NHS
Ayrshire & Arran

University Hospital Ayr
Dalmellington Road
Ayr

MMA Legal Limited
Stok
43-59 Princes Street
Stockport
SK11RY

Date 15/05/2026
Our Ref MF\1602890722
Your Ref 100883
Enquires to Maryann
Telephone 01292 616452

E-mail Maryann.Findlay@aapct.scot.nhs.uk

Dear Sir/Madam

RE: Kelly Marie Prowse

I refer to your recent request to myself regarding the above and enclose the relevant documents. I would be grateful if you could return the tear-off slip confirming receipt.

Yours faithfully,

Mr R H Bryden
Head of Health Records Services

Please return to: Maryann, Health Records, University Hospital Ayr, Dalmellington Road, Ayr, KA6 6DX
I acknowledge receipt of the copies of medical records pertaining to: Kelly Marie Prowse 1602890722

Signed: ---------- Date: ----------

Designation: ----------

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

Assessed 4th Feb 2026 at 16:51

Summary of contact	

Dear Ms Prowse,

As I have had no response from my 14 day opt in letter, I am therefore discharging you from the Community Mental Health Team.

Your GP has been informed by copy of this letter. Therefore, should you require any further input, please contact your GP.

ours sincerely

Diana Simpson
Staff Nurse

COMMUNITY MENTAL HEALTH TEAM

Cc: Dr Ajay Fowdar – Newmilns Surgery (Newmilns)

Assessed 13th Jan 2026 at 10:58

Summary of contact	

Dear Ms Prowse,

I am sorry you did not attend your arranged appointment on Tuesday 13th January 2026

Please contact the team on the above telephone number within 14 days of receipt of this letter if you wish to re arrange an appointment. If, however, we do not hear from you within 14 days you will be discharged from my caseload.

Yours sincerely

Diana Simpson
Staff Nurse

COMMUNITY MENTAL HEALTH TEAM (GREEN HUB)

Cc: Dr Ajay Fowdar – Loudoun Medical Centre (Darvel)

Assessed 13th Jan 2026 at 10:29

Summary of contact/details	
DNA appointment. 14 day letter sent.	

Assessed 24th Dec 2025 at 11:11

Summary of contact/details	
Appointment card sent for 13/01/26 -10am NWC	

Prowse, Kelly

CHI Number 1602890722 **Date of Birth** 16-Feb-1989 (37y)
Sex Female

ACMHS Intra-Team Referral

Date of Activity 08 October 2025 17:02 by Nikki Howie **Status** Closed
Centre of Care East Ayrshire CMHT

Referral Details

Referred by

CMHT Nursing

Note: Referral from DUTY assessment - SN Nikki Howie.

Is patient in treatment or on treatment waiting list with referring discipline

No

Referral (1)

Referred to

CMHT Nursing

Note: Green hub locality (Louden surgery) for waiting list for CPN input for further safety planning and 1-1 decider skills input.

For attention of

CN Kerry Patterson / Green hub

Reason for referral

Emotion disregulation

Rationale for referral

Referral for green hub treatment waiting list for CPN input for further safety planning and 1-1 decider skills input.

Assessed urgently today by duty following urgent referral from GP - due to increasing suicidal ideation with plan which she would initially not disclose. Engaged in safety planning during assessment process as documented on carer partner. Kelly reports to feeling anxious daily, report frequent panic attacks. Reports physical symptoms as constant pain in her chest and daily headaches, nil physical cause for same idenditifed from GP. Kelly describing fluctuations in her mood which she stated happened often and quickly, stating "I often don't recognise myself". Reports feeling angry due to her childhood and adverse experiences. Reports feeling resentful towards family members due to same. Kelly reports caring for her mum as extremely difficult. Describing emotional dysregulation and interpersonal difficulties. Disucssion regarding individuals window of tolerance and due to childhood events and stressors this results in a variation of emotions and feeling unable to regulate or own emotions, Kelly able to identify withy same. Disucssed matched intervention for emotional dysregulation, decider skills. Kelly declined attending decider skills group citing she struggles with social anxiety keen for 1-1 to decider skills input. Advised Kelly that writer will complete an intra team referral to locality hub for same but that due to a current waiting list writer could not establish when this could commence if accepted, Kelly accepting of same. Kelly reports feeling hypervigilant and on alert all of the time, difficulty concentration at present.

Happy to discuss further if required.

Kind regards
Nikki Howie.

Urgency of referral

Routine

Referral (2)

Referred to

Not applicable

For attention of

Not Recorded

Reason for referral

Not applicable

Rationale for referral

Not Recorded

Urgency of referral

Not applicable

Referral (3)

Referred to

Not applicable

For attention of

Not Recorded

Reason for referral

Not applicable

Rationale for referral

Not Recorded

Urgency of referral

Not applicable

Mental Health Liaison Service/CRT/Duty Assessment v2

Date of Activity 08 October 2025 14:30 by Nikki Howie **Status** Closed
Centre of Care East Ayrshire CMHT

Situation

Situation

DUTY CONTACT:

Phone contact recieved from Dr Newton Louden surgery looking to make an urgent referral for Kelly. Kelly attended the surgery this morning for a GP appointment - was in the room with her partner [redacted] at time of call. Previous history of low mood and anxiety, previous input from mental health services as documented on care partner. Kelly reporting low mood for around 18 months with increasing suicidal ideation, current daily suicidal thoughts. Kelly has disclosed to GP today, that she has a plan to end her life but would not disclose what that plan is or provide a time line. GP stated that she is "awaiting carers support being out into place for her mum [redacted]. GP unaware if care support is currently being put into place or if their is a time line for same. Currently prescribed Fluoxetine 20mg's, GP not keen to make ay changes to medication at present due to suicidal ideation. Chronic pain - partner has removed all excess medications and has locked these away in a cupboard. Nil substance or alcohol misuse. Nil risk to others identified. Nil evidence of any psychotic symptomology. Previous self harm documented 2007, previous suicidal ideation documented 2012. Lives with her NOK partner [redacted]. Nil children within the home. Possible stressor - mum declining health.

Referral accepted - advised GP to ask Kelly to return home if able to keep self safe, stated she could and writer would contact her by phone to triage / assess. Accepting of same.

Personal details checked different address and mobile number provide to what is on care partner system. New details provided to admin staff and uploaded to all systems as requested.

DUTY CALL:
SN Nikki Howie contact Kelly by phone as agreed.

Call answered by Kelly could be heard that she was in the car, she advised she was on her way to Ayr hospital where her mum was currently an inpatient [redacted] Kelly advised her dad passed away in January and they were not in communication despite him reaching out to her prior reports "having a lot of difficult feelings regarding same". Kelly reports that she has had difficulties with her mental health since childhood and at present is unable to cope with ongoing stressors and difficulties. Reports an increase in struggling with her mental since September 2024 reports an increase in suicidal ideation. Reporting daily fixed suicidal thoughts, reporting that she has a plan but dose not wish to disclose same to writer at this time would not disclose timeline. Stated "I had a date and plan but my mums had a heart attack so I cant do it just now, I am the only family here to help her get supports in pace". Stated "I do not want to disclose my plan to you because I don't want you to stop me". "I just want to end it, I don't want to be here". Reports she informed her partner [redacted] last week that she planned to commit suicide but did not disclose plan to him either. Conversation with Kelly regarding her telling her partner, attending the GP and accepting referral to CMHT would indicate to writer that she is keen for mental health support and for appropriate support to be provided that it is important that she is honest and discloses her plan with us. Kelly agreeable that she does want to engage with appropriate services for support. Element of safety planning as partner has removed medications. Reports having "a breakdown" often feeling extremely distressed, describing physical symptoms of panic / anxiety such as headaches, nausea, palpitations, tight chest and feeling like she is unable to breathe. Reports she previously self medicated with substances for many years. Denies any current substance misuse reporting she last smoked cannabis around 10 days ago reporting 2 bongs daily as previous use. Currently prescribed fluoxetine for mood. Kelly arrived at Ayr hospital to visit her mum, call cut out on two occasions due to signal dropping,.
Disucssed with CN Adam Knapper plan to offer face to face joint assessment at NWKAC with ICPNT if able today at NWKAC at 14:30pm. Kelly accepting of same.
Phone contact to ICPNT disucssed with SN Paula Carey who has agreed to attend for a joint assessment.

Kelly attended NWKAC today at 14:30pm for a joint assessment with DUTY writer SN Nikki Howie and ICPNT SN Paula Carey. She attended with Partner [redacted]

On mental state examination she was a 36 year old woman dressed casually, clothing was clean and weather appropriate. Appeared well kempt and taking care of personal hygiene. Rapport was initially difficult to establish, Kelly providing closed answers. Appeared to become more relaxed and open with her communication throughout building a rapport. Eye contact was appropriate throughout. Pace, tone and pitch were appropriate throughout the conversation. Her speech was spontaneous and coherent. Subjectively she described her mood as "rubbish" Kelly has a long standing history with low mood and anxiety difficulties which she reports as chronic since childhood. Kelly reports that she was taken into care at the age of 8years old, [redacted]. Reports her childhood as very difficult disclosing physical and emotional neglect and abuse. Reports she is currently caring for her mum and and mother in law due to their own going physical health difficulties, reports feeling exhausted. Poor sleep reports this as chronic reporting no regular sleep pattern over the last 7 years. Previous bad reaction to zopiclone and nil therapeutic benefit, disucssed possibility of the GP considering prescribing promethazine to aid sleep, accepting of same. Currently prescribed fluoxetine for low mood denies any current side effects, reports little therapeutic benefit of same. Keen to change anti-depressant medication, would benefit from same. Writer has agreed to send a clinical email to GP for consideration of same.

Kelly reports to feeling constantly anxious daily, report frequent panic attacks. Reports physical symptoms as constant pain in her chest and daily headaches, nil physical cause for same idenditifed from GP. Kelly stating "I need this pain away". Previous bad/possible allergic reaction reaction to propranolol.

On further disucssion Kelly describing fluctuations in her mood which she stated happened often and quickly, stating "I often don't recognise myself". Reports feeling angry due to her childhood and adverse experiences. Reports feeling resentful towards family members due to same. Kelly reports caring for her mum as extremely difficult.

Kelly describing emotional dysregulation and interpersonal difficulties. Disucssion regarding individuals window of tolerance and due to childhood events and stressors this results in a variation of emotions and feeling unable to regulate or own emotions, Kelly able to identify withy same. Disucssed matched intervention for emotional dysregulation, decider skills. Kelly declined attending decider skills group citing she struggles with social anxiety keen for 1-1 to decider skills input. Advised Kelly that writer will complete an intra team referral to locality hub for same but that due to a current waiting list writer could not establish when this could commence if accepted, Kelly accepting of same.

Kelly reports feeling hypervigilant and on alert all of the time, difficulty concentration at present.

Reports chronic pain and various physical health complications. Previous opiate addiction, has now been abstinent for some years. Reports previous misuse of various substances over the years as a way of coping, such as cocaine, alcohol and cannabis. Denies any cocaine or alcohol misuse for years. Reports to recreational use f cannabis at intermitted times reports last utilised cannabis 10 days ago stated 2 bongs that day, keen to remain abstinent from same. Accepting of a referral to we are with you service for further support with same.

Objectively, mood appeared dysregulated with a reactive affect. Denied any hallucinations of any type and no objective evidence to suggest otherwise. Conversation revealed no evidence of any thought disorder.

Reports ongoing suicidal thoughts, reports these as daily thoughts. Reporting a plan initially wouldn't disclose same, however further into the assessment she advised she planned to take a medicaiton overdose. Stated previous chosen date but due to mums poor health this was not a possibility. Did not identify a time line. Engaged in safety planning to reduce risk to self, partner [redacted] has removed all excess medication from the home. [redacted] is with Kelly each day, she has agreed that she would tell [redacted] if she felt unable to keep herself safe and would utilise services for further support if required. Nil current intent idenditifed. Reports her mums poor health and people / family relying on her as a protective factor. Risk of impulsivity. Spoke fondly of her nephew. No evidence of any mental illness which would impair judgement or decision making process. Cognition appeared to be intact.

Plan
- Engaged in safety planning today, partner [redacted] will keep medications.
- Referral to we are with for support with remaining abstinent from substances
- Provided with East Ayrshire Carer support information booklet
- Intra team referral to locality hub for input for further safety planning and 1-1 decider skills input, declined group. Aware of waiting list.
- Clinical email to GP for consideration of changing anti-depressant medication and medication to aid sleep.
- Provided with appropriate contact details for DUTY / CMHT and OHH if required.

Background

Background

Historic input from mental health services documented on care partner. Reports being in the care system from age 8. Previous substance misuse.

Assessment

Ayrshire Mental Health Risk Assessment Framework

Mental state

Mental state

Amber

Note: On mental state examination she was a 36 year old woman dressed casually, clothing was clean and weather appropriate. Appeared well kempt and taking care of personal hygiene. Rapport was initially difficult to establish, Kelly providing closed answers. Appeared to become more relaxed and open with her communication throughout building a rapport. Eye contact was appropriate throughout. Pace, tone and pitch were appropriate throughout the conversation. Her speech was spontaneous and coherent. Subjectively she described her mood as "rubbish" Kelly has a long standing history with low mood and anxiety difficulties which she reports as chronic since childhood. Kelly reports that she was taken into care at the age of 8years old, [redacted]. Reports her childhood as very difficult disclosing physical and emotional neglect and abuse. Reports she is currently caring for her mum and and mother in law due to their own going physical health difficulties, reports feeling exhausted. Poor sleep reports this as chronic reporting no regular sleep pattern over the last 7 years. Previous bad reaction to zopiclone and nil therapeutic benefit, disucssed possibility of the GP considering prescribing promethazine to aid sleep, accepting of same. Currently prescribed fluoxetine for low mood denies any current side effects, reports little therapeutic benefit of same. Keen to change anti-depressant medication, would benefit from same. Writer has agreed to send a clinical email to GP for consideration of same. Kelly reports to feeling constantly anxious daily, report frequent panic attacks. Reports physical symptoms as constant pain in her chest and daily headaches, nil physical cause for same idenditifed from GP. Kelly stating "I need this pain away". Previous bad/possible allergic reaction reaction to propranolol. On further disucssion Kelly describing fluctuations in her mood which she stated happened often and quickly, stating "I often don't recognise myself". Reports feeling angry due to her childhood and adverse experiences. Reports feeling resentful towards family members due to same. Kelly reports caring for her mum as extremely difficult. Kelly describing emotional dysregulation and interpersonal difficulties. Disucssion regarding individuals window of tolerance and due to childhood events and stressors this results in a variation of emotions and feeling unable to regulate or own emotions, Kelly able to identify withy same. Disucssed matched intervention for emotional dysregulation, decider skills. Kelly declined attending decider skills group citing she struggles with social anxiety keen for 1-1 to decider skills input. Advised Kelly that writer will complete an intra team referral to locality hub for same but that due to a current waiting list writer could not establish when this could commence if accepted, Kelly accepting of same. Kelly reports feeling hypervigilant and on alert all of the time, difficulty concentration at present. Reports chronic pain and various physical health complications. Previous opiate addiction, has now been abstinent for some years. Reports previous misuse of various substances over the years as a way of coping, such as cocaine, alcohol and cannabis. Denies any cocaine or alcohol misuse for years. Reports to recreational use f cannabis at intermitted times reports last utilised cannabis 10 days ago stated 2 bongs that day, keen to remain abstinent from same. Accepting of a referral to we are with you service for further support with same. Objectively, mood appeared dysregulated with a reactive affect. Denied any hallucinations of any type and no objective evidence to suggest otherwise. Conversation revealed no evidence of any thought disorder. Reports ongoing suicidal thoughts, reports these as daily thoughts. Reporting a plan initially wouldn't disclose same, however further into the assessment she advised she planned to take a medicaiton overdose. Stated previous chosen date but due to mums poor health this was not a possibility. Did not identify a time line. Engaged in safety planning to reduce risk to self, partner [redacted] has removed all excess medication from the home. [redacted] is with Kelly each day, she has agreed that she would tell [redacted] if she felt unable to keep herself safe and would utilise services for further support if required. Nil current intent idenditifed. Reports her mums poor health and people / family relying on her as a protective factor. Risk of impulsivity. Spoke fondly of her nephew. No evidence of any mental illness which would impair judgement or decision making process. Cognition appeared to be intact.

Engagement

Engagement with services

Green

Note: Attended assessment and engaged appropriately reports she is keen to engage with services for appropriate treatment

Medication management

Green

Note: Currently prescribed fluoxetine

Risk of absconding

Green

Note: Informal community based patient

Risk of suicide/self-harm

Risk of self-harm

Green

Note: Previous deliberate self harming documented. Nil current self harming behaviours idenditifed.

Risk of suicide

Amber

Note: Reports ongoing suicidal thoughts, reports these as daily thoughts. Reporting a plan initially wouldn't disclose same, however further into the assessment she advised she planned to take a medicalton overdose. Stated previous chosen date but due to mums poor health this was not a possibility. Did not identify a time line. Engaged in safety planning to reduce risk to self, partner [redacted] has removed all excess medication from the home. Hugh is with Kelly each day, she has agreed that she would tell [redacted] if she felt unable to keep herself safe and would utilise services for further support if required. Nil current intent idenditifed. Reports her mums poor health and people / family relying on her as a protective factor. Risk of impulsivity. Spoke fondly of her nephew. No evidence of any mental illness which would impair judgement or decision making process. Cognition appeared to be intact.

Risk of harm to or from others

Risk of harm to others

Green

Note: Nil risk to others identified

Abuse issues

Green

Note: Nil current abuse issues identified, reports previous childhood abuse. Reports physical and emotional abuse from her parents.

Neglect/Vulnerability issues (consider ASP/AWIA)

Green

Note: Nil concerns identified

Child protection concerns

Green

Note: No children of her own or within the family home and no concerns identified.

Child well-being concerns

Green

Note: No children of her own or within the family home and no concerns identified.

Risk from substance misuse

Substance misuse

Green

Note: Previous co-dolomol dependency, abstinent for many years. Reports to self medicating with alcohol and various substances such as cocaine and cannabis for many years. Nil alcohol or cocaine misuse for some years. Reports intermitted use of cannabis, last utilised 10 days ago. Keen to remain abstinent from all substances and alcohol, a referral to we are with you service for further support with same.

Social and personal risks

Support network

Green

Note: Lives with partner Hugh whom she reports as a great support. Reports poor family dynamics with various family members.

Physical health

Green

Note: Reports chronic pain and various physical health complexities such as issues with her bowels due to previous co-codamol dependencie

Occupation of time

Green

Note: Nil concerns idenditifed

Housing and finances

Green

Note: Nil concerns reported or identified.

Any other issues

Any other issues

Not applicable

Note: Nil other concerns identified

Overall Impression of Risk

Overall Impression of Risk

Amber

Note: Reports ongoing suicidal thoughts, reports these as daily thoughts. Reporting a plan initially wouldn't disclose same, however further into the assessment she advised she planned to take a medicaiton overdose. Stated previous chosen date but due to mums poor health this was not a possibility. Did not identify a time line. Engaged in safety planning to reduce risk to self, partner [redacted] has removed all excess medication from the home. [redacted] is with Kelly each day, she has agreed that she would tell [redacted] if she felt unable to keep herself safe and would utilise services for further support if required. Nil current intent idenditifed. Reports her mums poor health and people / family relying on her as a protective factor. Risk of impulsivity. Spoke fondly of her nephew. No evidence of any mental illness which would impair judgement or decision making process. Cognition appeared to be intact.

Immediate Risk Management Plan

Immediate Risk Management Plan

Plan
- Engaged in safety planning today, partner [redacted] will keep medications.
- Referral to we are with for support with remaining abstinent from substances
- Provided with East Ayrshire Carer support information booklet
- Intra team referral to locality hub for input for further safety planning and 1-1 decider skills input, declined group. Aware of waiting list.
- Clinical email to GP for consideration of changing anti-depressant medication and medication to aid sleep.
- Provided with appropriate contact details for DUTY / CMHT and OHH if required.

Recommendations

Recommendations

Plan
- Engaged in safety planning today, partner [redacted] will keep medications.
- Referral to we are with for support with remaining abstinent from substances
- Provided with East Ayrshire Carer support information booklet
- Intra team referral to locality hub for input for further safety planning and 1-1 decider skills input, declined group. Aware of waiting list.
- Clinical email to GP for consideration of changing anti-depressant medication and medication to aid sleep.
- Provided with appropriate contact details for DUTY / CMHT and OHH if required.

Gender Based Violence Assessment

Was gender based violence routine enquiry carried out during this assessment?

Yes - (Outcome: Disclosed - Victim)

Gender Based Violence Disclosure Assessment (ONLY COMPLETE THIS SECTION IF ANSWERED YES (OUTCOME VICTIM) ABOVE. FOR ALL OTHER ANSWERS LEAVE AS 'NOT APPLICABLE')

What type of GBV is involved

Other

Is abuse current or past or both?

Past

Describe the relationship between the service user and the perpetrator

Family member / friend

What is the sex of perpetrator(s)?

Male

Response to disclosure

Referred to other specialist service

Not applicable

Information given on local services

Not applicable

Shared information with other health professional

Not applicable

Shared information with external agency (e.g. police, social work etc)

Not applicable

Safety planning discussed

Not applicable

Child protection procedures initiated

Not applicable

Adult protection procedures initiated

Not applicable

No further action required

Not applicable

Documented plan in case record

Not applicable

Revisit enquiry at a later date

Not applicable

Has consent been given to share this information with GP?

Not applicable

Consent to care and treatment

Sufficient information provided?

Yes

Does the person understand the information given to them that is relevant to the decision?

Yes

Can the person retain that information long enough to be able to make the decision?

Yes

Can the person use or weigh up the information as part of the decision-making process?

Yes

Can the person communicate their decision?

Yes

Is consent valid?

Yes

Is the consent given voluntarily?

Yes

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) **undefined** Female **CHI Number** 1602890722

History for Summary of contact

From 11/05/1926 **Until** 11/05/2026

Assessed 2nd Dec 2025 at 09:15

Summary of contact/details	
Attempted phone call to Kelly to advise that appt today would have to be cancelled due to staff sickness. Phone went to voicemail and message left advising Kelly of same and advised to contact Duty if additional support required.	

Assessed 10th Nov 2025 at 10:45

Summary of contact/details	
ollowing your assessment appointment with the East Ayrshire Community Mental Health Team we are now in a position to commence appointments as detailed below: Date: Tuesday 2nd December 2025 Time: 10:00am Venue: North West Kilmarnock Area Centre If this appointment is not suitable, please contact the above number to re arrange. If you are suffering from recent new respiratory symptoms please do not travel to hospital/outpatient clinic for your appointment, please contact us on the telephone number provided within this letter.	

Assessed 8th Oct 2025 at 12:38

Summary of contact/details	
eferral: Urgent referral made by Dr Newton Louden's surgery for Kelly, due to escalating suicidal ideation. Background: History of low mood and anxiety; previous mental health input (2007 – self-harm; 2012 – suicidal ideation). Currently prescribed Fluoxetine 20 mg. No substance/alcohol misuse, no psychotic symptoms, and no identified risk to others. Current Presentation: Low mood for 18 months, daily suicidal thoughts, undisclosed plan and timeline. [redacted] Partner [redacted] aware of suicidal intent but not details; has removed/secured excess medications. Kelly stated she had a date and plan but postponed due to mother's illness. Expressed she does not want to disclose her plan because she does not want it stopped but does want support. Reports physical symptoms of panic/anxiety and feeling overwhelmed ("having a breakdown"). Living Situation: Resides with partner [redacted]; no children at home. Actions Taken: Referral accepted by CMHT; Advised Dr Louden Contact details updated across systems. Duty call made by SN Nikki Howie to Kelly for assessment- Discussed and agreed for Joint assessment at 14.30 with ICPNT. Kelly agreed to attend assessment identifying a willingness to engage.	

