becomes more suspicious of others. Her voices are troubling and distracting and tend to be derogatory. She also experiences periods of significant depression and anxiety. Her anxiety has been in the form of free-floating anxiety, agoraphobia and panic attacks. All her symptoms are fluctuating. Her hallucinations are made worse during periods of depression and respond to external stressors. Her mood fluctuates over a month period and during a month she tends to experience periods of low mood and anxiety for at least one week. She is never free of her hallucinations, but they do fluctuate in intensity.

She experiences several incapacities as a consequence of her mental health conditions, including:

1. Poor concentration and attention. She is easily distractible and has difficulty planning and execute serial actions. This interferes with her self-care and her ability to prepare meals.
2. Poor self-care resulting from her lack of energy and drive as well as her lowered self-esteem.
3. Difficulty getting out of the house owing to her low drive and anxiety. This has been particularly evident when going into novel situations and busy crowds. She has been reluctant to go out of the house and to engage in social engagements.

She has difficulty preparing meals for herself. She can make herself drinks and sandwiches but needs to be supervised to make herself a meal. She lacks the drive to prepare a meal regularly and she tends to break off from cooking and this has resulted in her burning food and leaving pans to boil over. She obtains most of her full meals from the drop-in centre and her support worker supervises her to put ready-made meals in the oven twice a week. During periods of low mood, she does not respond readily to prompting and will not make herself meals.

She uses a dosette box to manage her medication. She is prescribed medication by the clinic each month following her blood test and receives a weekly supply of her tablets which are delivered to her by her CPN. She is remined to take them by her CPN and support worker. If she does not take her medication regularly her condition deteriorates, and she needs to start her medication again from a low dose which means she has to have an increased number of blood tests.

Her self-care is poor. She needs to be reminded to wash each day and will not shower or take a bath without constant reminding. Her support worker has to be present in her flat when she showers as she experiences an increase in her hallucinations whilst in the shower. She has one shower a week and washes each day if remined to. During periods of low mood she does not wash each day and her hygiene deteriorates.

Her dressing follows a similar pattern to her washing. She needs prompting to change her clothes regularly and she often goes to bed in her day clothes, especially when her mood decreases, or her hallucinations increase. Staff at the drop-in centre support her to do her laundry and remind her about her personal hygiene and changing her clothes.

A further problem is seen when Ms Christmas has to interact with others. She finds mixing with others difficult, especially with people with whom she is unfamiliar. When she attends the drop-in centre, she tends to isolate herself. She mixes more readily with familiar staff and other users of the centre, but rarely with unfamiliar people. She is reluctant to approach people to speak to them but will engage if they approach her. During her periods of low mood, she will avoid people and becomes distressed if they approach her.

Her ability to manage money fluctuates. She can mange her money in shops when she attends them but finds it difficult to manage her bills and card payments. She requires prompting and supervision from her support worker to manage bills. Without this she gets into debt or fails to make regular payments and she has been threatened with legal action in the past.

Ms Christmas has difficulty making journeys. She can get to the clinic and drop-in centre on her own as these are familiar to her and are only a short walking distance from her home. She finds unfamiliar or longer journeys difficult and cannot make them without being accompanied. She can make bus journeys when someone accompanies her but will not make tube journeys. She becomes anxious on unfamiliar journeys, her hallucinations increase, and she becomes suspicious of others. She has experienced panic attacks and earlier this year got lost in the street after separating from her support worker. As a result of this she experienced a panic attack and ended up being taken to A&E by ambulance. During her periods of low mood, she is reluctant to leave her home and often stays there alone for several days if not visited.

Letter 2 – With mainly daily living needs

Re: Assessment for Personal Independence Payment
Mr X
dob
Address

Current medication: Risperidone, Fluoxetine

Diagnosis: Persistent Delusional Disorder

I am writing at the request of Mr X, in my capacity as his psychiatrist, to support his PIP application.

I can confirm Mr X is under the care of our community mental health team, managed on the Care Programme Approach (CPA) pathway for patients with the highest level of need. His longstanding diagnosis is Persistent Delusional Disorder, a psychotic illness characterised by false beliefs about which the sufferer is fully convinced. In his case beliefs relate to threats to his safety, though exact contact varies. In the past he has suffered acute episodes where symptoms have increased to the point he has felt it necessary to resort to physical violence to save his own life, which is not a usual character trait or behaviour. This has led to convictions for violent offences and several hospital admissions under the Mental Health Act, most recently in 2011. At peaks of illness he will neglect himself and has made allegations against professionals, neighbours and friends. There is a history of poor compliance with oral medications and repeated disengagement from mental health services. This has led to current treatment with long-acting antipsychotic depot injections and an assertive approach to follow-up by the team in order to safely monitor and manage his therapy.