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

Assessed 8th Oct 2025 at 11:18

Summary of contact/details	

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) **undefined** Female **CHI Number** 1602890722

History for Summary of contact

From 11/05/1926 **Until** 11/05/2026

DUTY CONTACT:

Phone contact recieved from Dr Newton Louden surgery looking to make an urgent referral for Kelly. Kelly attended the surgery this morning for a GP appointment - was in the room with her partner [redacted] at time of call. Previous history of low mood and anxiety, previous input from mental health services as documented on care partner. Kelly reporting low mood for around 18 months with increasing suicidal ideation, current daily suicidal thoughts. Kelly has disclosed to GP today, that she has a plan to end her life but would not disclose what that plan is or provide a time line. GP stated that she is "awaiting carers support being out into place for her mum [redacted]". GP unaware if care support is currently being put into place or if their is a time line for same. Currently prescribed Fluoxetine 20mg's, GP not keen to make ay changes to medication at present due to suicidal ideation. Chronic pain - partner has removed all excess medications and has locked these away in a cupboard. Nil substance or alcohol misuse. Nil risk to others identified. Nil evidence of any psychotic symptomology. Previous self harm documented 2007, previous suicidal ideation documented 2012. Lives with her NOK partner Hugh. Nil children within the home. Possible stressor - mum declining health.

Referral accepted - advised GP to ask Kelly to return home if able to keep self safe, stated she could and writer would contact her by phone to triage / assess. Accepting of same.

Personal details checked different address and mobile number provide to what is on care partner system. New details provided to admin staff and uploaded to all systems as requested.

DUTY CALL:
SN Nikki Howie contact Kelly by phone as agreed.

Call answered by Kelly could be heard that she was in the car, she advised she was on her way to Ayr hospital where her mum was currently an inpatient [redacted] Kelly advised her dad passed away in January and they were not in communication despite him reaching out to her prior reports "having a lot of difficult feelings regarding same". Kelly reports that she has had difficulties with her mental health since childhood and at present is unable to cope with ongoing stressors and difficulties. Reports an increase in struggling with her mental since September 2024 reports an increase in suicidal ideation. Reporting daily fixed suicidal thoughts, reporting that she has a plan but dose not wish to disclose same to writer at this time would not disclose timeline. Stated "I had a date and plan but my mums had a heart attack so I cant do it just now, I am the only family here to help her get supports in pace". Stated "I do not want to disclose my plan to you because I don't want you to stop me". "I just want to end it, I don't want to be here". Reports she informed her partner [redacted] last week that she planned to commit suicide but did not disclose plan to him either. Conversation with Kelly regarding her telling her partner, attending the GP and accepting referral to CMHT would indicate to writer that she is keen for mental health support and for appropriate support to be provided that it is important that she is honest and discloses her plan with us. Kelly agreeable that she does want to engage with appropriate services for support. Element of safety planning as partner has removed medications. Reports having "a breakdown" often feeling extremely distressed, describing physical symptoms of panic / anxiety such as headaches, nausea, palpitations, tight chest and feeling like she is unable to breathe. Reports she previously self medicated with substances for many years. Denies any current substance misuse reporting she last smoked cannabis around 10 days ago reporting 2 bongs daily as previous use. Currently prescribed fluoxetine for mood. Kelly arrived at Ayr hospital to visit her mum, call cut out on two occasions due to signal dropping,

Disucssed with CN Adam Knapper plan to offer face to face joint assessment at NWKAC with ICPNT if able today at NWKAC at 14:30pm. Kelly accepting of same.

Phone contact to ICPNT disucssed with SN Paula Carey who has agreed to attend for a joint assessment.

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) **undefined** Female **CHI Number** 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

Assessed 26th Oct 2021 at 10:55

Summary of contact	
Dear Ms Prowse As I have had no response from you following my 14-day opt in letter for assessment, I am therefore discharging you at this time. Your GP has been informed by copy of this letter. Therefore, should you require any further input, please contact your GP. ours sincerely COMMUNITY MENTAL HEALTH TEAM CC Dr Kondol, Lochore Terrace, Darvel, KA17 OHD	

Assessed 11th Oct 2021 at 09:09

Summary of contact	
Dear Ms Prowse Following referral to the Community Mental Health Team, please contact the above number within 14 days, should you wish to arrange an assessment appointment. If however, I do not hear from you within this time, I will therefore discharge you back to the care of your GP. .ours sincerely COMMUNITY MENTAL HEALTH NURSE c.c. Dr Kondol, Lochore Terrace, Darvel, KA17 OHD	

Assessed 7th Sep 2020 at 14:37

Summary of contact/details	
Discharged by Suzanne Rorison, MHP as Ms Prowse has moved to England.	

Assessed 9th Jul 2020 at 14:20

Summary of contact/details	
Offered initial appointment on 16th July 2020 by Suzanne Rorison, Mental Health practitioner(MHP) within GP Practice on behalf of the PCMHT. Outcome to follow.	

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) **undefined** Female **CHI Number** 1602890722

History for Summary of contact

From 11/05/1926 **Until** 11/05/2026

Assessed 16th Mar 2020 at 15:08

Summary of contact/details	
Ms Prowse has called to opt into the PCMHT and has chosen 1:1 treatment therefore will now be placed onto the waiting list and offered an appointment in due course.	

Assessed 12th Mar 2020 at 12:43

Summary of contact	

lear Patient

You have been referred to the Primary Care Mental Health Team and we would, therefore, like to invite you to opt in to our service.

I enclose a leaflet for your information and would be obliged if you could follow the steps detailed below:

Step 1: Read the leaflet and any attached forms. This will tell you who we are and what we do.

Step 2: Decide which of the options best meets your needs.

Step 3: Telephone the Team on the above telephone number to inform us of your choice.

Step 4: Complete the two questionnaires (GAD-7, PHQ-9). We would be grateful if you could complete these and bring these with you to any appointment offered. It is especially important that the questionnaires are completed one week before your appointment. Please be assured that you are welcome to attend the service whether or not you complete the forms.

What happens next?

- If you choose one of our classes, you will be placed on the waiting list for an assessment appointment and will be offered an appointment to discuss this in more detail in due course.

- If you choose to wait for 1:1 therapy, you will be placed on a waiting list for assessment/treatment and will again be offered an initial appointment in due course by an appropriate clinician based on your needs (see leaflet for examples). This will ascertain if this treatment is best provision of support.

- If we do not hear from you before Wednesday 1st April 2020 we shall assume you do not wish input from the Primary Care Mental Health Team and will discharge you back to your GP.

If you require any information on eligibility to reclaim travel expenses please visit

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

http://www.scotland.gov.uk/Resource/0039/00393022.pdf or alternatively phone 03003301343.

Yours sincerely

Assessed 8th Oct 2019 at 14:33

Summary of contact	

Dear Dr Kondol,

KELLY PROWSE DOB: 16/02/1989 CHI No: 1602890722
!4 MARGARET AVENUE, GALSTON, AYRSHIRE, KA4 8BZ

Thank you for your referral of the above lady. Unfortunately it is unclear from your referral what her current circumstances and symptoms are. If further details could be provided we would be able to consider whether or not she is suitable for CMHT. At the present time we will not be offering her an appointment.

Yours sincerely

ALLOCATIONS TEAM
EAST AYRSHIRE ADULT CMHT

Assessed 2nd Oct 2017 at 12:15

Summary of contact/details	

Note on Duty grid from landlord advising that Kelly has left belongings at property. Returned call, no answer. brief message left dvising that he had called east Ayrshire CMHT and the ladies address is North Ayrshire. No further information shared.

Assessed 31st Jul 2017 at 11:27

Summary of contact/details	

DUTY;
Returned call to DWP representative information shared as per appropriate.

Assessed 31st May 2017 at 10:27

Summary of contact/details	

Duty call from DWP information shared. Not opened to CMHT.

Assessed 27th May 2016 at 12:18

Summary of contact/details	

Dear Dr Williams

Re: Kelly Prowse, 9 Moncur Road, Kilwinning, KA13 7LD
D.o.B. 16.02.89 CHI 1602890722

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

Further to referral of the above-named, this patient has been offered the opportunity to contact us to arrange a telephone screening.

Unfortunately, as the patient has failed to make contact with the Department, I can only assume that she does not wish to pursue assessment with our service at this time. I have, therefore, no option but to discharge her from our service.

Please do not hesitate to re-refer this patient should she show a commitment to attend.

Assessed 4th May 2016 at 16:47

Summary of contact/details	

Dear Ms Prowse,

We are aware you have been waiting to be seen for assessment within our service. Experience and research tells us that sometimes over time people's mental health changes or their circumstances change so the type of treatment they require to help them get better will change.

The North Primary Care Mental Health Team would therefore like to offer you the opportunity to speak to one of our staff over the telephone about your problems to determine the most appropriate treatment. If you feel that you would still benefit from our service then please contact the above number to arrange a suitable telephone appointment. You will be asked to give your up to date contact number so that we can contact you at the arranged date and time.

If the Team does not hear from you by 19th May we will assume that you no longer wish to remain on our waiting list and you will be discharged back to your GP.

If you take up the offer of the telephone appointment please ensure that you have the time and privacy to speak about your circumstances and problems. If you are not available at the agreed time or you do not answer we will presume you no longer wish ur service. Our number will show up as 0800 678 3393/No Caller ID. The appointment will take up to 20 minutes.

Thank you for your co-operation with this exercise and I apologise for any inconvenience caused. If you need more information then please contact the Team at the telephone number above.

Assessed 2nd Mar 2016 at 09:22

Summary of contact/details	

Dear Ms Prowse,

You have been referred to the North Ayrshire Primary Care Mental Health Team by Dr Williams.

I enclose a leaflet for your information.

To confirm that you wish to meet with one of our clinicians to discuss your problems please telephone 01294 323216 or 01294 322044. When you call our admin staff will also ask you to confirm your contact details and availability for appointments.

On the basis of the information provided you have been allocated to a specific treatment option. The waiting list for each option varies. All first appointments involve gathering more information and then making a decision about how your treatment will be progressed. This might include referring you on to other agencies and services.

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

If you do not contact the Primary Care Mental Health Team by the 16th March 2016 we will assume that you no longer require to be seen and your GP will be informed that you have been discharged from our service.

Assessed 5th Feb 2014 at 13:52

Summary of contact/details	
-Did not attend assessment appointment. File placed in Kilmarnock Team tray to await contact by 15/2/14. If no contact discharge from service.	

sessed 28th Jan 2014 at 11:08

Summary of contact/details	
Dear Dr Pugh RE: KELLY PROWSE, 23C FULLARTON STREET, KILMARNOCK, KA1 2QZ, DOB: 16.02.1989, CHI NO: 1602890722 Please see enclosed copy of assessment for the above named patient. Please do not hesitate to contact me on the above number should you require any further information.	

Assessed 24th Jan 2014 at 13:28

Summary of contact/details	
Please see referral checklist.	

Assessed 21st Jan 2014 at 17:45

Summary of contact/details	
Received telephone call from Dr Pugh, GP. Advised of Kelly's account of current alcohol and substance misuse. GP advised that such information will be noted when she is being reviewed for repeat of acute" prescriptions. Corroborated Kelly's account of current medication regime. Also updated on purpose and outcome of our assessment and recommendation that she engage with additions services in first instance and that she has an appointment for same on 5th February 2014. Advised that letter detailing our assessment would be sent at the end of the week following discussion at CMHT MDT meeting.	

Assessed 20th Jan 2014 at 17:45

Summary of contact/details	
Telephone contact with addictions services Geoff Greer, Psychiatric Nurse who confirmed that Ms Prowse had self referred and advised that she has been allocated an assessment appointment for 5th February 2014. Time was also spent discussing Ms Prowse's current reported use of predicted and non prescribed medication in addition to her alcohol use some of which was in her referral. Also advised of her discharge from CMHT CPN in May of last year as it was thoughts that she was currently being seen by Tracey Harvey CPN. Advised that following assessment today that we felt her substance misuse would contraindicate her suitability for high intensity psychological intervention and thus that she will therefore be discharged from the Psychological Specialty within East Ayrshire Community Mental Health Team at this time.	

Ayrshire Mental Health Risk Assessment Framework

Date of Activity 20 January 2014 17:28 by Dr. Sarah Mackintosh **Status** Closed
Centre of Care East Ayrshire CMHT

Ayrshire Mental Health Risk Assessment Framework

Assessment completed by

Individual clinician

Mental state

Mental state

Amber

Note: Ms Prowse presents with a further exacerbation of long-standing difficulties with low mood and anxiety, which again appears to have been triggered by the ending of a romantic relationship in August of last year. She also presents with an exacerbation of illicit substance misuse and ongoing codeine dependency. She also reports long-standing difficulties with affect regulation and interpersonal relationships and has reported previous difficulties with re-experiencing of traumatic events, avoidance of reminders and hyper arousal, all of which I would continue to conceptualise as a complex traumatic stress presentation. She presented as tearful throughout the session and her affect appeared flat however, good rapport was established and she was able to provide a coherent detailed narrative of her difficulties. No cognitive problems or symptoms of psychosis or self neglect were evident.

Engagement

Engagement with services

Amber

Note: Ms Prowse has a history of disengaging with CMHT and addictions services.

Medication management

Amber

Note: Ms Prowse reported compliance with her current prescibed medication regime however reported using misusing street diazepam.

Risk of absconding

Green

Note: Has previously left GP surgery due to anxiety while GP was contacting duty system. Ms Prowse was able to wait in waiting room for approximately 20 minutes today during planned break in assessment appointment.

Risk of suicide/self-harm

Risk of self-harm

Green

Note: Ms Prowse stated that she previously self-harmed by cutting however denied suicidal intent at such times.

No current thoughts of deliberate self harm and Ms Prowse stated that she has not cut herself for a number of years.

Risk of suicide

Amber

Note: Ms Prowse reported that she continues to experience suicidal thoughts on a daily basis. She reported taking an overdose of medication in August of last year and it would seem this was triggered when her partner left her. M Prowse stated that this was impulsive and that she was intoxicated at the time. She reported taking 20/30 street Diazepam in addition to having consumed alcohol and "stupid amounts of drugs" as she felt there was no point in living. Mr Prowse stated that her brother "turned up" two hours, without her alerting him, and "stuck his fingers down (her) throat" as he thoughts she had taken something. Ms Prowse stated that she vomited and advised that she did not seek further medical attention. Ms Prowse stated that she continues to experience suicidal thoughts however, denied any current plans or having taken any steps to end her life. She reported that she has tried to end her life by taking overdoses in the past and as they have "not worked" she has "given up trying". Ms Prowse continued to state that as she is a Christian and as ending her life is against her religion, she would not be able to use any other means to end her life. She did however, continue to state that she is hopeful that her ongoing substance misuse may "kill (her) eventually" which she believes would be an acceptable way in terms of her religion for her to die and prevent herself from going to hell. However, she advised that her immediate intentions when using substances are to help cope with her emotions, rather than to end her life. Risk is rated as amber due to Ms Prowse's current use of prescribed and non prescribed substances, as aforementioned, in addition to misus alcohol and thus appears at significant risk of accidental overdose or physical harm to due long-standing frequenc and quantity of substance abuse. Ms Prowse has an assessment appointment with addictions services on 5th February 2014 and her GP has been contacted to advise of her current non prescibed use of drugs and alcohol misuse. Time was spent reiterating the risks of her current susbatnce and alcohol use.

Risk of harm to or from others

Risk of harm to others

Green

Note: Ms Prowse stated that she was charged with assault as a minor. She reported difficulties managing her temper and stated that has in the past contributed to her anxiety about leaving the house. Reported no current physical aggression when angry and has no thoughts of harming others.

Abuse issues

Amber

Note: Reports significant emotional, physical and sexual abuse as a child in addition to neglect which resulted in her going into care when she was 8 years old. Ms Prowse reported being raped when she was 15 years old by he sisters boyfriend. It is likely that her previous experiences are impacting on her current presentation, how she is expressing her needs in addition to her current view of and difficulties engaging with services.

Neglect/Vulnerability issues (consider ASP/AWIA)

Green

Note: No signs of neglect evident

Child protection concerns

Green

Note: Ms Prowse has no children. She has contact with her three year old nephew who she advised is always accompanied by her brother.

Risk from substance misuse

Substance misuse

Red

Note: Ms Prowse advised that she has been experiencing difficulties with alcohol and substance misuse since her partner left her at the beginning of August last year. She reported drinking excessively for the initial 3/4 weeks afte this, at which time she reported consuming a bottle of vodka and a bottle of cider each day. She reported gradually reducing this as the "drink ran" out and did not report experiencing any significant withdrawals at that time. She reported being aware of the danger of suddenly stopping alcohol use. At present she reported binge drinking" whereby she will wake up and decide to have a "drink" that day in order to cope with how she is feeling. She reported her last binge to be two weeks ago where she reported consuming a bottle of vodka and 2 bottles of cide over two days. she reported stopping as she awoke and had "no drink left". She reported abstinence from alcohol since this time. Ms Prowse reported that she also started using cannabis once more and advised that she uses £2 per week at present. She reported taking this in a "bucket2 each evening. She also reported that she began using street diazepam in June of this year when she was still with her partner as he was encouraging her to go out and these helped her to leave the house as they stopped the "jitters". At present she reported using 10 (blues 10's) pe day at present. She denied having experienced any unpleasant side effects from such. Ms Prowse stated that she has also been intermittently using cocaine and advised that she was "out of it" of Christmas as she took so much cocaine however advised that she cant remember how much she consumed. She reported not having used any cocaine since the weekend at which time she advised that she took 2 grams. Ms Prowse stated that since she has been prescribed her co-codomol by the GP she has not over used any over the counter pain killers. She was aware of the potential risks of her her current predicted medication regime and her substance and alcohol use anc was of the perception that her GP was aware of her recent alcohol and substance use.

Social and personal risks

Support network

Amber

Note: Reports close confiding relationship with brother. Reported having withdrawn from other supports and fiends.

Physical health

Amber

Note: advised that she attends a specialist for her kidneys and bladder however, struggled to elaborate on the difficulties she was experiencing with this and the input she is receiving.

Occupation of time

Amber

Note: She reported at present rarely leaving her home and spending the day in front of the television or attempting to occupy herself by doing housework. She reported that she sleeps for one or two hours at a time throughout the day or night in front of the television on an armchair however advised that she has no "pattern" and will sleep whe she is tired.

Housing and finances

Green

Note: No issues raised during assessment although this was not directly questioned.

Any other issues

Not known

Overall Impression of Risk

Amber

Note: Low mood with reported ongoing suicidal ideation and hopelessness, however denies current plans or intent. Recent exacerbation of addiction issues and ongoing associated physical health risks and risk of accidenta overdose.

Immediate Risk Management Plan

Immediate Risk Management Plan

It was discussed with Ms Prowse that her misuse of Diazepam, cannabis, cocaine and alcohol in addition to her ongoing codeine dependency would contraindicate her suitability for high intensity psychological intervention at this time, as this would initially increase her emotional vulnerability. Ms Prowse was in agreement with this and advised that she did not think it was the right time for psychological intervention. She reported that she recently referred herself to addictions services and described a desire to manage her substance misuse difficulties although, reported feeling hopeless regarding this. It was discussed with Ms Prowse that it would be helpful for her to address her substance misuse in the first instance and that she would therefore be discharged from the Psychological Specialty within East Ayrshire Community Mental Health Team at this time. We spent time reiterating the risks in relation to her current substance misuse in addition to discussing services she can contact if she felt unable to keep herself safe or was concerned about her physical health, such as NHS 24.

Contacted East Ayrshire addiction service who confirmed that Ms Prowse had self referred and advised that she has been allocated an assessment appointment for 5th February 2014. Time was also spent discussing Ms Prowse's reported use of predicted and non prescribed medication in addition to her alcohol use and her discharge from CMHT-CPN in May of last year.

Left a message for GP to return call to ensure that they have up to date information regarding drug and alcohol misuse.

Discharge from psychology was discussed at CMHT team meeting, who were in agreement.

Generic ICP Assessment V3

Date of Activity 20 January 2014 11:22 by Dr. Sarah Mackintosh **Status** Closed
Centre of Care East Ayrshire CMHT

Presentation

Source of current referral

Other NHS

Reason for referral

Ms Prowse was referred to the Psychology Specialty within East Ayrshire Community Mental Health Team in June 2012 by June Collins, CPN for consideration of suitability for cognitive behavioural therapy.

Assessment type

Reassessment

Note: As are aware, following referral I met with Ms Prowse on 3 September 2012. At that time, she presented with an exacerbation of long-standing difficulties with anxiety and low mood in addition to codeine misuse. She also reported long-standing difficulties with affect regulation, re-experiencing of traumatic events, avoidance of reminders and hyperarousal, which were conceptualised as a complex traumatic stress presentation and, as such, she was added to the waiting list for psychological intervention. At that time it was discussed that when a Psychologist became available for treatment, Ms Prowse's misuse of medication and engagement with low intensity psychological intervention with our CPN colleagues with would be considered to determine whether she could benefit from, and was ready to engage in, a high intensity psychological intervention. As you may be aware there has been a significant wait for this therapy option however, Ms Prowse recently reached the top of our treatment waiting list. I therefore met with her again on 20th January 2014 in our assessment clinic to review her difficulties and to determine whether it was the right time to engage in psychological intervention. Please find outlined below a summary of my assessment and recommendations.

Target date for completion

Was target date for completion met?

Not recorded

Current contact with other services

Yes

Note: Ms Prowse advised that she attends her GP every two to three weeks to obtain a repeat prescription for her medication. She advised that she last saw her GP three weeks ago. She advised that she also attends a specialist for her kidneys and bladder however, struggled to elaborate on the difficulties she was experiencing with this and the input she is receiving.

Previous contact with other services

No

Note: From viewing Ms Prowse's FACE record it would seem that she was initially referred to Mental Health services in Ayrshire and Arran by her GP in May 2012. It was noted in the referral that she was suffering from paralysing anxiety and it was noted that she often does not get out of the house. She was initially seen by June

Collins in June 2012 when Ms Prowse reported difficulties with anxiety over the past year. It was agreed that she would commence anxiety management work with her community psychiatric nurse and in addition a referral was made to Occupational Therapy and Psychology. It would seem that Ms Prowse was seen by psychiatric liaison services in July 2012 following an intentional mixed overdose of Paracetamol, Codeine and Diazepam. It was felt that Ms Prowse appeared to suffer from increased panic anxiety along with OCD traits and she was discharged with follow up from the Community Mental Health team. She was subsequently seen on two occasions by Tracy Harvey, Community Psychiatric Nurse and it would appear that low intensity anxiety management was discussed. In addition, Ms Harvey referred Ms Prowse to outpatient psychiatry appointment for review of her medication. Ms Prowse was subsequently seen by psychiatric liaison services in August 2012 following an apparent overdose of prescribed / unprescribed medication taken with suicidal intent. She was subsequently discharged with CMHT follow up. Following her assessment with myself in September 2012 it would seem that she received regular CMHT CPN input until March 2013 at which time she started to default from appointments and was eventually discharged in May 2013. It would also seem that she was discharged from physiotherapy at that time due to non-attendance. According to her FACE records, Ms Prowse was also seen by addictions services in October 2012 however she was subsequently discharged in August 2013 following the pharmacy alerting addictions services that she had not been collecting her prescription for three consecutive days. It was noted that "Dr Stirling advised that Ms Prowse should be reassessed and placed in the care of the new prescriber for further assessment and prescribing if appropriate ", that her "prescription has been stopped" and that she had been discharged.

Patient's perspective of current problems and interventions

Ms Prowse advised that the problems we discussed outlined in my previous correspondence, dated 6th September 2012, remain however, it would seem that her substance misuse has escalated since this time. She reported that she had felt better when she was involved with Tracey Harvey, CMHT CPN and addictions services in 2013 in that she had managed to reduce her codeine use to one box of co-codamol per day. She advised that she got back together with her ex-partner in April of last year and reported that he had told her that he would support her with her difficulties and that she did not "need to see anyone else". Ms Prowse advised that as she was able to manage her difficulties previously when she was in this relationship that she was hoping that she would feel better and no longer require additional support and thus disengaged. She reported however, that her partner left her in August of last year and advised that since this time she has felt "terrible" and reported that she has been "a mess". She reported drinking excessively for the initial month after this relationship ended at which time she reported consuming a bottle of vodka and a bottle of cider each day. She reported gradually reducing this as the "drink ran" out and did not report experiencing any significant withdrawals at that time. She also stated that she began using cannabis once more in addition to using cocaine. Ms Prowse stated that prior to this she began using street Diazepam, in June of this year, when she was still with her partner, as he was encouraging her to go out and these helped her to leave the house as they stopped the "jitters".

At present she reported "binge drinking" whereby she will wake up and decide to have a "drink" that day in order to cope with how she is feeling. She reported her last binge to be two weeks ago where she reported consuming a bottle of vodka and two bottles of cider over two days. She reported stopping as she awoke and had "no drink left". She reported abstinence from alcohol since this time. She advised that she is also currently using £20 per week of cannabis at present via a bong each evening. She also reported that she continues to obtain street Diazepam and advised that she is currently using 10 "blues 10's" per day. She denied having experienced any unpleasant side effects from such. Ms Prowse stated that she continues to intermittently use cocaine, the last time being at the weekend prior to our session at which time she advised that she took two grams. Ms Prowse stated that since she has been prescribed her current medication regime by her GP, that she has not used any over the counter pain killers. Ms Prowse advised that she has a desire to overcome her misuse of substances, predominantly due to the impact she perceives this to be having on her brother as she reported that he worries about her. However, she also reported that she "likes it" in that it helps her to feel "safe" and to be able to function. She was aware of the potential risks of her current predicted medication regime and her substance and alcohol use and was of the perception that her GP was aware of her recent alcohol and substance misuse.

In relation to her mental health, Ms Prowse continued to report her mood to be "low", charcaterised by lack of motivation, negative thoughts about herself, other people and her future in addition to behavioural withdrawal. She reported at present rarely leaving her home and spending the day in front of the television or attempting to occupy herself by doing housework. She reported that she sleeps for one or two hours at a time throughout the day or night in front of the television on an armchair however advised that she has no "pattern" and will sleep when she is tired. Ms Prowse reported that she continues to experience suicidal thoughts on a daily basis. She reported taking an overdose of medication in August of last year and it would seem this was triggered when her partner left her. Ms Prowse stated that this was impulsive and that she was intoxicated at the time. She reported taking 20/30 street Diazepam in addition to having consumed alcohol and "stupid amounts of drugs" , although struggled to elaborate, and reported at that time that she felt there was no point in living. Mr Prowse stated that her brother "turned up" two hours later, without her alerting him, and "stuck his fingers down (her) throat" as he thought she had "taken something". Ms Prowse stated that

she vomited and advised that she did not seek further medical attention. Ms Prowse stated that she continues to experience suicidal thoughts however, denied any current plans or having taken any steps to end her life. She reported that she has tried to end her life by taking overdoses in the past and as they have "not worked" she has "given up trying". Ms Prowse continued to state that as she is a Christian and as ending her life is against her religion, she would not be able to use any other means to end her life. She did however, continue to state that she is hopeful that her ongoing substance misuse may "kill (her) eventually" which she believes would be an acceptable way in terms of her religion for her to die and prevent herself from going to hell. However, she advised that her immediate intentions when using substances are to help cope with her emotions, rather than to end her life.

Ms Prowse reported that she continues to experience difficulties with anxiety and since her partner left again reported that she rarely leaves the house unaccompanied. It would appear that her anxiety continues to relate to concerns that "something bad is going to happen", for example, that someone may "kill (her)". Ms Prowse continued to describe a perception that "world is a bad place" and reported feeling "wary" of people and reported finding it difficult to trust others. She reported that she will therefore avoid leaving her home so that she is not hurt or let down by others. At present she advised that she can walk unaccompanied to her local shop, which she described to be a few minutes walk away.

As outlined in my previous correspondence, Ms Prowse previously reported experiencing "flashbacks" in relation to her previous abusive experiences, in particular the reported sexual abuse she suffered [redacted] and reported physical abuse [redacted] in addition to an alleged rape when she was 16-years old. She also reported experiencing flashbacks to her foster father dying in hospital. During our appointment today she advised that she has not experienced flashbacks for "ages" and advised that she "numbs them out with drugs".

Carer's perspective of current problems and interventions

Not available at time of assessment. It would seem that Ms Prowse's brother is involved in her care. She advised that he visits her on a daily basis to check in her welfare. She also reported that between August and October of last year he moved in with her due to being worried about her drug use.

Patient's perspective of previous problems and interventions

In relation to previous interventions Ms Prowse identified that she "felt better" when she was seeing Tracey Harvey, CPN and addictions services in that she had reduced her codeine misuse. She advised that she disengaged from such services as she got back together with her ex-partner in April of last year and advised that he had told her that he would support her with her difficulties and that she did not "need to see anyone else". Ms Prowse advised that as she was able to manage her difficulties previously when she was in this relationship that she was hoping that she would feel better and no longer require additional support and thus disengaged.

Summary of strengths, goals and aspirations

Not Recorded

Were alternative care options considered?

Not recorded

Has Care Programme Approach been considered?

Not known

Has the Adult Support and Protection Act been considered?

Not known

Has referral been made to local authority under ASP legislation for further investigation?

Not known

Has the Mental Health Act been considered?

Not known

Current medication

Ms Prowse advised that she is currently prescribed 3/500mg co-codomol and advised that she gets a "box of 100" every two to three weeks. She advised that she is unsure of the quantity she consumes per day. She also reported being prescribed naproxen for sciatica however was unsure of the dose. She reported that her GP commenced her on gabapentin three weeks ago for sciatic pain however again was unsure of the dose. She reported taking three tablets per day and advised that she has not over used this medication.

She reported a perception that her GP is aware of her current alcohol and illicit drug use.

Responsible for medication monitoring

General practitioner

Note: Ms Prowse advised that she attends her GP every two to three weeks to obtain a repeat prescription for her medication. She advised that she last saw her GP three weeks ago.

Summary of Assessment

Background
Ms Prowse's perception of her early life experiences was discussed in detail during our previous assessment and is documented in my previous correspondence dated 6th September 2012 and I will thus not reiterate this here.

Summary
Ms Prowse presents with a further exacerbation of long-standing difficulties with low mood and anxiety, which again appears to have been triggered by the ending of a romantic relationship. She also presents with an exacerbation of illicit substance misuse and ongoing codeine dependency. She also reports long-standing difficulties with affect regulation and interpersonal relationships and has reported previous difficulties with re-experiencing of traumatic events, avoidance of reminders and hyper arousal, all of which I would continue to conceptualise as a complex traumatic stress presentation.

Action points

It was discussed with Ms Prowse that her misuse of Diazepam, cannabis, cocaine and alcohol in addition to her ongoing codeine dependency would contraindicate her suitability for high intensity psychological intervention at this time, as this would initially increase her emotional vulnerability. Ms Prowse was in agreement with this and advised that she did not think it was the right time for psychological intervention. She reported that she recently referred herself to addictions services and described a desire to manage her substance misuse difficulties although, reported feeling hopeless regarding this. It was discussed with Ms Prowse that it would be helpful for her to address her substance misuse in the first instance and that she would therefore be discharged from the Psychological Specialty within East Ayrshire Community Mental Health Team at this time. We spent time reiterating the risks in relation to her current substance misuse in addition to discussing services she can contact if she felt unable to keep herself safe or was concerned about her physical health, such as NHS 24.

I therefore contacted East Ayrshire addiction service who confirmed that Ms Prowse had self referred and advised that she has been allocated an assessment appointment for 5th February 2014. Time was also spent discussing Ms Prowse's reported use of predicted and non prescribed medication in addition to her alcohol use and her discharge from CMHT CPN in May of last year.

It was discussed with Ms Prowse that she could seek a re-referral to mental health services her mental health difficulties remain following a period of abstinence from substances.

I trust this meets with your approval however, please do not hesitate to contact me if you have any comments or queries.

Risk

Risk to self

Significant risk

Note: Ms Prowse reported that she continues to experience suicidal thoughts on a daily basis. She reported taking

an overdose of medication in August of last year and it would seem this was triggered when her partner left her. M Prowse stated that this was impulsive and that she was intoxicated at the time. She reported taking 20/30 street Diazepam in addition to having consumed alcohol and "stupid amounts of drugs" as she felt there was no point in living. Mr Prowse stated that her brother "turned up" two hours, without her alerting him, and "stuck his fingers down (her) throat" as he thoughts she had taken something. Ms Prowse stated that she vomited and advised that she did not seek further medical attention. Ms Prowse stated that she continues to experience suicidal thoughts however, denied any current plans or having taken any steps to end her life. She reported that she has tried to end her life by taking overdoses in the past and as they have "not worked" she has "given up trying". Ms Prowse continued to state that as she is a Christian and as ending her life is against her religion, she would not be able to use any other means to end her life. She did however, continue to state that she is hopeful that her ongoing substance misuse may "kill (her) eventually" which she believes would be an acceptable way in terms of her religion for her to die and prevent herself from going to hell. However, she advised that her immediate intentions when using substances are to help cope with her emotions, rather than to end her life. Risk is rated as "significant' due to Ms Prowse's current use of prescribed and non prescribed substances, as aforementioned, in addition to misuse alcohol and thus appears at significant risk of accidental overdose or physical harm to due long-standing frequency and quantity of substance abuse. Ms Prowse has an assessment appointment with addictions services on 5th February 2014 and her GP has been contacted to advise of her current non prescibed use of drugs and alcohol misuse. Time was spent reiterating the risks of her current susbatnce and alcohol use.

Risk to others

Low apparent risk

Note: Ms Prowse previously described difficulties with "her temper" and asscoaited verbal agression. She stated that she has not been physically aggressive as an adult and she denied experiencing any thoughts of harming others at present.

Risk from others

No

Note: No issues identified.

Risk to child

No

Note: Ms Prowse has no children. She has contact with her three year old nephew who she advised is always accompanied by her brother.

Personal and social history

Aspects relevant to minority / ethnic communities

Not recorded

Maternal status

Not recorded

Is there a dependent child?

Not recorded

Gender based violence

Was routine gender based violence enquiry carried out?

Not recorded

Why was gender based violence enquiry not possible?

Not recorded

Did disclosure take place?

Not recorded

Forensic/Criminal

Has the patient been convicted of a criminal offence?

Yes - non drug related

Note: Mr Prowse reported charges when she was 14 for assaulting her brother's girlfriend. Ms Prowse reported feeling remorseful with regards to this and stated that "she felt terrible".

Forensic contact

Previous Criminal Justice Service involvement

Not recorded

Current Criminal Justice Service involvement

Not recorded

Charges pending

Not recorded

Psychological well-being

Behaviour

Physical harm to others

Not recorded

Aggressive behaviour

Mild problem

Note: As above under risk of harm to others. There was no evidence of aggressive behaviour during our session today.

Suspicious or accusatory behaviour

Not recorded

Suicidality

Not recorded

Self-harm

Not recorded

Alcohol or substance misuse

Very severe problem

Note: Ms Prowse advised that she has been experiencing difficulties with alcohol and substance misuse since her partner left her at the beginning of August last year. She reported drinking excessively for the initial 3/4 weeks afte this, at which time she reported consuming a bottle of vodka and a bottle of cider each day. She reported gradually reducing this as the "drink ran" out and did not report experiencing any significant withdrawals at that time. She reported being aware of the danger of suddenly stopping alcohol use. At present she reported binge drinking" whereby she will wake up and decide to have a "drink" that day in order to cope with how she is feeling. She reported her last binge to be two weeks ago where she reported consuming a bottle of vodka and 2 bottles of cide over two days. she reported stopping as she awoke and had "no drink left". She reported abstinence from alcohol since this time. Ms Prowse reported that she also started using cannabis once more and advised that she uses £2 per week at present. She reported taking this in a "bucket2 each evening. She also reported that she began using street diazepam in June of this year when she was still with her partner as he was encouraging her to go out and these helped her to leave the house as they stopped the "jitters". At present she reported using 10 (blues 10's) pe day at present. She denied having experienced any unpleasant side effects from such. Ms Prowse stated that she has also been intermittently using cocaine and advised that she was "out of it" of Christmas as she took so much cocaine however advised that she cant remember how much she consumed. She reported not having used any cocaine since the weekend at which time she advised that she took 2 grams. Ms Prowse stated that since she has been prescribed her co-codomol by the GP she has not over used any over the counter pain killers. She was aware of the potential risks of her her current predicted medication regime and her substance and alcohol use anc was of the perception that her GP was aware of her recent alcohol and substance use.

Eating problems

Not recorded

Wandering

Not recorded

Overactivity

Not recorded

Odd, inappropriate or unacceptable behaviour

Not recorded

Level of care required to manage behaviour

Not recorded

Cognition

Memory

Not recorded

ACE-III total score

-17

Attention and concentration

Not recorded

Understanding

Not recorded

Expression

Not recorded

Mental health

Thought disorganisation

Not recorded

Delusions

Not recorded

Hallucinations and other perceptual abnormalities

Not recorded

Elated or expansive mood

Not recorded

Depressed mood and ideation

Not recorded

Obsessional ideas and compulsive behaviour

Not recorded

Intrusive ideation

Not recorded

Anxiety, phobias and panics

Not recorded

Somatic preoccupations

Not recorded

Lowering of energy, drive or interest

Not recorded

Self-esteem

Not recorded

Sleep disturbance

Not recorded

Psychological Therapies and interventions

In need of psychological therapy

Yes

Currently suitable for psychological therapy

No

Alcohol or substance misuse

Alcohol misuse

Not recorded

Misuse of prescribed drugs

Not recorded

Misuse of non-prescribed drugs

Not recorded

Smoking

Not recorded

Current cigarette intake

Not known

Offered referral for smoking cessation support

Not known

Alcohol / substance profile

Main alcohol / substance name

Not Recorded

Prescribed

Not recorded

Route

Not recorded

Level of use

Not Recorded

Alcohol / substance name (2)

Not Recorded

Prescribed

Not recorded

Route

Not recorded

Level of use

Not Recorded

Alcohol / substance name (3)

Not Recorded

Prescribed

Not recorded

Route

Not recorded

Level of use

Not Recorded

Alcohol / substance name (4)

Not Recorded

Prescribed

Not recorded

Route

Not recorded

Level of use

Not Recorded

Alcohol / substance name (5)

Not Recorded

Prescribed

Not recorded

Route

Not recorded

Level of use

Not Recorded

Physical

Physical health check

Not recorded

Responsible for annual physical health check

Not applicable

Date of last physical health assessment

Physical health needs identified

Not Recorded

Significant past medical history

Not Recorded

Significant family medical history

Not Recorded

Physical health condition

Not recorded

Physical impairment or disability

Not recorded

Long term physical health conditions

Not recorded

Long term condition

Not recorded

Long term condition (2)

Not recorded

Long term condition (3)

Not recorded

Long term condition (4)

Not recorded

Mobility inside the home

Not recorded

Mobility over distances

Not recorded

Difficulty transferring to vehicles/transport?

Not recorded

Ease of movement (upper body)

Not recorded

Uses aids, equipment or adaptations

Not recorded

Sensory impairment

Not recorded

Nature of main impairment

Visual

Not recorded

Auditory

Not recorded

Tactile

Not recorded

Other

Not recorded

Side-effects of prescribed medication

Not recorded

Diet

Not recorded

Malnutrition Universal Screening Tool

Not recorded

Overall risk of malnutrition

Not recorded

Swallowing difficulties

Not recorded

Continence

Not recorded

Distress/pain caused by physical state or condition

Not recorded

Sexual health

Not Recorded

Blood borne virus testing

Not recorded

Health promotion advice required

Not recorded

Activities of daily living and life skills

Eating and drinking

Not recorded

Personal care

Not recorded

Activities of daily living in the home

Not recorded

Activities of daily living outside the home

Not recorded

Money management

Not recorded

Keeping occupied

Not recorded

Work/vocational/educational performance

Not recorded

Ability to work now

Not recorded

Current support received in activities of daily living

Not recorded

Formal Lifeskills Assessment

Not recorded

Family, friends and carers

Relationship with close family

Not recorded

Relationship with partner

Not recorded

Friendships

Not recorded

Social activities outside the home

Not recorded

Relationships with others close by

Not recorded

Carers Needs Assessment

Not Recorded

Impact of caring role upon independence of carer

Not recorded

Emotional impact of caring role upon carer

Not recorded

Consideration for respite care

Not recorded

Social circumstances

Housing

Not recorded

Current financial situation

Not recorded

Daytime activity

Not recorded

Vulnerability

Not recorded

Involvement in recovery

Involvement in treatment and care

Not recorded

Communication about emotions/difficulties

Not recorded

Reflectiveness

Not recorded

Concordance with medication

Not recorded

Self assessment

Not recorded

Crisis arrangements

Not Recorded

Capacity to consent to care and treatment

Sufficient information provided?

Not known

Does the person have capacity

Understand the information given to them that is relevant to the decision

Not known

Retain that information long enough to be able to make the decision

Not known

Use or weigh up the information as part of the decision-making process

Not known

Communicate their decision

Not known

Is consent valid?

Not known

Is the consent given voluntarily?

Not known

Summary

Overall change in state

Not recorded

Overall impact of difficulties upon quality of life

Not recorded

Identified needs/strengths

Priority	Description
Prioritised	Anxiety, phobias and panics
Prioritised	Depressed mood and ideation
Prioritised	Risk to self

Goals

Description	Person Responsible	Target	Attainment	Date Attained
Kelly to be support to attain her optimum level of community presence and participation.	June Collins	13/12/2013	Partially attained	
Kelly to be encouraged to develop coping strategies which minimise risk behaviours.	June Collins	13/12/2013	Partially attained	

Planned Care

Description	Frequency
Analgesics - narcotic	4 times a day
CPN monitoring	Twice per month
Crisis and contingency planning	As required
Education re skills pertaining to management of illness	Twice per month
Escitalopram (lexapro)	Daily
Refer to another service	As required

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) **undefined** Female **CHI Number** 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

Assessed 20th Jan 2014 at 17:44

Summary of contact/details	
Telephone call to GP. GP unavailable. Left a message for GP to return call to ensure that they have up to date information regarding drug and alcohol misuse.	

Assessed 20th Jan 2014 at 10:52

Summary of contact/details	
elly attended as planned. Stuart Cooney, Assistant psychologist was initially present and Kelly initially consented to this however asked if it would be ok if he left at the start of the session. She advised that she did not like someone looking at her whilst talking. Discussed with Kelly the purpose of today - that she had reached the top of the waiting list for psychological intervention following our assessment in September 2012 and today was a further assessment to think about whether it was the right time to engage in psychological intervention. Kelly advised that she was not sure of the reason for our appointment today and stated that although she recognised my face that she had no recollection of the outcome of her last assessment with myself. In terms of what she was hoping to gain from attending today she stated she was unsure and that she had come along to the appointment as her brother "dropped her off". Kelly consented to proceed with assessment. Please see ICP and ARAF for full details. Kelly continued to report the difficulties described in our last assessment including low mood with suicidal thoughts, anxiety and associated agoraphobia in addition to codeine dependence. She reported that things have been "terrible" since the summer of last year when her partner left her again and since this time she has also being experiencing substance misuse (cocaine, cannabis, Diazepam) and alcohol misuse. Kelly advised that she no longer experienced "flashbacks" due to "numbing" these out with drugs. Kelly also advised that she referred herself to the Bentinck centre 2 weeks ago and advised that she had a telephone interview and was advised that they would take this information back to the team and get in touch with her. It was discussed with Kelly that recommendations from our last assessment were that we would add her to the waiting list for psychological. However, it was discussed that at that time her levels of codeine misuse would have prevented her from deriving benefit from psychological intervention, thus that when a Psychologist became available for treatment, her misuse of medication would be considered to determine where she could benefit om, and is ready to engage in, a high intensity psychological intervention. It was discussed today that it would seem that Ms rowse's substance use has increased since our last assessment and it was discussed that her current misuse of Diazepam, cannabis, cocaine and alcohol in addition to her level of codeine use would contraindicate her suitability for high intensity psychological intervention at this time, as this would initially increase her emotional vulnerability. Ms Prowse was in agreement with this and advised that she did not think it was the right time for psychological intervention. She reported that she recently referred herself to addictions services and appeared motivated to engage with such to manage her substance misuse difficulties and it was discussed that it would be helpful for her to address this in the first instance. It was discussed that she would therefore be discharged from the psychological speciality within East Ayrshire Community Mental Health Team and that she could seek a re-referral to mental health services her mental health difficulties remain following a period of abstinence from substances. It was discussed that writer would also contact addictions services to ensure that a referral had been received and that I would only contact her if there was any follow up from this.	

Assessed 15th Nov 2013 at 14:07

Summary of contact/details	
Dear Kelly Thank you for indicating that you would like to attend for an assessment appointment with the Psychological Specialty within the East Ayrshire Community Mental Health Team. To confirm your assessment appointment will take place	

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) **undefined** Female **CHI Number** 1602890722

History for Summary of contact

From 11/05/1926 **Until** 11/05/2026

On: Monday 20th January 2013

At: 9.15am

In: North West Kilmarnock Area Centre

With: Dr Sarah Mackintosh, Clinical Psychologist

This appointment will be approximately 1 ½ hours in duration.

In advance of this appointment we would be grateful if you could:

" complete, and bring with you to the appointment, the enclosed CORE questionnaire. It is especially important that the questionnaire is completed one week before your appointment. Please be assured that you are welcome to attend the service whether or not you complete the form.
" read the attached Psychological Specialty Attendance Form.
If you fail to attend your appointment, and do not contact us within 14 days of your appointment, then we shall assume that you wish no further psychological input at this time and you will be discharged from the Psychological Specialty.

Yours sincerely

Amanda Lavery
TEAM SECRETARY

c.c. Dr Pugh, 31 Portland Road, Kilmarnock, KA1 2DJ
c.c. Tracy Harvey, Charge Nurse, CMHT, NWKAC

ic: CORE form; Psychological Specialty Attendance Form

Assessed 8th Aug 2013 at 15:09

Summary of contact/details	
Email conversation with DR Stirling regarding previous entry by writer. Dr Stirling advising that Kelly should be reassessed and placed in the care of the new prescriber for further assessment and prescribing if appropriate. Prescription has been stopped and Kelly has been discharged at this time.	

Assessed 7th Aug 2013 at 11:49

Summary of contact/details	
Telephone contact from community pharmacy, Morrisons that kelly had not been dispensed on the following days, 23/7, 27/07, 28/07, 31/07, 2/08, 5/08, 6/08 and 7/08. Due to missing 3 concesecutive days pharmacy have been advised not to dispense to Kelly and for Kelly to attend the Bentinck Centre for discussion of her care.	

Assessed 22nd May 2013 at 12:50

Summary of contact/details	
Discharge report sent to gp on behalf of alison mcdonald physio.	

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

Assessed 20th May 2013 at 12:09

Summary of contact/details	
Dear Kelly As you have not responded to my recent 14 day letter, I will therefore discharge you from my caseload at this present time. If you wish to be re referred, please discuss this with your GP.	

ıssessed 22nd Apr 2013 at 13:08

Summary of contact/details	
Dear Kelly I am sorry that you were not in for your appointment today. Please contact me on the above telephone number within 14 days of receipt of this letter if you wish a further appointment. Yours sincerely TRACY HARVEY COMMUNITY M ENTAL HEALTH NURSE	

ıssessed 19th Apr 2013 at 13:34

Summary of contact/details	
No answer when i called to see Kelly today. 14 day letter to be sent.	

Assessed 11th Apr 2013 at 14:17

Summary of contact/details	
Kelly phoned and cancelled her appt today as she has a chest infection, given further appt for next week - Fri 19th 11am at home.	

Assessed 10th Apr 2013 at 09:43

Summary of contact/details	
Kelly did not attend her second appointment	

Assessed 8th Mar 2013 at 15:41

Summary of contact/details	
Kellys brother [redacted] phoned back. I informed him re my position in terms of confidentiality, that i can listen to his concerns but cannot divulge any details re Kellys care. [redacted] accepting of this. [redacted]	

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

[redacted]

Assessed 8th Mar 2013 at 09:59

Summary of contact/details	

Dear Ms Prowse

ollowing referral to our service, we are writing to offer you an appointment to start relaxation/anxiety management. Please read this letter and information sheet carefully.