Consistent with this diagnosis, even between major episodes Mr X continues to suffer symptoms affecting daily functioning;

- He remains untrusting of others and will not answer his phone or door to anyone outside of a small circle of trusted confidants. He avoids face to face engagements if at all possible due to suspicions about the intentions of others, but also negative experiences of stigma upon revealing his mental health problems. He struggles to maintain a supportive social network, which severely limits his ability to cope with any changes or periods of increased stress.

- He has a number of obsessional worries about cleanliness. He is unable to prepare food at home due to intolerable anxiety about contamination from germs, leaving him unable to use a cooker, toaster or microwave. He will always eat out though is limited by funds as well as certain obsessional worries about specific food types (such as any cooked with oil). He is concerned about bodily contamination, having two showers per day (using an entire bottle of shampoo each time) and repeatedly washing his hands. He washes and replaces clothes on an extremely frequent basis, having specific outfits for different destinations to minimise cross-contamination.

- Due to difficulties with organisation and motivation (often persisting in psychotic illnesses), Mr X struggles to manage his finances, requiring the assistance of his primary carer (with whom there is a voluntary arrangement) to budget and arrange payment of bills. His carer also provides transport to appointments and prompts to eat, sometimes directly providing meals.

- There are also problems directly related to long-term treatment with antipsychotics, known as extrapyramidal side effects; restlessness / inability to sit still, involuntary movements, stiffness of all four limbs and parkinsonism (tremor and slowness of movement). These are variable in intensity and have continued despite attempts to minimise antipsychotic dose and provide other symptomatic relief. Mr X currently walks with the aid of a stick (roughly 300 yards before having to stop, less on hills). He suffers pain in both ankles and struggles to put on socks and shoes (also partly due to a previous liver operation). When showering he cannot reach his back, even with brush, or wash below the knee due to restricted range of movement. Mr X also suffers a degree of sedation on medication that affects his ability to plan journeys and reduces his awareness of hazards.

I would be grateful if you would consider these factors in making your award decision. If you require any further information, please do not hesitate to contact me.

Letter 2 – With mainly mobility needs

Re:	**Ms E**
D.o.B:	**1974**
Main Diagnosis:	**Bipolar Disorder**
ICD10: F31	
Other Diagnoses:	**Carpal Tunnel Syndrome, Unspecified pain and fatigue in back and legs.**

To whom it may concern,

I am writing regarding Ms E's PIP award to ask you to reconsider the mobility component of her award as I believe her physical mobility is more restricted than has been assessed.

Ms E has been known to the Community Mental Health Team for many years and is under care coordination. I have been her doctor here for around two years. In addition to her mental health issues Ms E has unexplained back and leg pain, plus fatigue in her legs. She mobilises slowly with the use of crutches and is physically very limited. Unfortunately, the medication regime required to maintain stability of her mental health comes with a number of side effects that negatively affect mobility. These include significant weight gain, sedation and parkinsonian symptoms (stiffness of limbs, tremor and overall slowness of movement).

Whilst my role with Ms E is focused on her mental health condition, her physical health is obviously a relevant factor to be considered. When she comes to her outpatient's appointments at the Community Mental Health Team she frequently struggles by the end of our corridor, which is completely flat and no more than 20 metres from the waiting room. I note that she was previously assessed as not being able to walk more than 50 metres under Disability Living Allowance and her physical mobility has not improved over the past few years.

I would be very surprised if she could walk more than 50 metres repeatedly and in a reasonable timescale as she has to take frequent breaks and rests due to her pain and fatigue, in addition to mitigating the risk of falls. As such I would ask that you reconsider the assessment of her mobility under the 'moving around' section as in our experience at the Mental Health team the descriptor "d*. Can stand and then move using an aid or appliance more than 20 metres but no more than 50 metres"* would likely be the most Ms E would be able to manage reliably. Given the nature of the fatigue she experiences and her medication it is likely that she is probably even more restricted that that at certain times of day (for example earlier in the morning or near the end of the day).

Thank you for your assistance but please feel free to contact me on the details above if you would like further information.