I can offer you an appointment:-

On: Wednesday 27th March 2013

At: 10.00am

At: Central Clinic, Old Irvine Road, Kilmarnock

Assessed 8th Mar 2013 at 09:20

Summary of contact/details	

Consulted DR Stirlings last letter re Kellys night sedation, phoned her, advised her Dr Stirling does not recommend nitrazepam and that letter suggests she initiated the zopiclone being discontinued so if she wishes to readress this she should return to her GP. Kelly said she did and her GP refused, advised kelly she should respect this medical opinion and perhaps try to do without it and he said she is.

Informed her that her brother in his letter has asked me to phone him and asked her thoughts on this, she said she didn't care, phone him if i want. I informed her that out of courtesy i would return the call but conversation would be within the realms of confidentiality and i would not be disclosing any information about her but at the same time listening to her brothers concerns.

Kelly was seen by DR Stirling in january and no concerns raised re her mental health. As her suicidal thoughts, ie not immediate but an ongoing desire to cause herself damage and eventual death through her chronic use of painkillers so that she doesnt commit the sin of committing suicide, are long term and have not changed, and Kelly has no insight impairing illness impacting on capacity, there is no indication for immediate request for psychiatric OPA. Dr Stirling suggests that both myself and CN Boyd of addictions team jointly work Kelly and this may be more effective in executing the care plan. Have e-mailed John re this.

Have made call to Kellys brother [redacted] and have left message asking him to call CMHT if he wishes to discuss his concerns for Kelly further.

Assessed 5th Mar 2013 at 15:48

Summary of contact/details	

Please see scanned letter.

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

Assessed 5th Mar 2013 at 14:48

Summary of contact/details	
Joint visit to kelly with Ot Pauline Rourke. In entry, Kelly's cousin gave me a letter from Kellys brother, [redacted] - to be scanned onto FACE. The letter is dated 17/2/13 [redacted] informed Kelly i had been given the letter and she informed me she did not want to know what is said as her and her brother had fallen out. Kelly was trucculent in mood today, attributing this to "nothing ever going right", to feeling that "every time i move forward something happens to put me right back." She gave an example regarding her GP having changed her sleeping tablet from zopiclone to nitrazepam a while ago and that Dr Stirling had been aware of this but that later her Gp refused to prescribe her any more, saying Dr Stirling has not recommended it. She states that she is now drinking up to a bottle of vodka a night to help her sleep. She later told me she is also taking up to 60 codeine/paracetamol tablets per day. She feels that if she is prescribed a sleeping tablet she will be able to reduce her intake of painkillers again. She is ambivalent about suicidal thoughts, denies immediate intent but states she hopes sh dies through her lifestyle as she feels life is rubbish and she has no future. At the same time she is worried about abnormal results re her kidney function and says she is going to choose not to go to any offered hospital appts re this. In terms of her sleeping tablet, I agreed to make the medics aware of her feelings but stressed that they will not prescribe a sleeping tablet whilst she is taking that amount of painkillers. She has an appt with CN Boyd of addictions team on 14th march and i have asked her to discuss reduction with him but stressed that ultimately it is up to her. Spent some time discussing her taking responsibility for her actions and discussed with her that i am willing to help her strive towards change but that it will be counter productive if she does not take some responsibility for modifying her behaviours and i will discharge her if she does not commit to some changes. Discussed her having capacity for her choices she is making. Informed her i will enquire as to when I have asked her to give this some thought over the next few weeks before i come back.	

Assessed 5th Mar 2013 at 10:47

Summary of contact/details	
Joint visit with Tracey Harvey, CPN. See Entry by Tracey Harvey, CPN. Kelly stated that she does not feel able to engage in Occupational Therapy at present however is aware she may be referred in the future should her situation change. She will therefore be discharged present. No further intervention required.	

Assessed 18th Feb 2013 at 11:43

Summary of contact/details	
Admin phoned duty to make aware that Kelly had contacted was expecting to be seen by Tracy am however inform Tracy was on training Kelly hung up on Admin staff. duty information only at this point.	

Assessed 14th Feb 2013 at 14:26

Summary of contact/details	
Dear Kelly Just a wee note to confirm our next appointment	

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) **undefined** Female **CHI Number** 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

On: Tuesday 5th March 2013

At: 10.30am

In: Within Your Own Home

Please note my colleague, Pauline Rourke, Occupational Therapist will accompany me on this visit.

Assessed 14th Feb 2013 at 10:52

ummary of contact/details	
Called to see Kelly today - kelly highlighting i have also further appointed her and this would suit her better.	

Assessed 30th Jan 2013 at 15:36

Summary of contact/details	
Entry by St/n Fiona Reid read and noted to be accurate.	

Assessed 30th Jan 2013 at 14:14

Summary of contact/details	
Received phone call from Kelly looking for advise on her prescription for sleeping tablets. Kelly explained that her GP had recently changed her sleeping tablet due to side i.e. metallic taste in the mouth). Kelly was advised to contact GP again regarding this issue.	

Assessed 21st Jan 2013 at 15:39

ummary of contact/details	
Received phone call from kelly stating she has asked her GP to review her sleeping tablet as advised by Dr Stirling but her GP has refused unless notified by Dr Stirling, advised i do not have this information and advised she should either contact bentick centre herself or ask her GP to do so to resolve the issue.	

Assessed 21st Jan 2013 at 15:09

Summary of contact/details	
HV to Kelly. Kelly appears drawn and tired, as per her usual presentation. Spoke of her worries re her cousin [redacted] Kelly also disclosed that her sister received a phone call re their mum being dead. Kelly, due to being from a travelling family, and to her mum having a nomadic and chaotic lifestyle does not have any way of finding out if this is true or not, she has phoned the police who cannot help, she states no-one has heard from her mum for some time. Kelly continues to be concordant with having cut down the extra solpadeine tablets from 60 to 16 prescribed daily tablets. She saw Dr Stirling last week and is to continue with this with view to commencing a 6 month reduction from codeine. There is an issue with her sleeping tablets which i have advised her to speak with her GP about. Kelly spoke today of the impact her anxiety is having on her and how she wishes her life to change but then she begun to overwhelm herself with thinking of potential barriers. Advised to take things a step at a time. Advised i have discussed with OT	

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

laura, re how she did confirm her appt and laura has continued to Keep kelly on the waiting list for an appt to be offered. Discussed art group with Kelly but she declined this.

Kelly spoke of how she went to the hospital to see her cousin and how anxiety provoking this was for her but how she forced herself to cope. Agreed this showed that she can do it. Kelly disclosed that she took some diazepam to do this which i thought she meant was prescribed but she explained that no she had to buy this.

Further appt made for 3 weks time to see kelly again.

Assessed 15th Jan 2013 at 17:41

Summary of contact/details	

Received phone message via admin from kelly earlier today to cancel tonights appt and to keep original appt on Friday. Phoned kelly informed he i have already filled this space but will see her Monday 3.30pm at home. Kelly fine with this, explained it is because her cousin is critically ill and various family members are at her house.

Assessed 15th Jan 2013 at 14:21

Summary of contact/details	

KELLY PROWSE 23C FULLARTON STREET, KILMARNOCK, KA1 2QZ
CHI No: 1602890722

Diagnosis: F11.2 - Opioid Dependence

Psychiatric Medication: Dihydrocodeine 6 x 60mgs daily (in divided doses) (from Addiction Services)
Buscopan 20mgs twice daily (from Addiction Services)
Zopiclone 7.5mgs at night (from Addiction Services and non-compliant)
Nitrazepam 5mgs at night (from GP)

I saw Kelly at my outpatient clinic in the Bentinck Centre on the 15th January 2013. Her medication at time of review is as above.

She told me that Zopiclone had given her side effects in the form of a metallic taste in her mouth and she did not feel she helped with sleep. I understand that her GP prescribed Nitrazepam as above, but I am not sure what the duration of this was.

She said that she had not yet drawn up a management plan with her key worker. She had managed however to reduce her Co-codamol tablets down to 16 a day.

I have suggested we continue the Dihydrocodeine at 360mgs daily for the next three months and then reduce by 30mgs every 2-weeks. I have discontinued the Zopiclone but will continue the Buscopan as she finds this helpful. I would not be comfortable about prescribing her Benzodiazepines for sleep difficulties. I think it would be helpful if her key worker from Addiction Services could also meet with Tracy Harvey, CPN from the CMHT to co-ordinate supports.

She has been put down for an annual review or as requested.

Assessed 11th Jan 2013 at 19:02

Summary of contact/details	

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

Phoned Kelly inforemd her i have been requested to do a confirmation letter for pharmacy re her condition which i will submit later today. kelly saying she is feeling a bit better today but would still like to speak to me earlier due to some bad new she has recieved, appt arranged for Tuesday.

Assessed 11th Jan 2013 at 17:50

Summary of contact/details	

Following letter of confirmation hand delivered to Laura (supervisor pharmacy) Morrissons this evening11/1/13 -

CMHT
IWKAC
Western Road
KILMARNOCK
KA3 1NQ

Phone 01563 578592

To supervisor, Morrissons pharmacy.

Re - Kelly Prowse DOB - 16/02/89

Current Address - 23c Fullarton Street Kilmarnock. KA1 2QZ.

I am writing on behalf of the above lady in my capacity as CPN to confirm that she has an agoraphobic condition resulting in her having long periods of time where she suffers severe anxiety and cannot leave her home. Due to this she relies on family members to collect her prescription.

.he family members she identifies as able to assist her are -

- [redacted]

Kelly contacted me yesterday distressed re not being able to collect her prescription and her relative being refused it when he presented at Morrissons pharmacy for it.

My colleague Charge Nurse Young discussed with one of your team last evening. I have therefore been asked to speak with the supervisor, Laura, re this and to put in writing confirmation of Kellys condition in order for her relatives to collect her prescription.

Yours Sincerely

Tracy Harvey CPN

Assessed 10th Jan 2013 at 18:13

Summary of contact/details	

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) **undefined** Female **CHI Number** 1602890722

History for Summary of contact

From 11/05/1926 **Until** 11/05/2026

-finally made phone call with Morrisons pharmacist who told me that her manager had made the decision.
-she had noticed that different people were collecting prescription and had put a note in her file to say that Kelly needed to collect it herself.
-she was apparently unaware of Kelly's problems.
-pharamcist said she would sanction someone collecting tonights prescription but would require Tracy to phone pharmacy manager, Laura, after 2:00pm tomorrow to discuss situation.
-Kelly informed.

Assessed 10th Jan 2013 at 16:59

Summary of contact/details	
Kelly phoned to say that her cousin has been to Morrissons to collect her prescription as he has doen this for the last 3 weeks and has been refused same, that she must collect it herself. Due to kellys agoraphobia, i said i would phone and ask if they would reconsider this. However constantly engaged. I will ask duty nurse to phone. Informed kelly she will have to phone duty back in half hour and collect it herself if duty nurse has had no answer.	

Assessed 11th Dec 2012 at 17:30

Summary of contact/details	
Hv to Kelly today. kelly appeared more reactive in mood today. Denies any suicidal thoughts. Stated she has been benefiting from dihydrocodiene prescription from addictions in that she is using half the amount of bought painkillers she used previously. Is worried about some sweling she has on one of her kidneys became tearful when discussing this and spoke of her fears of the damage she is doing to herself with painkillers. Spoke of the anniversaries of bereavements being last week and next week, and is appropriately sad re same. Spoke of her house and how she is looking for a new private let as she does not feel safe in her flat due to the buzzzer constantly going off at the weekend and other tenants having parties. She has told the council about this. Wishes her sleeping tablet to be reviewed due to after taste of zopiclone, but does not wish temazepam as this does not work for her. Advised to put on GP appt and i will e-mail GP inform them that she is requesting this reviewed. Kelly spoke of having been to see)R Stirling. Kelly spoke of pressure from her family, she has fallen out with her dad and her cousin is staying with her (this was not negotiated with Kelly but helps with the rent which her dad previously paid). Kelly struggles with change to her routine and described recently putting her foot through a table and breaking the glass in the doors because her cousin moved the couch. She said her anger is a huge problem for her, but that she largely manages to conceal this. She says her anger is like her dads - that she has seen him hurting people and she fears being like this. Discussed pressure from her family to let her mother-[redacted], to stay with her, Kelly described when she has let her mum stay with her previously her mum has stolen from her. Kelly described feelign tron becasue she knows her mum staying with her would be destructive for her but she feels she knows she will get a phone call one day to say she is dead. Kelly spoke of the future for the first time today, she said she wants to get better and have a life again. She used to be busy for instance at christmas, but just now feels she couldnt cope with it and prefers being alone although she admits she is lonely. Also spoke of times in the past when she had happy times, which is also new for her. Kelly agreed going out is good for her, and continues to go out for her meds and shopping at quiet times. States she is often so anxious she cant remember this. Agrees to go to physiotherapy if i refer her and agrees for me to speak with OT re remaining open. I informed Kelly i feel her mood is improving as she reduces the painkillers and she agrees. Further appt made at home for the new year. Discussed with OT Laura who will offer kelly opportunity for a further appointment. referral to physiotherapy done.	

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

Assessed 28th Nov 2012 at 10:58

Summary of contact/details	
Dear Kelly I received your message cancelling today's appointment. I would like to offer you a further appointment with myself On: Tuesday 11th December 2012 At: 11am In: Within Your Own Home If this appointment is not suitable, please contact me on the above number to re arrange.	

Assessed 27th Nov 2012 at 12:02

Summary of contact/details	
Received message from CMHT receptionist that Kelly has phoned and cancelled her appt for this afternoon. Kelly gave no reason for this other than "I just don't want to see her today". Writer will send Kelly another appt.	

Assessed 22nd Nov 2012 at 15:23

Summary of contact/details	
Kelly cancelled her appoitnment today due to feeling unwell. Also requesting for Dr Stirling to discontinue sleeping tablet due to metallic aftertaste. Writer wil discuss same wit hDr Stirling at earliest convenience.	

Assessed 20th Nov 2012 at 15:11

Summary of contact/details	
Dear Kelly I hope this letter finds you well. I apologise for having to cancel our last appointment, due to unexpected leave. I can offer you a further appointment with myself On: Tuesday 27th November 2012 At: 3.30pm In: Within Your own Home If this appointment is not suitable, please contact me on the above number to re arrange. I look forward to seeing you then.	

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

Assessed 15th Nov 2012 at 15:53

Summary of contact/details	
Kelly attended arranged appointment. running late due to the taxi running late to bring her to the appointment. Looking clean and well kempt as usual. Kelly reports she is still buying 2 packets of tablets per day but using only 1 pack (32 tablets) per day. Explored the reasons for this and it appears to be an entrenched habit/behaviour that has given her the escape from day to day life she had been looking for. Kelly reports she has chronic free floating anxiety. She reports it doesn't matter where she lives she struggles to go outside at all because being outside is unsafe. Writer explored how unsafe it potentially can be being inside however, Kelly adamant she will continue to go outside when only it is necessary. Explored CMHT notes re psychology input and he has been put on the waiting list to see a clinical psychologist. Writer also noted potential OT input however, Kelly had not esponded to a letter sent from CMHT OT and therefore had been discharged from their care. I have asked Kelly to discuss a further referral with C/N Tracey Harvey as addictions OT is currently on A/L and will not be back until the end of the month. On Heather's return I will discuss the possibility of OT input regarding anxiety management. With regards to her ongoing over the counter tablet abuse, i have asked Kelly to stick to the minimal amount of OTCtablets. SHe reprots thsi as being a 16 pack of 8/500 co-codamol tablets costing £1.02. Writer explained that because Kelly reprots that is the absolute minimum she has in the past functioned on, we can start here with a view to reducing this tablet use gradually. Kelly not keen on the idea but understood writers rationale. Reluctantly accepting of same. Writer also highlighted to Kelly that sooner or later she is going to have to take control and responsibility for the decisions she is making. SHe is utilising addictions services in order to address and cease the OTC tablet abuse and as long as she continues to buy and use the tablets without a second thought then the chances of success of this intervention will be minimal. Kelly reporting she is committed to stopping the OTC use due to recent bereavements in the family.	

Assessed 13th Nov 2012 at 11:58

Summary of contact/details	
Writer attempted to contact Kelly on the number listed on FACE at 1030. Call went straight through to message saying number vas unavailable. Writer attempted to call again at 1145h and was met with same response. Writer will not attempt to call again oday but will see Kelly at her appointment on the 15/11/12	

Assessed 9th Nov 2012 at 11:51

Summary of contact/details	
Telephone support to Kelly as arrange through myself and Dr Stirling. Kelly reports that she believes the new prescription regime is helping her. She states she has bought only 1 x 16 over the counter preparation of painkillers containing codeine. Advised Kelly this was a very positive step and something she should be looking to continue to decrease. Writer reminded Kelly of the options that were discussed at her appointment with Dr Stirling including potentially being prescribed methadone if the dihydrocodeine stabilsation/reduction was unsuccessful. Kelly remains adamant that she does not want to go down the methadone prescription route of treatment. No other concerns voiced and Kelly reminded of next telephone contact due 13/11/12 at 1030h	

Assessed 8th Nov 2012 at 13:27

Summary of contact/details	
Dear Kelly As Tracy Harvey, CPN, is currently on sick leave, it is necessary to cancel your appointment on 8th November 2012. You will be re-appointed in due course.	

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) **undefined** Female **CHI Number** 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

If however, you wish to speak to another member of staff, please do not hesitate to call the number above.

I apologise for any inconvenience this may cause.

Yours sincerely

Denise Smith
TEAM SECRETARY

Cc: Dr Prowse 31 Portland Road Kilmarnock

Assessed 7th Nov 2012 at 16:58

Summary of contact/details
Called via duty. Charge Nurse Harvey. Currently on sick leave. Kelly aware to call if needed.

Assessed 6th Nov 2012 at 15:46

Summary of contact/details
KELLY PROWSE 23C FULLARTON STREET, KILMARNOCK, KA3 2QZ CHI No: 160 289 0722 Diagnosis: F11.2 - Opioid Dependence Psychiatric Medication: NIL prescribed by Addiction Services I saw Kelly at my outpatient clinic in the Bentinck Centre on the 6th November 2012. I will not go over all her history again in this letter as this has been well documented before. She told me she was taking 8-Codeine Phosphate tablets daily as well as 64-Co-codamol tablets daily. She told me that she was buying the Co-codamol but prescribed the Codeine from yourselves. She gave a history consistent with Opiate dependence. She was quite adamant she did not wish to be prescribed Methadone and her mental health difficulties would make me quite cautious about Suboxone. I did agree to try and stabilise her on: " Dihydrocodeine 6 x 60mgs daily " Buscopan 20mgs twice daily " Zopiclone 7.5mgs at night I will ask for feedback on her progress. I would be grateful if you could discontinue any Codeine or Opiate Analgesics.

Assessed 6th Nov 2012 at 12:09

Summary of contact/details
KELLY PROWSE 23C FULLARTON STREET, KILMARNOCK, KA3 2QZ CHI No: 160 289 0722 Diagnosis: F11.2 - Opioid Dependence Psychiatric Medication: NIL prescribed by Addiction Services

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

I saw Kelly at my outpatient clinic in the Bentinck Centre on the 6th November 2012. I will not go over all her history again in this letter as this has been well documented before. She told me she was taking 8-Codeine Phosphate tablets daily as well as 64-Co-codamol tablets daily. She told me that she was buying the Co-codamol but prescribed the Codeine from yourselves. She gave a history consistent with Opiate dependence.

She was quite adamant she did not wish to be prescribed Methadone and her mental health difficulties would make me quite cautious about Suboxone. I did agree to try and stabilise her on:

" Dihydrocodeine 6 x 60mgs daily
" Buscopan 20mgs twice daily
Zopiclone 7.5mgs at night

I will ask for feedback on her progress. I would be grateful if you could discontinue any Codeine or Opiate Analgesics.

Assessed 5th Nov 2012 at 16:14

Summary of contact/details	

Dear Dr Pugh

Re: Kelly Prowse DOB: 16/02/1989 CHI: 1602890722
23c Fullarton Street, Kilmarnock KA1 2QZ

Kelly was referred to Occupational Therapy by June Collins, Community Mental Health Nurse. Kelly was recently sent a letter asking her to make contact to confirm details of an assessment appointment, however, she did not get in touch to confirm attendance.

Kelly has therefore been discharged from Occupational Therapy, however can be re-referred in the future if appropriate.

Yours sincerely

Laura Campbell
OCCUPATIONAL THERAPIST

Assessed 31st Oct 2012 at 16:41

Summary of contact/details	

Dear Dr Pugh

KELLY PROWSE CHI No: 160 289 0722 23C FULLARTON STREET, KILMARNOCK, AYRSHIRE, KA3 2QZ

Kelly did not attend her out-patient review appointment with me on 31 October 2012. I note that when she was seen by my colleague, Dr Kessavalou, in the clinic at the end of August 2012 he diagnosed generalised anxiety and opiate dependence. I also note that he did not feel that prescribing was appropriate for Kelly and that follow up had been arranged through CPN, OT and Psychology services.

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

It seems that out-patient review would have little to offer Kelly that she is not receiving from other sources and therefore I will not send her a further appointment. She has been discharged from the clinic.

Kind regards

Yours sincerely

Authorised on 05/11/2012 09:06:29 by Morag Henderson.

Dr M Henderson
Consultant Psychiatrist

cc June Collins, CPN
Laura Campbell, OT

Assessed 26th Oct 2012 at 08:53

Summary of contact/details	

Hv to kelly. Her cousin came in when i was in, as Kelly states he does every day to check she is Ok. Also Kelly states he uncle was in this morning to check on her. Kelly states she is fed up with their concern but at the same time understands her abuse of tablets causes them concern. Kelly stated that she recieved a full 2 weeks supply of her tablets on Monday (should have been daily dispensed) and has taken them all, about 100 codiene tablets. States she has not taken any paracetamol based tablets. States she normally takes more tablets when she receives her daily prescription as she will then buy paracetamol based codeine tablets to augment her prescription. Has no more prescribed tablets for the next two weeks and plans to buy them if her GP won't prescribe any more. has been to her GP today re ongoing kidney pain and has had bloods done for kidney and liver function. Denies any other form of self harm, still maintains she wishes to kill herself accidentally due to feeling no enjoyment in her life and expecting "everything goes wrong" and "i will always get hurt", states this is based on the belief that she can't trust anyone. Kelly discussed her upbringing a little in relation to her trust issues - she described going from one foster home to another and when she was in one where she felt happy and the foster parents were planning to adopt her and her siblings, the man then died and then so did his wife. [redacted]

kelly states her relationship with her boyfriend broke down earlier this year as she "just cant be happy".
Kelly states she chooses to stay in the house as she has control of who comes in and can keep herself safe. Has applied for a council house as she has neighbours who are noisy and often come to her door to borrow things and she feels unsafe due to this intrusion.
Discussed with kelly focusing on -
1/ working with addictions to detox from pain killers.
2/ working with me and OT on anxiety management.

Left Kelly some literature on symptoms of anxiety and a HADs scale to complete for our next appt in two weeks time.

Assessed 22nd Oct 2012 at 14:08

Summary of contact/details	

Dear Kelly

You previously received a letter informing you that you were on a waiting list for Occupational Therapy Assessment.

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

An appointment has now been made available for you. Please contact me on the above number if you would like to know details of this appointment and confirm your attendance.

If you do not contact us by 29th October 2012, your appointment will be re allocated to someone else, and you will be discharged back to your referrer.

I look forward to meeting with you.

Yours sincerely

Laura Campbell
OCCUPATIONAL THERAPIST

Assessed 18th Oct 2012 at 12:54

Summary of contact/details	
Dear Kelly As we discussed on the phone, I would like to offer you an appointment with myself On: Thursday 25th October 2012 At: 3.30pm In: Within Your Own Home this appointment is not suitable, please contact me on the above number to re arrange. I look forward to seeing you then.	

Assessed 9th Oct 2012 at 09:32

Summary of contact/details	
Telephone call to Kelly to offer her a cancellation appointment with Dr Stirling for this afternoon. Kelly declined the appointment citing having no one to accompany her as the reason. Kelly accepting of next routine appointment with Dr . Stirling on the 6/11/12.	

Assessed 3rd Oct 2012 at 17:50

Summary of contact/details	
Received phone call from Kelly stating that she is attending her granpas funeral tomorrow and therefore cancel our appt. Same to be rearranged.	

Assessed 3rd Oct 2012 at 16:48

Summary of contact/details	
Clinical email sent 03/10/2012 assessment	

Prowse, Kelly

CHI Number 1602890722 **Date of Birth** 16-Feb-1989 (37y)
Sex Female

Ayrshire Mental Health Risk Assessment Framework

Date of Activity 02 October 2012 16:06 by Mr John Boyd **Status** Closed
Centre of Care East Ayrshire RADAR

Ayrshire Mental Health Risk Assessment Framework

Assessment completed by

Individual clinician

Mental state

Mental state

Amber

Engagement

Engagement with services

Green

Medication management

Red

Risk of absconding

Amber

Risk of suicide/self-harm

Risk of self-harm

Red

Risk of suicide

Red

Risk of harm to or from others

Risk of harm to others

Green

Abuse issues

Amber

Neglect/Vulnerability issues (consider ASP/AWIA)

Green

Child protection concerns

Green

Risk from substance misuse

Substance misuse

Red

Social and personal risks

Support network

Green

Physical health

Green

Occupation of time

Amber

Housing and finances

Green

Any other issues

Green

Overall Impression of Risk

Amber

Immediate Risk Management Plan

Immediate Risk Management Plan

Crisis arrangements appear to be already in situ from CMHT and Crisis Team

Addiction Service Assessment V2

Date of Activity 02 October 2012 16:05 by Mr John Boyd **Status** Closed
Centre of Care East Ayrshire RADAR

Referral

New referral to service

Yes

Reason for referral

Reason for referral

Substitute medication

Brief intervention

No

Patient's reason for attending

Wanting to address current over the counter drug misuse.

Summary of strengths, goals and aspirations

Not Recorded

Current contact with other services

Yes

Previous involvement with services

No previous service involvement

Risks

History of risk

Yes

Risk to self

Significant risk

Risk to others

No apparent risk

Risk to child

No

Risk from others

No

Gender based violence

Was routine gender based violence enquiry carried out?

No

Why was gender based violence enquiry not possible?

Not relevant as already carried out

Did disclosure take place?

No

Substance career

Teens

Cannabis, speed ecstacy (one off) alcohol

20's

Codeine over the counter

30's

-

40's

-

50's

-

60's

-

History

History of presenting complaint

Significant family history

Yes

Significant social history

No

Is there a dependent child?

No

Child protection issues

Absent, no known history

Housing

Mild problem

Physical health

Physical health

Abdominal pain from laparscopy some 2 years ago to remove a blockage and scar tissue from ?1 fallopian tube. ALso reports kidney problems from when she was 3 years old. ?valve missing from kidneys that causes urine to over flow and causes frquent kidney and urinary tract infections.

Seizure activities

No

Current medication

Reported only Codeine phosphate 30mg x 8 per day from GP. Informed writer GP had discontinued anti depressant medication following recent overdose.

Psychiatric history

Reports history of anxiety

Current mental state

Generally poor

Forensic history

1 Incident

Assessment

Current substance use

Up to 64 OTC tablets of paracetamol or ibuprofen based analgesics containg codeine over and above prescribed 8 x 30mg codeine phosphate tabs per day.

Clinical Institute Withdrawal Assessment score

-17

The Alcohol Use Disorder Identification Test (AUDIT)

Total incidence

-17

Mini Mental State Examination

Mini Mental State score

-17

Addenbrooke's Cognitive Examination - ACE-III

ACE-III total score

-17

Domain Scores

Attention

Not Recorded

Memory

Not Recorded

Fluency

Not Recorded

Language

Not Recorded

Visuospatial

Not Recorded

Summary of Assessment

Summary of Assessment

Kelly attended arranged assessment appointment with her friend. Kelly appearing clean and well kempt and dressed appropriately for gender season and weather. Kelly was referred to the service from CPN Tracy Harvey from EACMHT as Kelly is buying and using up to 64 OTC paracetamol and/or ibuprofen based analgesics containing codeine. She reports this has been ongoing for 2 and a half years.
Kelly reports she has had 7 family bereavements in as many years and says she has not dealt with these issues. She has contact with her brother and cousins but has no contact with either birth parent.
Kelly lives at her private let accommodation in Fullarton Street alone, although her brother and cousin do visit frequently due to nuisance neighbours.
Kelly says she wants to stop using the illicit drugs, but is unwilling to to do so because she enjoys the feeling it gives her. She describes it as being wrapped in cotton wool. Writer explored this with her and she did admit to experiencing troubling thoughts from past issues but would not elaborate on these.
Kelly reports wanting to die. She says her faith dictates that her soul will go to hell if she commits suicide, but if she kills herself slowly through prolonged use of OTC analgesia it would be recorded as accidental overdose. She reprots having a plan "to a point" but refused to elaborate on the plan when asked. Kelly also reports self harming through self cutting of legs.
Kelly is unwilling to consider Methadone as she states she doesn't want to substitute one substance for another. Writer highlighted that although methadone itself is a potentially dangerous drug, what she is currently doing could be argued to be more destructive due to the massive amounts of paracetamol she is ingesting.
Kelly was tearful at times and very guarded about past issues and refused to disclose and information. SHe did admit there were issues however. Her mood appeared low and she reports symptoms of anxiety on a daily basis and reports her last panic attack was on Saturday. No evidence of psychotic symptoms in any form thoroughout.

At end of assessment Kelly was able to admit she felt there was an opportunity fer her to address not only her substance issues but other issues that she is trying to block out by using the OTC analgesia.

Action plan

1. Discuss with C/N J MacPhail if there is any interventions that can be provided from a relapse team perspective
2.Contact GP and Tracey Harvey to update them on today's assessment.
3. Arrange appointment with Dr Stirling or Dr Laraway and discuss possible prescribing interventions i.e.. dihydrocodeine to alleviate risk from paracetamol poisoning.

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

Assessed 2nd Oct 2012 at 16:54

Summary of contact/details	
See assessment notes for contact details	

Assessed 26th Sep 2012 at 10:17

Summary of contact/details	
-Kelly seen at clinic as arranged. Informed writer that her grandfather had died unexpectedly yesterday. [redacted] Kelly concerned that she will be unable to attend his funeral in England next week. She might be able to get a lift from a cousin but is unsure if she would be able to cope with the stress of the funeral. Is going to ask her general practitioner for a short course of diazepam to enable her to attend. Discuss alternatives if unable to go. Kelly felt that at a later date she would be able to visit her grandfathers grave to pay her respects. However, is worried that he will be cremated and is distressed at the thought of his body being burned. Feeling that she is now in a pattern of family members dying regularly at this time of year. Would like to take some pills but does not have access to this. Has been using body piercing as a form of safe self harming. Has not been cutting herself. Continues to buy street drugs to top up prescribed medication, is aware of the risks of doing so. Has appointments with addiction services and Tracy Harvey next week. Is aware of contact numbers for the team and will utilise these if support is required prior to next appointment.	

Assessed 20th Sep 2012 at 16:38

Summary of contact/details	
Please see scanned CORE form.	

Assessed 18th Sep 2012 at 11:53

ummary of contact/details	
SEE ATTACHED REFERRAL	

Assessed 17th Sep 2012 at 12:47

Summary of contact/details	
Phone message left by Kelly to cancel today's appointment as she is waiting for her general practitioner to sign prescription for diazepam. New appointment to be sent.	

Assessed 14th Sep 2012 at 16:20

Summary of contact/details	
Discussed with CN Boyd of addictions team and referral has been made to addictions team for discussion at their meeting re kellys options of support for detox.	

Assessed 14th Sep 2012 at 15:22

Summary of contact/details	

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) **undefined** Female **CHI Number** 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

Hv to kelly. No change in Kellys presentation, continues to isolate herself in the house. Describes having an upsetting week in that her two sisters from England came to see her and expected her to want to have a house party. Kelly struggled with this and asked them to leave, resulting in other family members getting involved and apparently laughing at her and saying she should be in hospital. Reinforced to kelly that she did the right thing to ask them to leave and also that she had coped without deliberately overdosing which was progress.

Kelly continues to take codeine to excess - up to 30 or 40 tablets per day. Her GP has commenced her on a daily pick up, her brother is collecting them for her. She feels she cant cope on her prescribed dose and therefore her brother continues to buy her extra tablets.

Informed Kelly i had discussed admission for detox with consultant at team meeting but this is not felt to be clinically indicated at present. Discussed how consultants agreed medications should be prescribed on daily pick up. Discussed with her that i have spoke with CN Boyd of addictions team and that one option of home detox may involve methadone being prescribed as a substitute and the other option may involve reducing through GP herself with support from Turning Point. Kelly does not want to do methadone substitute prescribing but would like the other option of support.

Informed Kelly i had completed report for DLA for her and sent it away today.

Informed Kelly i am going on 2 weeks AL and that CN Collins would see her in my absence.

Appointed for my return.

Discussed small goals she can attempt meantime - like opening her curtains or not keeping her dressing gown all day.

Assessed 13th Sep 2012 at 09:56

Summary of contact/details	

Dear Kelly

As Tracy Harvey, Charge Nurse is currently on leave, it is necessary to cancel your appointment on Thursday 13th September 2012.

However, she would like to offer you a further appointment

On: Friday 14th September 2012

At: 2pm

In: Within Your Own Home

If this appointment is not suitable, please contact the above number to re arrange.

I apologise for any inconvenience this may cause.

Assessed 12th Sep 2012 at 16:30

Summary of contact/details	

Duty

~~~~

Due to unforeseen circumstances appointment arranged for Thursday 12th Sept 2012 with Tracy Harvey will need to be cancelled.
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Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) **undefined** Female **CHI Number** 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

Telephoned at home and offered appt for Friday 14th Sept 2012 at 2pm with Tracy Harvey at home, Kelly agreed to this.

Assessed 12th Sep 2012 at 13:09

Summary of contact/details	

Dear Kelly

I would like to offer you an appointment with myself

In: Monday 17th September 2012

At: 12.30

In: North West Kilmarnock Area Centre

If this appointment is not suitable, please contact me on the above number to re arrange.

Assessed 7th Sep 2012 at 10:11

Summary of contact/details	

DISCUSSED AT MDT MEETING -

Kelly Prowse - 1st presentation, lady in her early 20's, who has trauma related presentation with associated self harm. She has been taking Codeine, between 30-40 per day & also taking paracetamol on top of this on occassion. States this is because she would not deliberately kill herself as she is religious and believes she would go to hell. However, ambivalent about this happening accidentally. She is not presenting as depressed or psychotic, has been assessed by Dr Kessavolou last week. Tracy plans to liscuss with Addiction Services re potential codeine detox. Very isolated since breakdown of relationship and wont engage with RT. Tracy is presently seeing her on a weekly basis, as she has presented at A&E twice following overdoses in the past month . Tracy has discussed with her hospital admission due to isolation and risk. Dr Kessavolou feels this would not be beneficial in the longer term and her religion is a protective factor for her but if risk increases in terms of definite plan or intent then this can be reviewed . Dr Henderson suggested Tracy contact her GP & discuss a daily dispense for her, as this will also encourage her to get out the house.

Assessed 5th Sep 2012 at 17:31

Summary of contact/details	

Home visit to kelly. With prompting Kelly re-iterated to me how she had taken the overdose last week due to feeling "there was just no point". She also spoke of her brother working more hours and also her ex boyfriend has a new girlfriend both of which are impacting on her mood. Kelly admits to ongoing thoughts of suicide but denies any intent at present. Her thoughts are around overdosing and of "just walking in front of a bus". Again denies any plan of doing this. I asked Kelly about her overuse of codeine tablets and she confirmed she takes about 32 codeine tablets a day and when feeling anxious in reaction to stressors she takes over the counter paracetamol, states she took 32 a few days ago and does this frequently. She confirmed that she does this as it would be an acceptable way in terms of her Christian religion to die but to obviously kill herself would result in her going to hell. Discussed her ambivalence around suicide and she said she does not want to go to hell. Discussed her religion being a safety behaviour for her. She states however she dos not get comfort from it at present though as she feels guilty re her thoughts. States she cannot speak to fellow members due to this.
Discussed detox from codeine based tablets and Kelly is keen for this but feels it would be safer in hospital as she uses codeine as a coping mechanism to cope with her anxiety. Agreed this may be an option but informed her of role of addictions team and she

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

agreed to be referred, same to be done (will request joint visit with me to discuss options).
Discussed "Break the silence" but Kelly not keen for this. Discussed her isolation and agoraphobic symptoms and phone call made on her behalf to OT to confirm she wishes to remain on the waiting list. Also suggested referral to SW re support worker to help her motivate herself in the house but Kelly also declined this. Discussed role of CRT also and Kelly declined this at this time. She states she could not have males visiting her and finds it difficult to trust people. Kelly is keen for hospital admission and says her brother was considering "signing her in" . Advised this would not be the case as she has capacity for her decision making. However, i do think an arranged hospital admission to look at detox in a safe environment may be helpful. I stated i would discuss this with consultant but that there are pros and cons to this and it ws not definite. Also discussed CRT input whilst she is being detoxed being another option.
Kelly presented as reactive in mood today but sad and hopeless re her perceived inability to move on / cope. Said her house is her safe zone. Eating and sleeping reasonably. tearful at times but responsive to reassurance. Has insight into her heightened anxiety last week being due to her brother being working and her ex having new girlfriend. Identified several anniversaries of bereavements between sep and Dec where she predicts she will be vulnerable. Discussed how support of team could help her cope with this. At present has supportive visits form her brother a couple of times a week and her uncle visits her once a week, she receives a phone call from fellow Christians twice a week.
Agreed to visit from me next week and reminded of details of duty system should she require to speak to duty nurse should her suicidal thoughts increase in intensity.

Assessed 3rd Sep 2012 at 14:48

Summary of contact/details	

Ms Prowse attended her appointment as planned today to screen her suitability for psychological intervention. Please see scanned correspondence and ARAF for further details. Assessment and proposed plan discussed and agreed with psychology colleagues during planned break in assessment.

It was discussed with Ms Prowse that psychological intervention may be helpful in the future and it was thus agreed that she would be placed on the Clinical Psychology treatment waiting list as it is approximately a one year wait at this time. It was discussed that she has been referred to Occupational Therapy and it was discussed it would be helpful for her to engage a behavioral intervention to help structure her day and improve her social support as she appears to have limited strategies for managing her distress. She was also encouraged to engage with planned reduction in codeine as it was discussed that she would be unable to benefit from psychological intervention if her current level of use persist. When a Clinical Psychologist becomes available for treatment her level of motivation and engagement with intervention offered from Occupational Therapy and nursing within the CMHT will be considered to determine where she could benefit from, and is ready to engage in, a high intensity psychological intervention. Ms Prowse was agreeable to this. Discussed the importance of looking after herself after the session given some of the unpleasant experiences she discussed during the assessment. Ms Prowse stated that her brother was collecting her from the session and she informed me that she was planning to spend time with him today.

Given her presentation I discussed her case with colleagues in the crisis team and we then discussed her presentation with Tracey Harvey, CPN given that she is known to Tracey. Tracey felt that her presentation today was similar to how Ms Prowse presents during her contact whereby she will present with feelings of hopelessness, express suicidal ideation and can be observed to be low and tearful. Tracy also informed me that she was seen recently by Dr Kessavolou. It was agreed that the most appropriate risk management plan, given that there did not appear to be a change to her presentation and given that Ms Prowse has no current plan to end her life, would be for Tracy to continue with planned appointment with Ms Prowse on 5th September and for Tracey to liaise with crisis following this if she felt that additional input was required. Telephoned Ms Prowse and informed her that I had discussed with colleagues and we felt that no additional input would be helpful at this time and re-iterated her next appointment with Tracey and the above discussed plan with regards to future treatment within the team. Also re-iterated services she can contact in the interim if she notices a deterioration in her symptoms/feel unable to keep herself safe and encouraged her use of such supports. Ms Prowse stated that her brother would contact on her behalf if needed given that she finds it difficult to utalise the duty service.

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

Assessed 3rd Sep 2012 at 11:47

Summary of contact/details	

Dear June

RE: KELLY PROWSE DOB: 16/02/1989 CHI: 1602890722
23C FULLARTON STREET, KILMARNOCK KA1 2QZ

Thank you for referring the above mentioned lady to the Psychology Speciality Service within East Ayrshire Community Mental Health Team. I met with Ms Prowse on 3 September 2012 in our assessment clinic, to screen her suitability for psychological intervention. Please find outlined below a summary of my assessment and proposed recommendations.

Presenting Problems
Ms Prowse stated that she has experienced difficulties with anxiety "all through (her) childhood" however, stated that it has "taken over" in the last six months. Ms Prowse identified the trigger to the exacerbation of her difficulties with anxiety to be the ending of a romantic relationship. She stated that she was with her ex-partner for five years and stated that the relationship ended due to the impact her anxiety was having on their relationship and her partner "wanting to be with someone normal". Ms Prowse stated that since this time, she has been unable to leave the house. Prior to this, Ms Prowse described being able to leave the house with her partner however, stated that she continued to experienced anxiety when outside and in the company of other people. It would appear that her anxiety is related to concerns that "something bad is going to happen", for example, that she may be sexually assaulted. Ms Prowse described a perception that "world is a bad place" and reported feeling "wary" of people and reported finding it difficult to trust others. Ms Prowse also reported difficulties with excessive worry about "bad things happening" to her and to those that she cares about. She stated that she is particularly concerned about cancer. She described selective attention to internal bodily processes and reported catastrophically misinterpreting any changes in her body to be cancer.

Ms Prowse described her mood to be "very low" and stated that it has been particularly low over the last two months. Ms Prowse described her low mood to be characterised by lack of motivation, negative thoughts about herself, other people and her future in addition to behavioural withdrawal. Ms Prowse reported that she has been experiencing suicidal thoughts on a daily basis over the last two months. She reported taking an overdose of medication one week prior to our appointment. It would seem this was triggered following her discovery that her ex-partner had a new girlfriend in addition to an argument with her father. Ms Prowse stated that she decide to take an overdose of medication on the Thursday however, she stated that she was unable to carry out her plan as she was not alone until the following Monday. She stated that she attended a GP appointment to discuss her medication on the Monday morning. She stated that she left the surgery when her GP was telephoning the duty system due to feeling anxious. Mr Prowse stated that she retuned home and proceeded to take an overdose. Ms Prowse stated that her brother had an "inkling" that something was "not right" and asked her cousin to check on her. She stated that her cousin came to her house and contacted her brother to say that she had seen an empty packet of medication in the bin. It would appear that her brother subsequently contacted her sister-in-law who then telephoned an ambulance. Ms Prowse reported a belief that the medication she had consumed would be lethal and she expressed ambivalence about surviving. Ms Prowse also reported taking another overdose of medication around six weeks ago.

Ms Prowse stated that she continues to experience suicidal thoughts however, denied any current plans or having taken any steps to end her life. She was unable to guarantee that she would not take another overdose however, stated that she does not have access to medication at home other than that prescribed by her GP which I believe to be on a daily pick up of 30mg of Codeine per day. She stated that her brother has limited her money so that she is unable to buy over the counter medication and she reported that she would be unable to obtain this herself due to being unable to leave the house unaccompanied. Mr Prowse stated that her brother has "ordered" other family members not to bring her medication as she previously fabricated that she was experiencing physical pain and would request her family to bring her pain killers. Ms Prowse also stated that she is a Christian and ending her life is against her religion. She reported that she has considered taking an overdose to end her life as this may be seen as an

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) **undefined** Female **CHI Number** 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

"addiction" or an "accident" and not suicide. She reported feeling hopeless that her mood can improve and stated that she was thinking of other ways to end her life so that it would not be perceived to be suicide however, had not managed to think of any other methods.

Ms Prowse also described difficulties with "her temper". She stated that she had on occasion been verbally abusive and is frightened that she may hurt someone in the future and therefore attempts not to "lose it". She reported such concerns to be contributing to her anxiety as regards to leaving the house independently. Mr Prowse reported charges when she was 14 for assaulting her brother's girlfriend. Ms Prowse reported feeling remorseful with regards to this and stated that "she felt terrible". She stated that she has not been physically aggressive as an adult and she denied experiencing any thoughts of harming others.

Ms Prowse also reported experiencing "flashbacks" in relation to her previous abusive experiences [redacted] in addition to an alleged rape when she was 16-years old. She also reported experiencing flashbacks to her foster father dying in hospital. Ms Prowse stated that she began using cannabis as a teenager to cope with the memories of such experiences. She stated that the last time she used cannabis was one year ago. Ms Prowse stated that previously self-harmed by cutting when she was younger in order to manage the painful emotions that she experiences in relation to memories of her early life experiences. She stated that she has not self-harmed for two years as it "does not work" and denied any current thoughts of deliberate self harm. At present, Ms Prowse describes using "loads of pain killers" to manage memories of her past and to "get them out of her mind". Ms Prowse is currently abusing codeine phosphate and reported using up to 32 tablet per day. She stated that she experienced withdrawal symptoms when she attempted to remain abstinent for four days. Ms Prowse stated that she is motivated to reduce her codeine misuse and reported that she has consulted her GP to discuss a planned reduction. However, she described limited confident in her ability to do this stating that she has used some substances all her life to cope with emotions.

History of presenting complaint

From viewing Ms Prowse's FACE record it would seem that she was initially referred to Mental Health services in Ayrshire and Arran by her GP in May of this year. It was noted in the referral that she was suffering from paralysing anxiety and it was noted that she often does not get out of the house. She was initially seen by June Collins in June 2012 when Ms Prowse reported difficulties with anxiety over the past year. It was agreed that she would commence anxiety management work with her community psychiatric nurse and in addition a referral was made to Occupational Therapy and Psychology. It would seem that Ms Prowse was seen by sychiatric liaison services in July 2012 following an intentional mixed overdose of Paracetamol, Codeine and Diazepam. It was felt that Ms Prowse appeard to suffer from increased panic anxiety along with OCD traits and she was discharged with follow up from the Community Mental Health team. She was subsequently seen on two occasions by Tracy Harvey, Community Psychiatric Nurse and it would appear that low intensity anxiety management was discussed. In addition, Ms Harvey referred Ms Prowse to outpatient psychiatry appointment for review of her medication. Ms Prowse was subsequently seen by psychiatric liaison services in August 2012 following an apparent overdose of prescribed / unprescribed medication taken with suicidal intent. She was subsequently discharged with CMHT follow up.

Background

Ms Prowse stated that she is second eldest of a sib-ship of four, with an elder sister and a younger sister and brother. She stated that she grew up with her mother and father and lived with them until she was eight years old. She reported moving around Scotland regularly during this time. [redacted] She stated that she has a number of half siblings due to her father's previous relationships. Ms Prowse described the atmosphere at home with her mother and father as "horrible". [redacted] She stated that she would be questioned by Social Services with regards to this and recalled being taken to GP surgeries to be examined physically. Ms Prowse denied any sexual abuse from her father. [redacted] She stated that this happened on one occasion. She reported confronting her mother about this when she was 14 and reported that her mother responded by stating "[redacted]

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

and she stated that she has a number of scars due to this. She stated that she has a number of burn marks and scalds from when she was a toddler and stated that she has been told that this is due to her scolding herself accidently. Ms Prowse stated that she is now beginning to question whether or not her parents scolded her deliberately however, she denied any memories of this. [redacted] Ms Prowse reported a perception that her father was "a bragging man" and would therefore present a "front" to the outside world that her and her siblings were well cared for. Ms Prowse described feeling constantly feeling "scared" when she was growing up as a child and recalled hiding under her bed on her own to attempt to prevent her father from beating her. She stated that she had no-one to go to to discuss her problems as her older sister was concerned with caring for her younger sister.

Ms Prowse stated that she attended regular Children's Panel meetings [redacted] She stated that when she was eight years old she attended a meeting and was put into care and never returned home. Ms Prowse described mixed feelings with regards to experiences of care and stated that she was glad she was taken away from her parents as she would not like to think what would have happened if she had not been. However, she described experiences of care as "unsettling" and reported feeling passed from one place to another. She described moving to a number of foster families and stated that when she became settled, she would be uprooted to another family. She denied any experiences of physical or sexual abuse when in care. Ms Prowse described one positive experience of a foster family in Ardrossan. She described this as "a great life" and stated that all her siblings stayed with her foster mother and father when she was 11-years old. She described this as being like "a proper family". She described her foster mother as "amazing, the nicest person" and reported her foster father to be the same. She stated that she felt cared for during this time and felt that she could go to her foster mother and father if she needed anything. She said she felt accepted within this family and that her foster mother and father's own children had accepted them as their siblings. She stated that her basic needs were taken care of and that she was well clothed and fed and wanted for nothing. Ms Prowse stated that her foster mother and father were planning to adopt Ms Prowse and her siblings. However, she stated that her foster father was diagnosed with cancer and subsequently passed away. Ms Prowse stated that her foster mother felt unable to carry on with the adoption and due to this she went to stay with another foster mother and father. She described this as a difficult experience and reported a perception that they did not "want her". Ms Prowse stated that this placement broke down when she was 14 and she returned to a Children's home where she stayed until she was 16. She described this experience as "horrible". Ms Prowse stated that when she was 16 she left the children's home to live with her elder sister. She alleged that her sister's boyfriend raped her at that time. She stated that she informed the police of this however, stated that her sister did not believe her [redacted] She informed me that her alleged perpetrator has subsequently been convicted of three charges of rape.

Summary and management plan

Ms Prowse presents with a recent exacerbation of recent long-standing difficulties with anxiety and low mood. In addition, she also reports long-standing difficulties with affect regulation, re-experiencing of traumatic events, avoidance of reminders and hyperarousal, which may be conceptualised as a complex traumatic stress presentation. It would appear that her difficulties have been exacerbated by the ending of a romantic relationship. From Ms Prowse's description, it would seem that a number of her early life experiences have contributed to the development of her current difficulties. She describes prolonged neglectful and physically abusive experiences with her caregivers during her formative years, with limited opportunity to learn how to comfort and soothe herself when distressed. Such experiences may have contributed to the development of her beliefs that the "world is a bad place", her difficulties trusting other people, in addition to her difficulties managing overwhelming emotions and communicating her needs. It would also appear that Ms Prowse has internalised such experiences as indicating that there must be "something wrong with (her)". Her difficulties are being maintained by unhelpful ways of managing her distress including ongoing substance misuse and cognitive and behavioural avoidance. It is likely that her substance misuse developed through reinforcement, by helping her cope with traumatic memories.

It was discussed with Mr Prowse that she may benefit from psychological intervention in the future, with an initial focus on safety and emotional regulation prior to processing some of the powerful emotions she experiences in relation to her early life experiences. With her agreement she has therefore been placed on the psychology treatment waiting list. It was discussed with Ms Prowse that there is currently a significant wait for this therapy option, of approximately one year. Additionally, it was

Ayrshire Mental Health Risk Assessment Framework

Date of Activity 03 September 2012 15:43 by Dr. Sarah Mackintosh **Status** Closed
Centre of Care East Ayrshire CMHT

Ayrshire Mental Health Risk Assessment Framework

Assessment completed by

Individual clinician

Mental state

Mental state

Amber

Note: Ms Prowse reports a 6 month history of difficulties with low mood and anxiety which appear to have been triggered by the ending of a relationship. She presented as tearful throughout the session however, developed good rapport and was able to describe her difficulties in detail. No symptoms of psychosis evident and speech was normal. No obvious evidence of self-neglect. Mr Prowse initially presented as anxious however this appeared to lessen as the session progressed.

Engagement

Engagement with services

Amber

Note: Ms Prowse reported feeling let down by the CMHT and described an unhelpful experience with the duty system and thus stated that she would not use this support. However, she stated that she would confide in her brother and that she would allow him to contact services if he had any concerns.

Medication management

Amber

Note: Ms Prowse is currently abusing codeine phosphate. Reported using 32 tablets per day and stated that she experienced withdrawal symptoms when she attempted to remain abstinent for 4 days. Stated that there is a planned reduction from her GP and that she discussed this is her recent psychiatric appointment. She presented as ambivalent with regards to this reduction stating that she would like to manage without codeine however, stated that she has "always used something" to cope with her emotions. Noted during a recent assessment at liaison psychiatry taking diazepam tablets prescribed to a friend. Ms Prowse stated that she has a daily pick up of her prescribed codeine tablets and stated that she is not on any other prescribed medication.

Risk of absconding

Green

Note: Recently left GP surgery due to anxiety while GP was contacting duty system. Ms Prowse was able to wait in clinic room for approximately 20 minutes today during planned break in assessment appointment.

Risk of suicide/self-harm

Risk of self-harm

Green

Note: Ms Prowse stated that she previously self-harmed by cutting however denied suicidal intent at such times. No current thoughts of deliberate self harm and Ms Prowse stated that she has not cut herself for 2 years.

Risk of suicide

Amber

Note: Ms Prowse reported taking an overdose of her medication 6 weeks ago and again a week prior to our assessment appointment. She stated that she had cancelled her appointment with her CPN the previous week due to suicidal ideation. Stated that she was not alone until the Monday and thus could not carry out plan of taking her medication. She reported proceeding to take an overdose following GP appointment last Monday as she was on her own after her brother left for work. She stated her brother had an "incline" that she was "not right" and reported that he phoned her cousin who visited her at home. She stated that her cousin telephoned her brother to say that she had seen an empty packet of medication in the bin. Ms Prowse stated that her brother contacted her sister-in-law who then telephoned an ambulance. She reported a belief that taking such medication would be letha and she expressed ambivalence about surviving. Ms Prowse stated that she continues to experiences daily suicid thoughts however denied any current plans or having taken any steps to end her life. She was unable to guarantee that she would not take another overdose however, stated that she does not have access to medicatio at home other than that prescribed by GP. She stated that her brother has limited her money so that she is unable to buy medication and she reported that she would be unable to obtain this herself due to being unable to leave the house on her own. She also stated that her brother has "ordered" other family members not to bring Ms Prowse medication as she previously pretended that she was experiencing physical pain and would request them to bring her pain killers. Ms Prowse stated that she is a Christian and that ending her life is against her religion. She reported that she has only considered taking an overdose to end her life as this may be seen as an addiction and thus not suicide. She reported feeling hopeless (1 out of 10, 0=no hope) that her mood can improve and stated that she was thinking of other ways of ending her life so that it did not look like suicide however had not thought of anything other than medication.

Risk of harm to or from others

Risk of harm to others

Green

Note: Ms Prowse stated that she was charged with assault as a minor. She reported difficulties managing her temper and stated that this contributes to her anxiety about leaving the house. Reported no current physical aggression when angry and has no thoughts of harming others.

Abuse issues

Amber

Note: Reports significant emotional, physical and sexual abuse as a child in addition to neglect which resulted in her going into care when she was 8 years old. Ms Prowse reported being raped when she was 15 years old by he sisters boyfriend. It is likely that her previous experiences are impacting on her current presentation, how she is expressing her needs in addition to her current view of and difficulties engaging with services.

Neglect/Vulnerability issues (consider ASP/AWIA)

Green

Note: No signs of neglect evident

Child protection concerns

Green

Risk from substance misuse

Substance misuse

Amber

Note: Ms Prowse is currently abusing codeine phosphate. Reported using 32 tablet per day and stated that she experienced withdrawal symptoms when she attempted to remain abstinent for 4 days. Stated that there is a planned reduction from her GP and that she discussed this is her recent psychiatric appointment. She presented as ambivalent with regards to this reduction stating that she would like to manage without codeine however, statec that she has "always used something" to cope with her emotions. Noted during a recent assessment at liaison psychiatry taking diazepam tablets prescribed to a friend. Reports previous difficulties with alcohol and cannabis misuse. Denies current use of alcohol or cannabis.

Social and personal risks

Support network

Green

Note: Reports close confiding relationship with brother and cousin. Intermittent contact with father however report this to be stressful. No current contact with mother.

Physical health

Green

Occupation of time

Amber

Note: Reports being unable to leave the house unaccompanied due to anxiety and appears to have limited structure to her day.

Housing and finances

Green

Note: No difficulties raised during assessment.

Any other issues

Not applicable

Overall Impression of Risk

Amber

Note: Recent overdose with ongoing suicidal ideation and hopelessness, however denies current plans or intent. Ongoing addiction issues and ongoing physical health risks associated with level of medication misuse.

Immediate Risk Management Plan

Immediate Risk Management Plan

-Discussed her case with colleagues in the crisis team and then discussed her presentation with Tracey Harvey, CPN. Tracey felt that her presentation today was similar to how Ms Prowse presents during her contact.
-It was agreed that the most appropriate risk management plan, given that there did not appear to be a change to her presentation and given that Ms Prowse has no current plan to end her life, would be for Tracy to continue with planned appointment with Ms Prowse on 5th September and for Tracey to liaise with crisis following this if she felt that additional input was required.
-Telephoned Ms Prowse and informed her that I had discussed with colleagues and we felt that no additional input would be helpful at this time and re-iterated her next appointment with Tracey.

-Also re-iterated services she can contact in the interim if she notices a deterioration in her symptoms/feel unable to keep herself safe and encouraged her use of such supports. Ms Prowse stated that her brother would contact on her behalf if needed given that she finds it difficult to utalise the duty service.

-Added to treatment waiting list for psychological intervention. When a Clinical Psychologist becomes available for treatment her level of motivation and engagement with intervention offered from Occupational Therapy and nursing within the CMHT will be considered to determine where she could benefit from, and is ready to engage in, a high intensity psychological intervention.
-Ongoing CPN input and on waiting list for Occupational Therapy input.

Ayrshire Mental Health Risk Assessment Framework

Date of Activity 28 August 2012 16:29 by Jillian Fleming **Status** Closed
Centre of Care Adult Psy Lia Ward Ref -xh

Ayrshire Mental Health Risk Assessment Framework

Assessment completed by

Individual clinician

Mental state

Mental state

Amber

Note: -Referred by and assessed on Ward 3E. Kelly had been admitted to Ward 3E yesterday following an apparent overdose of prescribed / unprescribed medication taken with suicidal intent. Kelly reports attending her GP surgery with the plan to discuss a detox regime from codeine however reported that she was unable to attend her appointment with CPN due to feeling that she couldnt face going on. GP requested that Kelly remain in the GP practice until she had contacted CMHT however Kelly reports that she was feeling anxious therefore had to leave. Kelly reports that upon return home at 9.30am she took 120 x 15/500 codeine tablets and 2 illicit valium tablets then at 10.30am took a further 30 codeine 8/500 tablets. Kelly reports that she took medication with suicidal intent. Kelly however reports that she was aware that her brother and cousin would be visiting her later that morning. Kelly reports that she "implied" to her brother that she had taken an overdose and when her cousin visited there was empty packages of medication noticed. Her cousin apparently discussed this with her brother who then informed the sister in law who contacted an ambulance. Kelly agreeable to come into hospital for medical treatment. Mental State Examination:- Co operative with assessment, maintained reasonable eye contact. No obvious evidence of self neglect. Appearing relaxed for majority of assessment. Complaining of anxiety symptoms throughout - evidence of mild anxiety symptoms however appearing able to control same. Complaining of ongoing low mood, objectively evidence of mild low mood in response to social stressors, affect however appropriate and reactive, speech normal in rate and tone. Tearful at times however responding well to reassurance. Appearing preoccupied with social stressors however no obvious evidence of distraction. No obvious evidence of auditory / visual hallucinations. No delusional / paranoid ideation expressed. Complaining of withdrawal symptoms of codeine and requesting medication for same however no obvious evidence of same. fully orientated to date, time and place No obvious evidence of impaired judgement. Expressing constant negative thoughts regarding self and others and lack of support. When challenged on thoughts however became very defensive and appeared unwilling to engage with support services available. Appearing unwilling to take responsibility for helping self. Appearing very focused on social isolation and inability to attend meetings etc. Discussed different coping mechanisms and importance of attending appointments - Kelly agreeable to speak with her brother to ascertain whether he would be able to escort her to appointments in Ayr and agreeable to take taxi to appointment tomorrow. Reports that she is unsure whether she will take further overdose and admits to previous fleeting suicidal thoughts however denies active plan or intent.

Engagement

Engagement with services

Amber

Note: Appearing unwilling to engage with services at present time.

Medication management

Amber

Note: Drugs:- Initially denies drug abuse however reports that she takes diazepam tablets (prescribed to a friend) in an attempt to alleviate anxiety symptoms. Reports that she can take up to 3 tablets daily if having to go outside. Kelly also reports being addicted to codeine tablets (approx 30 - 40 daily) for the last 2 years. Reports four day period of abstinence however reports that she was unable to control withdrawal symptoms. Medication:- Reports that she is prescribed codeine on a weekly basis.

Risk of absconding

Green

Note: Agreeable to remain in hospital until medically discharged.

Risk of suicide/self-harm

Risk of self-harm

Amber

Note: Previous history of self harming behaviour. Kelly had been admitted to Ward 3E yesterday following an apparent overdose of prescribed / unprescribed medication taken with suicidal intent. Kelly reports attending her GP surgery with the plan to discuss a detox regime from codeine however reported that she was unable to attend her appointment with CPN due to feeling that she couldnt face going on. GP requested that Kelly remain in the GP practice until she had contacted CMHT however Kelly reports that she was feeling anxious therefore had to leave. Kelly reports that upon return home at 9.30am she took 120 x 15/500 codeine tablets and 2 illicit valium tablets then at 10.30am took a further 30 codeine 8/500 tablets. Kelly reports that she took medication with suicidal intent. Kelly however reports that she was aware that her brother and cousin would be visiting her later that morning. Kelly reports that she "implied" to her brother that she had taken an overdose and when her cousin visited there was empty packages of medication noticed. Her cousin apparently discussed this with her brother who then informed the sister in law who contacted an ambulance. Kelly agreeable to come into hospital for medical treatment. Impression:- Kelly appears to suffer from increased anxiety / panic when having to address social stressors. It remains unclear whether Kelly took an overdose of medication as she self reports that she has been taking 30 - 40 codeine tablets on a daily basis. Kelly's engagement with services may be limited due to her reluctance to deal with difficulties she has faced.

Risk of suicide

Amber

Note: Kelly had been admitted to Ward 3E yesterday following an apparent overdose of prescribed / unprescribed medication taken with suicidal intent. Kelly reports attending her GP surgery with the plan to discuss a detox regim from codeine however reported that she was unable to attend her appointment with CPN due to feeling that she couldnt face going on. GP requested that Kelly remain in the GP practice until she had contacted CMHT however Kelly reports that she was feeling anxious therefore had to leave. Kelly reports that upon return home at 9.30am she took 120 x 15/500 codeine tablets and 2 illicit valium tablets then at 10.30am took a further 30 codeine 8/500 tablets. Kelly reports that she took medication with suicidal intent. Kelly however reports that she was aware that her brother and cousin would be visiting her later that morning. Kelly reports that she "implied" to her brother that she had taken an overdose and when her cousin visited there was empty packages of medication noticed. Her cousin apparently discussed this with her brother who then informed the sister in law who contacted an ambulance Kelly agreeable to come into hospital for medical treatment. Kelly has a previous history of overdose - last overdose approximately 20/7. Previous history of self harming behaviour. Reports that she is unsure whether she will take further overdose and admits to previous fleeting suicidal thoughts however denies active plan or intent. Impression:- Kelly appears to suffer from increased anxiety / panic when having to address social stressors. It remains unclear whether Kelly took an overdose of medication as she self reports that she has been taking 30 - 4(codeine tablets on a daily basis. Kelly's engagement with services may be limited due to her reluctance to deal witl difficulties she has faced.

Risk of harm to or from others

Risk of harm to others

Green

Abuse issues

Not known

Note: Unwilling to discuss during assessment.

Neglect/Vulnerability issues (consider ASP/AWIA)

Green

Child protection concerns

Green

Risk from substance misuse

Substance misuse

Amber

Note: Denies alcohol abuse. Drugs:- Initially denies drug abuse however reports that she takes diazepam tablets (prescribed to a friend) in an attempt to alleviate anxiety symptoms. Reports that she can take up to 3 tablets daily if having to go outside. Kelly also reports being addicted to codeine tablets (approx 30 - 40 daily) for the last 2 years. Reports four day period of abstinence however reports that she was unable to control withdrawal symptoms

Social and personal risks

Support network

Green

Note: Although reports limited support has support from CPN, brother and cousin.

Physical health

Green

Occupation of time

Red

Note: Reports that she is unable to go outside the home environment. Lacks structure to day.

Housing and finances

Amber

Note: Self reports difficulties with accomodation.

Any other issues

Green

Overall Impression of Risk

Amber

Note: Amber due to recent apparent overdose and continual addiction to codeine. Impression:- Kelly appears to suffer from increased anxiety / panic when having to address social stressors. It remains unclear whether Kelly took an overdose of medication as she self reports that she has been taking 30 - 40 codeine tablets on a daily basis. Kelly's engagement with services may be limited due to her reluctance to deal with difficulties she has faced

Immediate Risk Management Plan

Immediate Risk Management Plan

Plan:- OPA with Dr Kessavolou on 29/8 at 11am.
? Psychology appointment on 3rd September.
Appointment for medical on 4th September (in relation to benefits).
Ongoing support from CPN if appropriate - writer unable to contact CPN T Harvey however assessment discussed with Dr Kessavalou who has agreed that he will discuss further support with CPN.
Kelly aware of how to contact duty service if mental state deteriorates.
Discharge from pln point of view.

Mental Health Unscheduled Care ICP Assessment V2

Date of Activity 28 August 2012 16:19 by Jillian Fleming **Status** Closed
Centre of Care Adult Psy Lia Ward Ref -xh

Presentation

Source of current referral

Other NHS

Note: Ward 3E

Reason for referral

--Referred by and assessed on Ward 3E.

Kelly had been admitted to Ward 3E yesterday following an apparent overdose of prescribed / unprescribed medication taken with suicidal intent. Kelly reports attending her GP surgery with the plan to discuss a detox regime from codeine however reported that she was unable to attend her appointment with CPN due to feeling that she couldnt face going on. GP requested that Kelly remain in the GP practice until she had contacted CMHT however Kelly reports that she was feeling anxious therefore had to leave. Kelly reports that upon return home at 9.30am she took 120 x 15/500 codeine tablets and 2 illicit valium tablets then at 10.30am took a further 30 codeine 8/500 tablets. Kelly reports that she took medication with suicidal intent. Kelly however reports that she was aware that her brother and cousin would be visiting her later that morning. Kelly reports that she "implied" to her brother that she had taken an overdose and when her cousin visited there was empty packages of medication noticed. Her cousin apparently discussed this with her brother who then informed the sister in law who contacted an ambulance. Kelly agreeable to come into hospital for medical treatment.

Assessment type

New

Current contact with other services

Yes

Note: CPN T Harvey

Carer's perspective of current problems and interventions

-Not available at time of assessment.

Current medication

-Self reports Codeine phosphate 60mg qds

Side-effects of prescribed medication

No problem

Risk

Risk to self

Low apparent risk

Note: Previous history of self harming behaviour. Kelly has a previous history of overdose - last overdose approximately 20/7. Recent diagnosis of anxiety / panic disorder. Has had previous contact with CPN however appears unwilling to attend appointments. Kelly reports that she has been prescribed two anti depressants in past months. Reports that she was initially prescribed escitalopram for approximately 6 weeks and latterly mirtazepine for approximately 2 weeks (Kelly reports GP discontinued same yesterday). Reports that she is unsure whether she will take further overdose and admits to previous fleeting suicidal thoughts however denies active plan or intent. Risk to Self:- Low risk of further self harm in response to stressors.

Risk to others

No apparent risk

Personal and social history

Gender based violence

Was routine gender based violence enquiry carried out?

Yes, first contact

Why was gender based violence enquiry not possible?

Not relevant as already carried out

Did disclosure take place?

No

Psychological well-being

Behaviour

Alcohol or substance misuse

Moderate problem

Note: Denies alcohol abuse. Drugs:- Initially denies drug abuse however reports that she takes diazepam tablets (prescribed to a friend) in an attempt to alleviate anxiety symptoms. Reports that she can take up to 3 tablets daily if having to go outside. Kelly also reports being addicted to codeine tablets (approx 30 - 40 daily) for the last 2 years. Reports four day period of abstinence however reports that she was unable to control withdrawal symptoms

Eating problems

Mild problem

Note: Complains of long standing appetite difficulties.

Cognition

Memory

No problem

Note: No evidence of memory deficits.

Attention and concentration

Mild problem

Note: Appearing preoccupied with social stressors.

Mental health

Thought disorganisation

No problem

Delusions

No problem

Hallucinations

No problem

Elated or expansive mood

No problem

Depressed mood and ideation

Mild problem

Note: Kelly describes long history of fluctuating mood and anxiety symptoms. Reports long standing difficulties with sleep and appetite. Kelly also describes 2 year history of abuse of codeine tablets - reports that she consumes 30 40 tablets daily. Kelly reports deterioration in her mood over the last 4 months due to break up in relationship, family difficulties and increase in anxiety symptoms resulting in social isolation, experiencing suicidal ideation. Since Kelly's relationship break up she has had regular contact with her brother and cousin who take Kelly to appointments and carry out tasks that she feels unable to do eg shopping. Since last week however Kelly's brother has been working additional hours resulting in less contact with Kelly which Kelly reports has increased her feelings of suicide. Kelly is also experiencing increase in anxiety symptoms as having to attend a medical on 4th September in Ayr in regards to benefits however feels unable to attend. Co operative with assessment, maintained reasonable eye contact. No obvious evidence of self neglect. Appearing relaxed for majority of assessment. Complaining of anxiety symptoms throughout - evidence of mild anxiety symptoms however appearing able to control same. Complaining of ongoing low mood, objectively evidence of mild low mood in response to social stressors, affect however appropriate and reactive, speech normal in rate and tone. Tearful at times however responding well to reassurance. Appearing preoccupied with social stressors however no obvious evidence of distraction. No obvious evidence of auditory / visual hallucinations. No delusional / paranoid ideation expressed. Complaining of withdrawal symptoms of codeine and requesting medication for same however no obvious evidence of same. fully orientated to date, time and place. No obvious evidence of impaired judgement. Expressing constant negative thoughts regarding self and others and lack of support. When challenged on thoughts however became very defensive and appeared unwilling to engage with support services available. Appearing unwilling to take responsibility for helping self. Appearing very focused on social isolation and inability to attend meetings etc. Discussed different coping mechanisms and importance of attending appointments - Kelly agreeable to speak with her brother to ascertain whether he would be able to escort her to appointments in Ayr and agreeable to take taxi to appointment tomorrow. Reports that she is unsure whether she will take further overdose and admits to previous fleeting suicidal thoughts however denies active plan or intent.

Obsessional ideas and compulsive behaviour

No problem

Intrusive ideation

No problem

Anxiety, phobias and panics

Moderate problem

Note: Kelly describes long history of fluctuating mood and anxiety symptoms. Reports long standing difficulties with sleep and appetite. Kelly also describes 2 year history of abuse of codeine tablets - reports that she consumes 30 40 tablets daily. Kelly reports deterioration in her mood over the last 4 months due to break up in relationship, family difficulties and increase in anxiety symptoms resulting in social isolation, experiencing suicidal ideation. Sinc Kelly's relationship break up she has had regular contact with her brother and cousin who take Kelly to appointments and carry out tasks that she feels unable to do eg shopping. Since last week however Kelly's brothe has been working additional hours resulting in less contact with Kelly which Kelly reports has increased her feelings of suicide. Kelly is also experiencing increase in anxiety symptoms as having to attend a medical on 4th September in Ayr in regards to benefits however feels unable to attend. Was in a relationship for the last 5 years however Kelly reports that her partner ended this relationship due to her anxiety symptoms and inability to go outside. Evidence of mild anxiety symptoms evident however responding well to reassurance.

Somatic preoccupations

No problem

Lowering of energy, drive or interest

No problem

Self-esteem

Moderate problem

Sleep disturbance

Moderate problem

Note: Reports long standing sleep difficulties.

Physical

Physical health condition

No problem

Physical impairment or disability

No problem

Activities of daily living and life skills

Work/vocational/educational performance

Moderate problem

Note: Reports that she is unable to work due to anxiety symptoms.

Family, friends and carers

Relationship with close family

Moderate problem

Note: Reports limited support from family however admits to almost daily visits from brother or cousin.

Relationships with others close by

Moderate problem

Note: Reports that she has no contact with friends.

Social circumstances

Housing

Moderate problem

Note: Self reports that housing is a problem due to having to stay on own.

Financial situation

Not known

Note: Has appointment to attend medical on 4th September in relation to benefit review.

Daytime activity

Moderate problem

Note: Reports unable to leave the home environment.

Social vulnerability

Moderate problem

Note: Reports no contact with others due to inability to leave home environment.

Involvement in recovery

Involvement in treatment and care

Moderate problem

Note: Reluctance to take any responsiblity for behaviour or attend appointments.

Crisis arrangements

Plan:- OPA with Dr Kessavolou on 29/8 at 11am.
? Psychology appointment on 3rd September.
Appointment for medical on 4th September (in relation to benefits).
Ongoing support from CPN if appropriate - writer unable to contact CPN T Harvey however assessment discussed with Dr Kessavalou who has agreed that he will discuss further support with CPN.
Kelly aware of how to contact duty service if mental state deteriorates.
Discharge from pln point of view.

Capacity to consent to care and treatment

Sufficient information provided?

Yes

Does the person have capacity

Understand the information given to them that is relevant to the decision

Yes

Retain that information long enough to be able to make the decision

Yes

Use or weigh up the information as part of the decision-making process

Yes

Communicate their decision

Yes

Is consent valid?

Yes

Is the consent given voluntarily?

Yes

Summary

Summary of Assessment

--Referred by and assessed on Ward 3E.

Kelly had been admitted to Ward 3E yesterday following an apparent overdose of prescribed / unprescribed medication taken with suicidal intent. Kelly reports attending her GP surgery with the plan to discuss a detox regime from codeine however reported that she was unable to attend her appointment with CPN due to feeling that she couldnt face going on. GP requested that Kelly remain in the GP practice until she had contacted CMHT however Kelly reports that she was feeling anxious therefore had to leave. Kelly reports that upon return home at 9.30am she took 120 x 15/500 codeine tablets and 2 illicit valium tablets then at 10.30am took a further 30 codeine 8/500 tablets. Kelly reports that she took medication with suicidal intent. Kelly however reports that she was aware that her brother and cousin would be visiting her later that morning. Kelly reports that she "implied" to her brother that she had taken an overdose and when her cousin visited there was empty packages of medication noticed. Her cousin apparently discussed this with her brother who then informed the sister in law who contacted an ambulance. Kelly agreeable to come into hospital for medical treatment.

Kelly describes long history of fluctuating mood and anxiety symptoms. Reports long standing difficulties with sleep and appetite. Kelly also describes 2 year history of abuse of codeine tablets - reports that she consumes 30 - 40 tablets daily. Kelly reports deterioration in her mood over the last 4 months due to break up in relationship, family difficulties and increase in anxiety symptoms resulting in social isolation, experiencing suicidal ideation. Since Kelly's relationship break up she has had regular contact with her brother and cousin who take Kelly to appointments and carry out tasks that she feels unable to do eg shopping. Since last week however Kelly's brother has been working additional hours resulting in less contact with Kelly which Kelly reports has increased her feelings of suicide. Kelly is also experiencing increase in anxiety symptoms as having to attend a medical on 4th September in Ayr in regards to benefits however feels unable to attend.

Kelly has a previous history of overdose - last overdose approximately 20/7. Recent diagnosis of anxiety / panic disorder. Has had previous contact with CPN however appears unwilling to attend appointments.
Kelly reports that she has been prescribed two anti depressants in past months. Reports that she was initially prescribed escitalopram for approximately 6 weeks and latterly mirtazepine for approximately 2 weeks (Kelly reports GP discontinued same yesterday).

Denies alcohol abuse.

Drugs:- Initially denies drug abuse however reports that she takes diazepam tablets (prescribed to a friend) in an attempt to alleviate anxiety symptoms. Reports that she can take up to 3 tablets daily if having to go outside.
Kelly also reports being addicted to codeine tablets (approx 30 - 40 daily) for the last 2 years. Reports four day period of abstinence however reports that she was unable to control withdrawal symptoms.

Medication:- Reports that she is prescribed codeine on a weekly basis.

Physical Health:- Continues to report difficulties with stomach pain.

Forensic History:- Previous minor charges for assault and BOP but no recent charges.

Family/Social History:- Kelly unwilling to discuss family / social history in detail. Reports that she was brought up in the travelling community and had no periods of stability throughout childhood. Also reports that she was placed in care due to family's inability to cope. [redacted] and has very limited contact with her. Also reporting limited contact with her dad and sisters. Was in a relationship for the last 5 years however Kelly reports that her partner ended this relationship due to her anxiety symptoms and inability to go outside. Kelly feels that the travelling community is now against her and unwilling to help her due to her inability to remain in a relationship.

Mental State Examination:-

Co operative with assessment, maintained reasonable eye contact. No obvious evidence of self neglect. Appearing relaxed for majority of assessment. Complaining of anxiety symptoms throughout - evidence of mild anxiety symptoms however appearing able to control same. Complaining of ongoing low mood, objectively evidence of mild low mood in response to social stressors, affect however appropriate and reactive, speech normal in rate and tone. Tearful at times however responding well to reassurance. Appearing preoccupied with social stressors however no obvious evidence of distraction. No obvious evidence of auditory / visual hallucinations. No delusional / paranoid ideation expressed. Complaining of withdrawal symptoms of codeine and requesting medication for same however no obvious evidence of same. fully orientated to date, time and place.
No obvious evidence of impaired judgement. Expressing constant negative thoughts regarding self and others and lack of support. When challenged on thoughts however became very defensive and appeared unwilling to engage with support services available. Appearing unwilling to take responsibility for helping self. Appearing very focused on social isolation and inability to attend meetings etc. Discussed different coping mechanisms and importance of attending appointments - Kelly agreeable to speak with her brother to ascertain whether he would be able to escort her to appointments in Ayr and agreeable to take taxi to appointment tomorrow.
Reports that she is unsure whether she will take further overdose and admits to previous fleeting suicidal thoughts however denies active plan or intent.

Risk to Self:- Low risk of further self harm in response to stressors.

Risk to Others:- No risks identified.

Impression:- Kelly appears to suffer from increased anxiety / panic when having to address social stressors. It remains unclear whether Kelly took an overdose of medication as she self reports that she has been taking 30 - 40 codeine tablets on a daily basis. Kelly's engagement with services may be limited due to her reluctance to deal with difficulties she has faced.

Immediate plan of care

Plan:- OPA with Dr Kessavolou on 29/8 at 11am.
? Psychology appointment on 3rd September.
Appointment for medical on 4th September (in relation to benefits).
Ongoing support from CPN if appropriate - writer unable to contact CPN T Harvey however assessment discussed with Dr Kessavalou who has agreed that he will discuss further support with CPN.
Kelly aware of how to contact duty service if mental state deteriorates.
Discharge from pln point of view.

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) **undefined** Female **CHI Number** 1602890722

History for Summary of contact

From 11/05/1926 **Until** 11/05/2026

discussed with Ms Prowse that her current levels of codeine misuse would prevent her from deriving benefit from psychological intervention. It was therefore discussed that when a Psychologist becomes available for treatment, Ms Prowse's misuse of medication would be considered to determine where she could benefit from, and is ready to engage in, a high intensity psychological intervention. Mr Prowse was also encouraged to continue to engage with her current CPN support to help develop her coping strategies and resources for managing her distress and we discussed that her level of motivation and engagement with intervention offered from the CPN's will be considered at the time of treatment being available, to determine her readiness to engage.

I trust this meets with your approval however, please do not hesitate to contact me if you have any comments or queries in relation to the above.

Yours sincerely

Dr Sarah Mackintosh
Clinical Psychologist

Cc: Dr Pugh The Surgery 31 Portland Street KILMARNOCK KA1 2DJ
Dr Kessavalou ST6 Psychiatrist NWKAC
Occupational Therapy, NWKAC

Assessed 29th Aug 2012 at 14:57

Summary of contact/details	

Dear Dr Pugh,

KELLY PROWSE DOB: 16/02/1989 CHI No: 1602890722
3C FULLARTON STREET, KILMARNOCK, AYRSHIRE, KA3 2QZ

Date of Review: 29th August 2012

Diagnosis: 1.Significant Generalised Anxiety Symptoms on a Back ground of anxious avoidant traits
2. There was no evidence of active depressive or Psychotic illness
3. Opiate Dependence Syndrome, currently active use

Psychotropic Medications: Not on any antidepressants or antipsychotics

Follow Up Arrangements: 1. Continue anxiety management work with her CPN, Tracy Harvey
2. Awaiting input from Occupational therapist for graded exposure
3. Awaiting initial assessment by psychology Services
4. Outpatient review in about 4 to 6 weeks time at North West Kilmarnock Area Centre

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) **undefined** Female **CHI Number** 1602890722

History for Summary of contact

From 11/05/1926 **Until** 11/05/2026

5. I have encouraged her to discuss with you about dependence to codeine and possible detox regime.

Thank you for referring Ms Prowse to the East Ayrshire Community Mental Health Team. Upon request by my colleague Tracy Harvey, I have appointed her to the outpatient clinic and seen her on 29th August 2012 in North West Kilmarnock Area Centre. This appointment was mainly to review the need for antidepressants.

HISTORY OF PRESENTING COMPLAINTS
On interview, she stated that everything is too much. She then complained of persistent feelings of tension and apprehension. She described suffering from "nervousness" since her childhood. She relates this to various traumatic incidents in her childhood.

She then stated that "always been with someone and I don't have anyone at the moment". She relates currents distress to breakdown of her relationship with her boyfriend a few months ago. She has been having difficulties adjusting to this and then how to feel about going out of the house. She described physical symptoms of anxiety including shakiness, palpitations, tenseness, nausea and then becomes tearful. This has progressed to avoiding coming out of the house on her own, using public transport or going to crowded places. She also described anticipatory anxiety. Nowadays she feels anxious even in the house and tends to check on her windows and doors but not in a ritualistic manner. Her description did not sound like obsessive thoughts.

She then stated that her brother was providing some support to her until recently. Her brother would usually accompany her to GP appointments or to the supermarket etc. She then stated "my brother is now working, he can't put his life on hold". She feels rejected by rest of her family. This appears to have triggered the recent overdose attempts.

Another issue is her relationship with her sister. She told me that this has never been great and relates this to some issues from the past. She then described a recent incident in that she has been receiving prank calls from a male saying "I am going to come and kill you when you are sleeping". This understandably made her fear worse. She recently found out that this prank call was made by her sister's boyfriend and that her sister knew about this.

When asked about mood symptoms, she told me that it tends to fluctuate and relates this to worsening anxiety. She generally feels low in the last few weeks and feels as if she is wasting other's time. On the other hand, she stated that she required increased support. She stated that she wants "help" and requested all clinicians to see her in her home. She admits to feeling insecure and socially inept.

She openly stated that she never thought of living on her own. She realised that she has always relied on someone. She stated that she may have to change but does not think she can do it in the near future.

Her energy levels and sleep has remained erratic and puts this down to substance misuse. She also has a tendency to sleep during the day. When I asked her about a typical day, she told me that she does nothing other than lying in her bed or in the living room. She only goes out to collect her prescription or medications and sometimes illicit drugs. She also requests her sister-in-law and a friend to bring her illicit drugs or illicit diazepam occasionally.

When asked about her substance misuse, she told me that she is prescribed codeine 60mg 4 times daily for some kind of abdominal problem. She was not sure about the exact diagnosis. She stated that she has been abusing same and takes on an average about 30 to 40 codeine (30mg) tablets. She told me that her GP has discussed detox a few times and was worried what it would be without same. She admitted that she also buys over the counter co-codamol and Nurofen plus. She is aware that it has Paracetamol and ibuprofen respectively and the dangers of taking them excessively. She said that she has been advised of possible liver failure. She then stated that she does this if her sister-in-law is not able to bring in any illicit codeine. She feels that her addiction is ruling her life. She wants to come off codeine but was worried about how to do it.

When asked about recent overdose, she admitted that it was impulsive. She said that she does not really want to die but there is no hope of coming out of her current situation. She stated that she is a Christian and believes that she would go to hell if she

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

were to take her own life. When asked again why she had taken the overdose, she stated that these were impulsive in nature. She continues to have thoughts of not wanting to live like this but denied thinking about ending her life. She did not verbalise any other specific plans. The intent appears low. She admits on occasional thinking that if she were to die accidentally that is accidental overdose, then God will understand and that she will not go to hell.

There was no bipolarity to her affective symptoms and she denied any psychotic symptomotology.

With regards her current circumstances, she feels isolated and said that she does no have any friends. Only support is from her brother and sister-in-law. She is living in a private let and is claiming benefits. She also receives Employments Support Allowance.

PAST PSYCHIATRIC HISTORY

The first contact with psychiatric services was in June 2012 when significant anxiety symptoms were identified as her main problem and the plan was for some anxiety management work by her CPN. Referral was made at the same time for OT for some graded exposure therapy and was also referred to psychology services. In July this year she took an overdose of unknown quantity of Paracetamol, codeine and Diazepam. Her blood Paracetamol level was 135 and she was discharged the following day. She recently took an overdose on 26th August 2012 and this was a total of 40 co-codamol 30/500 tablets. Her initial blood Paracetamol level was 143 but later on the same day her level came down to 53. She was seen by Psychiatric Liaison the next day and was discharged following discussion with myself. Upon assessment the total amount of codeine she alleged taking in the overdose, appears to have been her average daily maximum but she took them all at once in the morning.

She has previously been prescribed antidepressants and the most recent one was Escitalopram and she has not been on anything since August.

PAST MEDICAL HISTORY

She told me that she has an abdominal problem but did not go into the details of the diagnosis. She is prescribed codeine for same. She denied any known drug allergies.

BACKGROUND HISTORY

Ms Prowse did not want to discuss this in detail. She told me that she comes from a travelling community and described her childhood as disruptive and difficult. She was subjected physical, emotional and sexual abuse between the ages of 9 and 15 when she was in care. She also reported that she was raped by her sister's boyfriend when she was 16. Her relationship with her boyfriend which lasted 5 years ended earlier this year. She has no children.

She was not sure of any family history of mental health problems.

With regards to forensic history, she once was accused of stealing and was put on a rehabilitation order. She has also been previously charged with minor breaches of peace and minor charges for assault. There are no pending charges.

MENTAL STATE EXAMINATION

On examination, she was casually dressed and well kempt. She maintained good eye contact and rapport. She was initially anxious but settled as the interview progressed. She was tearful when discussing current symptoms and that of her relationship breakdown. Her affect was reactive. Her speech was spontaneous and coherent with normal tone, rhythm and volume. Subjectively she described her mood as "can't carry on anymore". Objectively she was anxious and mildly low. Her thought form, stream and possession were normal. There was no evidence of delusion. She was quite negative about herself and generally about recovery from her current difficulties. There were no active thoughts of ending her life. There was no suicidal or homicidal plan or intent. She described constant fear and there was evidence of catastrophising thinking. There was no evidence of perceptual abnormalities. Her cognitive function was grossly intact. With regards to her insight, she feels that she needs to be helped with her anxiety and feels that all professional should see her at home. She admits the recent overdoses as impulsive and out of desperation. She also admits to codeine intake as problematic and was aware of the dangers of taking additional over the counter analgesics.

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

IMPRESSION
Significant generalised anxiety symptoms on a background of anxious avoidant traits. This includes persistent and pervasive feelings of tension and apprehension, beliefs that she is socially inept, inferior to others, restrictions in life due to need for physical security and avoidant social activities and also sensitive to criticism.

She is also struggling with life on her own, seeking reassurance, quite insecure and feeling helpless. These indicate some features of dependency.

All the above difficulties are on a background of childhood adversities in all forms. Recent trigger for her anxiety symptoms appears to be breakdown in her relationship causing free floating anxiety.

There is also evidence of her externalising her difficulties which is likely hinder her response to any kind of cognitive work. In the first instance I think more of a behavioural intervention like graded exposure is likely to work. Pharmacological treatments are unlikely to benefit her difficulties and there is also risk associated with misuse of prescribed medications.

There is no evidence suggestive of active depressive or psychotic illness. She also fulfils the criteria for a diagnosis of opiate dependence syndrome, currently active use.
Risk to self through non-fatal self harm (overdoses) is likely to be a feature given the nature of distress and underlying absence of coping strategies. Risk of physical damage secondary to abuse of over the counter Paracetamol/NSAID is likely to continue in the context of her seeking medications containing codeine. Risk of accidental death due to misadventure is low.

Risk of suicide is low. Risk of violence towards to others is low.

MANAGEMENT PLAN
1. Continue anxiety management with her CPN, Tracy Harvey.
2. Already referred to Occupational Therapist for graded exposure and is also assessment by psychology services.
3. I did not feel that she requires any use of antidepressants
. Outpatient review in about 4 to 6 weeks time in North West Kilmarnock Area Centre
5. I have encouraged her to discuss with you about possible reduction of opiate use.

Yours sincerely

Authorised on 21/09/2012 12:08:08 by Karthik Kessavalou.

Dr K Kessavalou
Registrar in Psychiatry

Tracy Harvey
CPN
NWKAC
Western Road
KILMARNOCK
KA3 1NQ

Assessed 29th Aug 2012 at 10:11

Summary of contact/details	

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

Dear Kelly

You have previously received a letter advising you were on a waiting list for Occupational Therapy assessment.

As our waiting times remain high, I am writing to enquire if you wish to continue to wait for an assessment appointment.

If you do, please contact the above number by Friday 7th September 2012 to confirm, and your name will remain on the waiting list. You will then be contacted when an appointment becomes available.

If we do not hear from you by the date requested, your name will be taken off the waiting list, and I will assume you no longer equire Occupational Therapy assessment.

Thank you for your time.

Assessed 28th Aug 2012 at 18:19

Summary of contact/details	

Discussed with Dr Kessavolou who has discussed with psychiatric liason service, where Kelly has been seen post apparent overdose (although she admits to regularly taking this amount).

Plan is to encourage Kelly to attend appt tomorrow with DR Kessavolou and to arrange CPN appt for next week.

Phoned Kelly - she is going to try and attend appt tomorrow and plans to speak to GP Dr Frew re prescribing her an anxiolytic beforehand - i advised her however this might not be agreed by GP but she wishes to ask anyway. Agrees for me to see her at home next week.

Assessed 28th Aug 2012 at 15:39

ummary of contact/details	

-Referred by and assessed on Ward 3E.

Kelly had been admitted to Ward 3E yesterday following an apparent overdose of prescribed / unprescribed medication taken with suicidal intent. Kelly reports attending her GP surgery with the plan to discuss a detox regime from codeine however reported that she was unable to attend her appointment with CPN due to feeling that she couldnt face going on. GP requested that Kelly remain in the GP practice until she had contacted CMHT however Kelly reports that she was feeling anxious therefore had to leave. Kelly reports that upon return home at 9.30am she took 120 x 15/500 codeine tablets and 2 illicit valium tablets then at 10.30am took a further 30 codeine 8/500 tablets. Kelly reports that she took medication with suicidal intent. Kelly however reports that she was aware that her brother and cousin would be visiting her later that morning. Kelly reports that she "implied" to her brother that she had taken an overdose and when her cousin visited there was empty packages of medication noticed. Her cousin apparently discussed this with her brother who then informed the sister in law who contacted an ambulance. Kelly agreeable to come into hospital for medical treatment.

Kelly describes long history of fluctuating mood and anxiety symptoms. Reports long standing difficulties with sleep and appetite. Kelly also describes 2 year history of abuse of codeine tablets - reports that she consumes 30 - 40 tablets daily. Kelly reports deterioration in her mood over the last 4 months due to break up in relationship, family difficulties and increase in anxiety symptoms resulting in social isolation, experiencing suicidal ideation. Since Kelly's relationship break up she has had regular contact with her brother and cousin who take Kelly to appointments and carry out tasks that she feels unable to do eg shopping. Since last week however Kelly's brother has been working additional hours resulting in less contact with Kelly which Kelly reports has increased her feelings of suicide. Kelly is also experiencing increase in anxiety symptoms as having to attend a medical on 4th

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

September in Ayr in regards to benefits however feels unable to attend.

Kelly has a previous history of overdose - last overdose approximately 20/7. Recent diagnosis of anxiety / panic disorder. Has had previous contact with CPN however appears unwilling to attend appointments.
Kelly reports that she has been prescribed two anti depressants in past months. Reports that she was initially prescribed escitalopram for approximately 6 weeks and latterly mirtazepine for approximately 2 weeks (Kelly reports GP discontinued same yesterday).

Denies alcohol abuse.

Drugs:- Initially denies drug abuse however reports that she takes diazepam tablets (prescribed to a friend) in an attempt to alleviate anxiety symptoms. Reports that she can take up to 3 tablets daily if having to go outside.
Kelly also reports being addicted to codeine tablets (approx 30 - 40 daily) for the last 2 years. Reports four day period of abstinence however reports that she was unable to control withdrawal symptoms.

Medication:- Reports that she is prescribed codeine on a weekly basis.

Physical Health:- Continues to report difficulties with stomach pain.

Forensic History:- Previous minor charges for assault and BOP but no recent charges.

Family/Social History:- Kelly unwilling to discuss family / social history in detail. Reports that she was brought up in the travelling community and had no periods of stability throughout childhood. Also reports that she was placed in care due to family's inability to cope. [redacted] Also reporting limited contact with her dad and sisters. Was in a relationship for the last 5 years however Kelly reports that her partner ended this relationship due to her anxiety symptoms and inability to go outside. Kelly feels that the travelling community is now against her and unwilling to help her due to her inability to remain in a relationship.

Mental State Examination:-

Co operative with assessment, maintained reasonable eye contact. No obvious evidence of self neglect. Appearing relaxed for majority of assessment. Complaining of anxiety symptoms throughout - evidence of mild anxiety symptoms however appearing able to control same. Complaining of ongoing low mood, objectively evidence of mild low mood in response to social stressors, affect however appropriate and reactive, speech normal in rate and tone. Tearful at times however responding well to reassurance. Appearing preoccupied with social stressors however no obvious evidence of distraction. No obvious evidence of auditory / visual hallucinations. No delusional / paranoid ideation expressed. Complaining of withdrawal symptoms of codeine and requesting medication for same however no obvious evidence of same. fully orientated to date, time and place.
No obvious evidence of impaired judgement. Expressing constant negative thoughts regarding self and others and lack of support. When challenged on thoughts however became very defensive and appeared unwilling to engage with support services available. Appearing unwilling to take responsibility for helping self. Appearing very focused on social isolation and inability to attend meetings etc. Discussed different coping mechanisms and importance of attending appointments - Kelly agreeable to speak with her brother to ascertain whether he would be able to escort her to appointments in Ayr and agreeable to take taxi to appointment tomorrow.
Reports that she is unsure whether she will take further overdose and admits to previous fleeting suicidal thoughts however denies active plan or intent.

Risk to Self:- Low risk of further self harm in response to stressors.

Risk to Others:- No risks identified.

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) **undefined** Female **CHI Number** 1602890722

History for Summary of contact

From 11/05/1926 **Until** 11/05/2026

Impression:- Kelly appears to suffer from increased anxiety / panic when having to address social stressors. It remains unclear whether Kelly took an overdose of medication as she self reports that she has been taking 30 - 40 codeine tablets on a daily basis. Kelly's engagement with services may be limited due to her reluctance to deal with difficulties she has faced.

Plan:- OPA with Dr Kessavolou on 29/8 at 11am.
? Psychology appointment on 3rd September.
Appointment for medical on 4th September (in relation to benefits).
Ongoing support from CPN if appropriate - writer unable to contact CPN T Harvey however assessment discussed with Dr Kessavalou who has agreed that he will discuss further support with CPN.
Kelly aware of how to contact duty service if mental state deteriorates.
Discharge from pln point of view.

Assessed 27th Aug 2012 at 13:36

Summary of contact/details	
Received further phone call from Dr Frew re Kelly giving me her new mobile phone no. He has spoken with Kelly on the phone since this morning and she continues to have thoughts of suicide but did not outline any plan . Her sister phoned the surgery with concerns re her and surgery was informed that Kellys cousin would be with her today. Advised Dr Frew i would contact Kelly by phone today with view to seeing her. Phoned Kelly on both mobile nos but no answer. Also texted her and asked her to contact team. No response so phoned GP surgery back, checked new mobile no which is correct, informed GP surgery i would go and see Kelly. HV to Kelly with SN Agnew, door answered by a male who informed us that Kelly has gone to the hospital as she wasnt feeling well.	

sessed 27th Aug 2012 at 09:11

Summary of contact/details	
Phone call received from Dr Frew at Portland Road advising that he had had Kelly in this am stating that she couldn't face going on and had cancelled her arranged appointment with Tracy on Thursday due to feeling low. Writer discussed with Dr Frew Kelly's need to take responsibility to engage with supports in place such as attending appointments and using duty system. Dr Frew advised that he also was a bit disgruntled with Kelly's behaviour this am as he had asked that she wait in surgery until he could speak with duty worker and Kelly chose to leave. Dr Frew asked that Tracy make contact with Kelly by phone today.	

Assessed 14th Aug 2012 at 11:20

Summary of contact/details	
Please see scanned location confirmation.	

Assessed 9th Aug 2012 at 12:29

Summary of contact/details	
Dear Kelly Thank for responding to the opt in letter.	

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) **undefined** Female **CHI Number** 1602890722

History for Summary of contact

From 11/05/1926 **Until** 11/05/2026

You have been referred to the Psychological Specialties with the East Ayrshire Community Mental Health Team by June Collins, Charge Nurse .

On receipt of this letter please TELEPHONE the number noted above to let us know if you are able to attend an assessment appointment on Monday 3rd September 2012 at 11am in North West Kilmarnock Area Centre with Dr Sarah Mackintosh, Clinical Psychologist.

Unfortunately, we can only hold this appointment open for 7 working days so please contact us as soon as you can. If we do not hear from you by Thursday 16th August 2012 this space will be offered to someone else and you will be discharged from Psychology Services back to the care of your GP.

If you no longer feel you need an appointment, please could you also let us know.

I am enclosing a CORE questionnaire, which we would be grateful if you could complete and bring with you to the appointment - it is especially important that the questionnaire is completed one week before your appointment. Please be assured that you are welcome to attend the service whether or not you complete the form.

We look forward to hearing from you as soon as possible.

Assessed 7th Aug 2012 at 11:18

Summary of contact/details	

Dear Kelly

You have been referred to the Psychological Specialty within the East Ayrshire Community Mental Health Team by June Collins, Charge Nurse. We would like to invite you to contact the Psychological Specialty to arrange an assessment appointment. The purpose of this appointment is to consider whether there is a psychological intervention that we could offer that would assist with the difficulties that you are experiencing.

On receipt of this letter, please:

Step 1: Read the attached form and be prepared to advise us of clinic locations that you are able to attend.

Step 2: TELEPHONE the number noted above to arrange an appointment. This appointment will be approximately 1 ½ hours in duration.

If we do not hear from you by 15th August 2012 we will assume that you do not wish to attend our service and you will be discharged from the Psychological Specialty.

We look forward to hearing from you as soon as possible.

Assessed 6th Aug 2012 at 13:45

Summary of contact/details	
Intra team referral done for DR Henderson re OPA.	

Ayrshire Mental Health Risk Assessment Framework

Date of Activity 23 July 2012 14:27 by Ms Tracey Harvey **Status** Closed
Centre of Care East Ayrshire CMHT

Ayrshire Mental Health Risk Assessment Framework

Assessment completed by

Individual clinician

Note: Joint visit - writer and SN Barron.

Mental state

Mental state

Amber

Note: Kelly appears calm and relaxed today. Mood reactive. Describes overdose at weekend as reaction to family relationships, and thinking she "was a burden". Has little family or social support and felt isolated. Phoned CMHT and was disappointed with advice given. Denies any plans to self harm again.

Engagement

Engagement with services

Green

Medication management

Green

Risk of absconding

Not applicable

Risk of suicide/self-harm

Risk of self-harm

Amber

Note: Denies any intent to self harm by overdose.

Risk of suicide

Amber

Note: States suicidal thoughts are long term. Prior to overdose at weekend took overdose a year ago after a bereavement in the family. Denies any intent to take another overdose, although thoughts are ongoing.

Risk of harm to or from others

Risk of harm to others

Green

Abuse issues

Amber

Note: History of childhood physical and emotional abuse. In care for 9 years. Later went to live with her sister, sister's then boyfriend then raped Kelly when she was 16 years.

Neglect/Vulnerability issues (consider ASP/AWIA)

Green

Note: IN pyjamas but clean and well presented, well nourished, environment clean and well maintained.

Child protection concerns

Not applicable

Risk from substance misuse

Substance misuse

Amber

Note: Describes herself as addicted to codeine.

Social and personal risks

Support network

Amber

Note: Has supportive brother. Feels she is a burden to him.

Physical health

Green

Occupation of time

Amber

Note: States she has not been out the house for a long time, other than to go to the GPs or to see CN Collins. States she can walk to places, as long as someone with her, can't go in a taxi as she doesnt like being in a confined space with a man she doesnt know. States she cant concentrate to watch TV or read. Enjoys the company of her cat.

Housing and finances

Green

Any other issues

Green

Overall Impression of Risk

Amber

Note: Amber due to her recent overdose.

Immediate Risk Management Plan

Immediate Risk Management Plan

Kelly will phone duty nurse if she feels she is going to overdose again.

Appt given with writer for next week.

Mental Health Unscheduled Care ICP Assessment V2

Date of Activity 22 July 2012 09:55 by Ms Lorraine Hope **Status** Closed
Centre of Care ANP Service (MH)

Presentation

Source of current referral

Other NHS

Reason for referral

Psychiatric Liaison Assessment following referral from ward 3E. Kelly was admitted following an intentional mixed overdose of Paracetamol, Codeine and Diazepam ?quantity. Kelly reports researching overdoses on the internet and had been planning it for 24 hours. She also lied to her friend and brother saying to each that the other was visiting so no one would visit, however they both arrived at house and called an ambulance.

Assessment type

New

Current contact with other services

Yes

Note: Currently engages with CMHT

Carer's perspective of current problems and interventions

Aware of ongoing anxieties/panic. Keen for support for this

Current medication

Self reports
Codeine Phosphate 60mg QDS
Escitalopram 10mg mane
Diazepam ?dose PRN
Temazepam every other night

Side-effects of prescribed medication

No problem

Risk

Risk to self

Low apparent risk

Note: States she could not guarantee she would not take another overdose, however no plans at present and states she has no more medications at home and her brother will be staying with her for 2 weeks

Risk to others

No apparent risk

Personal and social history

Gender based violence

Was routine gender based violence enquiry carried out?

No

Why was gender based violence enquiry not possible?

Not recorded

Did disclosure take place?

No

Psychological well-being

Behaviour

Alcohol or substance misuse

No problem

Eating problems

No problem

Cognition

Memory

Mild problem

Note: Reports poor short term memory

Attention and concentration

Mild problem

Note: Reports poor concentration, cannot concentrate on television or reading

Mental health

Thought disorganisation

No problem

Delusions

No problem

Hallucinations

No problem

Elated or expansive mood

No problem

Depressed mood and ideation

Moderate problem

Note: MENTAL STATE EXAMINATION On mental state examination she was a 23 year old woman, dressed in casual clothing. There was good eye contact and rapport. Her speech was normal in rate, volume and intonation. Her affect was reactive. Subjectively she described her mood as 'really, really low', rating it 2-3/10 (1 being suicidal). Objectively she appeared tearful and anxious. Her thought form, possession and stream were normal. Her thought content revealed no evidence of any psychotic symptomatology. Kelly could not give a guarantee that she would never take another overdose, however has no active plans at present. There were no perceptual abnormalities and her cognitive function was grossly intact.

Obsessional ideas and compulsive behaviour

Mild problem

Note: Reports having to check plugs/windows 7 times before going out or going to bed or she cannot settle

Intrusive ideation

No problem

Anxiety, phobias and panics

Moderate problem

Note: Ongoing anxieties about going out her house. States she has not left the house for 4-5 months, only to attend appointments. Keen for support in this

Somatic preoccupations

No problem

Lowering of energy, drive or interest

No problem

Self-esteem

No problem

Sleep disturbance

Mild problem

Note: Reports only sleeping for 30 minutes at a time due to increasing anxiety

Physical

Physical health condition

No problem

Physical impairment or disability

No problem

Activities of daily living and life skills

Work/vocational/educational performance

Moderate problem

Note: Reports she cannot leave her house due to increasing anxiety. Unable to work at present due to this

Family, friends and carers

Relationship with close family

Mild problem

Note: Brother and cousin supportive. Little contact with sisters or parents

Relationships with others close by

No problem

Note: Reports has a supportive friend

Social circumstances

Housing

No problem

Financial situation

No problem

Daytime activity

No problem

Social vulnerability

No problem

Involvement in recovery

Involvement in treatment and care

No problem

Crisis arrangements

Kelly has contact details for NHS24 if any further support required over weekend. Liaison will contact CMHT on Monday to arrange soon visit and Kelly happy with same

Capacity to consent to care and treatment

Sufficient information provided?

Yes

Does the person have capacity

Understand the information given to them that is relevant to the decision

Yes

Retain that information long enough to be able to make the decision

Yes

Use or weigh up the information as part of the decision-making process

Yes

Communicate their decision

Yes

Is consent valid?

Yes

Is the consent given voluntarily?

Yes

Summary

Summary of Assessment

IMPRESSION

Kelly appears to suffer from increased anxiety/panic along with OCD traits. States she cannot go to bed without checking plugs and windows 7 times. Has not left the house in 4-5 months and agrees that therapy may be beneficial. Kelly happy for writer to contact CPN on Monday and Kelly given contact details if any further support required over the weekend. Brother will be staying with her.

Immediate plan of care

DISCUSSED AND AGREED ON FOLLOWING PLAN

Liaison will discuss with CMHT in am
Contact details given for NHS24 if any further support required
Discharged from Psychiatric Liaison point of view

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) **undefined** Female **CHI Number** 1602890722

History for Summary of contact

From 11/05/1926 **Until** 11/05/2026

Assessed 2nd Aug 2012 at 16:54

Summary of contact/details	
Please see scanned referral	

Assessed 2nd Aug 2012 at 15:09

Summary of contact/details	
Hv to Kelly. Her brother also present. Kelly sitting on the couch with a blanket over her, in her pyjamas. Appears reactive in mood. Appears pale and tired. States she is not sleeping. Her brother appeared very supportive and stated he has been accompanying Kelly to go out on short journeys today to GPs surgery and on another occassion to Morrissons. Kelly stated she found these very difficult and suffered panic attacks during same, her brother verified this. However, encouraged kelly to continue with this graded exposure. Discussed breathing techniques to help with Kellys hyperventilation, Kelly states she cant do breathing exercises when she is in a panic attack, i agreed and advised her to practice this in a calm environment in the first instance. Kelly said she tries to do breathing exercises and to talk positively to herself but the more she does so the more she brings a panic attack on. We discussed physiological anxiety response and how it will peak then reduce, but Kelly scathing of this, stating she often ends up "crawling on all fours" because of the anxiety. Kelly reports her GP has stopped the escitalopram due to it not helping. I later confirmed this with GP and have asked him to review or let me know if he wishes to wait to psychiatric OP appt. Also discussed sleeping tablet with kelly and she agrees for me to discuss same with her GP. However, on discussion with GP surgery it appears she is already prescribed TEMAZEPAM and has collected this recently. Have tried to phone Kelly re this but there has been no answer on her phone. Have requested OP appt for Kelly to assess need for anti-depressant and Kelly has been accepted on to psychology waiting list for assessment. Kelly has voicing no suicidal intent today and brother is safe keeping her tablets. Further appt arranged - advised to look at "Living Life to the Full " interactive website meantime and that we would look at anxiety management booklets next visit. Aware of duty system meantime.	

ssessed 23rd Jul 2012 at 14:48

Summary of contact/details	
HV to kelly - please see risk assessment. OUTCOME - kelly to phone duty system if she feels she is going to overdose again. NHS 24 if at night. kelly has further appt with writer for next week.	

Assessed 23rd Jul 2012 at 12:25

Summary of contact/details	
No answer on Kellys phone this morning. To be visited jointly at home with two members of staff this afternoon.	

Assessed 21st Jul 2012 at 18:07

Summary of contact/details	
PRESENTING COMPLAINT Psychiatric Liaison Assessment following referral from ward 3E. Kelly was admitted following an intentional mixed overdose of Paracetamol, Codeine and Diazepam ?quantity. Kelly reports researching overdoses on the internet and had been planning it for 24	

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

hours. She also lied to her friend and brother saying to each that the other was visiting so no one would visit, however they both arrived at house and called an ambulance.

HISTORY OF PRESENTING COMPLAINT

NIL

PAST PSYCHIATRIC HISTORY

Reports recent diagnosis of anxiety/panic disorder. Had been seeing a CPN, however has not seen anyone since CPN went off sick. ıtates she contacted services, however no one could see her

ALCOHOL/DRUG HISTORY

NIL

FORENSIC HISTORY

Previous minor charges for assault and BOP, however not for a few years

MEDICATION

Self reports
Escitalopram for anxiety
Codeine Phosphate, initially prescribed for stomach pain, however now states she is addicted
Temazepam every other night
Diazepam PRN

›HYSICAL HEALTH

Ongoing issues with stomach and kidneys

FAMILY/SOCIAL HISTORY

Kelly currently lives alone. She reports she has been unable to leave the house for past 4-5 months due to increased anxiety/panic. Her Brother and Cousin do her shopping. Has engaged with CPN, who she reports has referred her for therapy.

MENTAL STATE EXAMINATION

On mental state examination she was a 23 year old woman, dressed in casual clothing. There was good eye contact and rapport. Her speech was normal in rate, volume and intonation. Her affect was reactive. Subjectively she described her mood as 'really, really low', rating it 2-3/10 (1 being suicidal). Objectively she appeared tearful and anxious. Her thought form, possession and stream were normal. Her thought content revealed no evidence of any psychotic symptomatology. Kelly could not give a guarantee that she would never take another overdose, however has no active plans at present. There were no perceptual abnormalities and her cognitive function was grossly intact.

RISK TO SELF

States she could not guarantee she would not take another overdose, however no plans at present and states she has no more medications at home and her brother will be staying with her for 2 weeks.

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

RISK TO OTHERS OR FROM OTHERS

No evidence of risk

IMPRESSION

Kelly appears to suffer from increased anxiety/panic along with OCD traits. States she cannot go to bed without checking plugs and windows 7 times. Has not left the house in 4-5 months and agrees that therapy may be beneficial. Kelly happy for writer to contact CPN on Monday and Kelly given contact details if any further support required over the weekend. Brother will be staying with her.

DISCUSSED AND AGREED ON FOLLOWING PLAN

Liaison will discuss with CMHT in am
Contact details given for NHS24 if any further support required
Discharged from Psychiatric Liaison point of view

Assessed 17th Jul 2012 at 14:35

Summary of contact/details	
Kelly phoned requesting to be seen soon as she is struggling badly with heightened anxiety. Was due to see June last week but cancelled due to sickness. As she may be off work for a further 4 weeks I will ask if anyone isavailable to see in her absence but aware of duty system and will utilise this if required.	

Assessed 10th Jul 2012 at 13:33

Summary of contact/details	
Dear Kelly As June Collins, Charge Nurse is currently on sick leave, it is necessary to cancel your appointment on Thursday 12th June 2012. You will be re-appointed in due course. If however, you wish to speak to another member of staff, please do not hesitate to call the number above. I apologise for any inconvenience this may cause.	

Assessed 10th Jul 2012 at 13:09

Summary of contact/details	
Phone call made to cancel appointment with C/N June Collins due to sick leave. Advised to phone duty if support needed.	

Assessed 26th Jun 2012 at 15:43

Summary of contact/details	

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

Kelly seen at clinic as arranged. Reporting to accepting that partner has left and is not going to return. Feeling guilty that she has become reliant to stay with her on bad days. Reports that her father is not talking to her as he does not understand her current presentation. This has caused arguments between her father and her brother. [redacted] Kelly unable to identify why they can cope and she can't. On discussion accept that she is different from her siblings in that she was the only one who was sexually abused. Kelly reporting that she can not talk to others about this abuse. Feels that she is always in a state of heightened anxiety. Discussed deep breathing techniques and Kelly agreed to practice same. Discussed Chris Williams anxiety management workbook which Kelly agreed to complete and bring to the next session. Discussed referral to occupational therapy for graded exposure and referral to psychology for assessment for cognitive behaviour therapy. Kelly expressing fear of meeting unknown people but willing to try as wants to get back in control of her life and "to be normal".

Assessed 22nd Jun 2012 at 17:40

Summary of contact/details	
Phone call received from Kelly who was distressed following her ex partner coming to collect his belongings. Feeling useless and worthless because she cannot have children and is too young for IVF treatment, sister and ex sister in law are both pregnant. This is impacting on mood as ex partner had wanted children. He has told her that he cannot stay with her because he wants an ordinary life. Discussed safety factors, collected prescribed medication this morning, brother is due to visit this evening and Kelly has agreed to give him the medication for safe keeping. Discussed the natural pain of any relationship ending. Explored coping strategies. Kelly agreed that she would contact out of hours if further advise / support is required.	

Assessed 19th Jun 2012 at 15:34

Summary of contact/details	
Dear Kelly You have been referred to the Occupational Therapy Service by June Collins, Charge Nurse. At present your name has been put on a waiting list and you will be contacted as soon as an appointment becomes available. Hope this does not cause too much inconvenience. I look forward to meeting you.	

Assessed 19th Jun 2012 at 11:41

Summary of contact/details	
Dear Karen RE: KELLY PROWSE.23C FULLARTON STREET, KILMARNOCK; KA1 2QZ, DOB: 16.02.1989, CHI NO: 1602890722 Further to our conversation of 15th June 2012, please see attached assessment for the above named patient. I would be grateful if you could assess with a view to cognitive behavioural therapy. Thanking you in anticipation.	

Assessed 14th Jun 2012 at 13:16

Summary of contact/details	

Care Partner

Prowse, Kelly

Date of Birth 16-Feb-1989 (37y) undefined Female CHI Number 1602890722

History for Summary of contact

From 11/05/1926 Until 11/05/2026

Kelly seen for assessment as arranged. History of childhood physical and emotional abuse. In care for 9 years. Later went to live with her sister, sister's then boyfriend then raped Kelly when she was 16 years. [redacted] Kelly was fined and served 16 month rehabilitation order.

Over the past year has become increasingly anxious. Socially isolating. Some ritualistic checking. Feel out with father as she was unable to stay at his wedding a couple of weeks ago due to panic symptoms. Kelly's partner of 5 years left a few months ago as he could not cope with the constant worry of leaving her alone at home. Kelly stating that she " is a burden, takes up peoples time, causes hassle, is useless, can't do anything right, is stupid, does not deserve to be here".

Sleep very poor. Appetite and weight varies. Concentration and short term memory poor. No alcohol use. History of cocodamol abuse. Now prescribed codeine phosphate 60mg qds but takes about 900mg a day. Tops this up with shop bought cocodamol and Neurofen plus.

Brother is moving in to help care for Kelly. Very little contact with 2 sisters who live in Whitehaven.

Plan:- anxiety management work with community psychiatric nurse.
refer to occupational therapy for graded exposure work
refer to psychology for cognitive behaviour therapy intervention.

Assessed 1st Jun 2012 at 13:35

Summary of contact/details	
Dear Kelly I would like to offer you an appointment with myself On: Thursday 14th June 2012 At: 11.30am In: North West Kilmarnock Area Centre If this appointment is not suitable, please contact me on the above number to re arrange.	

Assessed 31st May 2012 at 15:51

Summary of contact/details	
Referral Checklist - SCI referral	

Prowse, Kelly

CHI Number 1602890722 **Date of Birth** 16-Feb-1989 (37y)
Sex Female

Primary Care Mental Health Assessment

Date of Activity 14 June 2012 13:52 by Mrs June Collins **Status** Closed
Centre of Care East Ayrshire CMHT

Presentation

New referral to service

Yes

Source of current referral

GP

Current problems and interventions

History of childhood physical and emotional abuse. [redacted] In care for 9 years. Later went to live with her sister, sister's then boyfriend then raped Kelly when she was 16 years. [redacted] Kelly was fined and served 16 month rehabilitation order.
Over the past year has become increasingly anxious. Fearful of going out or of opening the door to her accommodation. Can't go out shopping. Socially isolating. Some ritualistic checking. Feel out with father as she was unable to stay at his wedding a couple of weeks ago due to panic symptoms. Kelly's partner of 5 years left a few months ago as he could not cope with the constant worry of leaving her alone at home. Kelly stating that she " is a burden, takes up peoples time, causes hassle, is useless, can't do anything right, is stupid, does not deserve to be here". Has detached from alcoholic mother who Kelly reports physically and emotionally abused her as a child.
History of self harming by cutting leg. Brother has removed knives from the household. Some fleeting suicidal ideation but no plan or intent.
Sleep very poor. Appetite and weight varies. Concentration and short term memory poor. No alcohol use. History of cocodamol abuse. Now prescribed codeine phosphate 60mg qds but takes about 900mg a day. Tops this up with shop bought cocodamol and Neurofen plus.
Brother is moving in to help care for Kelly. Very little contact with 2 sisters [redacted]

Current medication

Codeine Phosphate 60mg qds
Escitalopram 10mg mane

Risk

Risk to self

Low apparent risk

Note: History of self harming by cutting leg. Brother has removed knives from the household. Some fleeting suicida ideation but no plan or intent.

Risk to others

No apparent risk

Mental health

Depressed mood and ideation

Moderate problem

Note: Rates mood 3/10. Poor sleep, concentration and short term memory. Lacking meaningful activity, lacking motivation.

Anxiety, phobias and panics

Moderate problem

Note: Over the past year has become increasingly anxious. Fearful of going out or of opening the door to her accommodation. Can't go out shopping. Socially isolating. Some ritualistic checking

Gender based violence

Routine gender based violence enquiry carried out

Yes, first contact

Why was gender based violence enquiry not possible?

Not recorded

Did disclosure take place?

Yes - Victim

Form of abuse disclosed

Domestic?

Yes

Childhood sexual abuse?

No

Other form of abuse?

Yes

Note: Raped by sisters boyfriend.

Is abuse current or past or both

Past

Relationship of perpetrator

Multiple perpetrators, various relationships

Sex of perpetrator

Multiple perpetrators - mixed gender

Response to disclosure

Referred to other specialist service

No

Note: Declined referral to support services.

Information given on local services

No

Shared information with other health professional

Yes

Shared information with external agency (e.g. police, social work etc)

No

Safety planning discussed

No

Child protection procedures initiated

No

Adult protection procedures initiated

No

No further action required

No

Documented plan in case record

Yes

Revisit enquiry at a later date

Yes

Has consent been given to share this information with GP?

Yes

Summary

Summary of Assessment

History of childhood physical and emotional abuse. [redacted] In care for 9 years. Later went to live with her sister, sister's then boyfriend then raped Kelly when she was 16 years. [redacted] Kelly was fined and served 16 month rehabilitation order.
Over the past year has become increasingly anxious. Fearful of going out or of opening the door to her accommodation. Can't go out shopping. Socially isolating. Some ritualistic checking. Feel out with father as she was unable to stay at his wedding a couple of weeks ago due to panic symptoms. Kelly's partner of 5 years left a few months ago as he could not cope with the constant worry of leaving her alone at home. Kelly stating that she " is a burden, takes up peoples time, causes hassle, is useless, can't do anything right, is stupid, does not deserve to be here". Has detached from alcoholic mother who Kelly reports physically and emotionally abused her as a child.
History of self harming by cutting leg. Brother has removed knives from the household. Some fleeting suicidal ideation but no plan or intent.
Sleep very poor. Appetite and weight varies. Concentration and short term memory poor. No alcohol use. History of

cocodamol abuse. Now prescribed codeine phosphate 60mg qds but takes about 900mg a day. Tops this up with shop bought cocodamol and Neurofen plus.
Brother is moving in to help care for Kelly. Very little contact with 2 sisters [redacted]

Action points

anxiety management work with community psychiatric nurse.
refer to occupational therapy for graded exposure work
refer to psychology for cognitive behaviour therapy intervention.