Training & Development

Continual Professional Development

Bipolar Disorder Module

(Workbook)

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Document control

Superseded documents

Version history

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1a (draft)	23rd August 2016	Initial draft MTB	MTB
2 Final	22-08-2022	Internal review of material, updated and set to Final	MG

Changes since last version

Added Document Reference Number to Title page and footers. Some re-formatting; Updated PIAG reference, copyright statement, Foreword, headers and footers; Added in information on Bipolar with seasonal pattern and Unspecified bipolar in the 'Types' section; Amended the FO SOH, CH and medications to be concise as per current practise and some activity information strengthened. Added References page at the back and Observations page; References checked and updated; Spelling and Grammar checked.

Outstanding issues and omissions

Updates to Standards incorporated

PIP Assessment Guide Parts 1-3 updated 21st July 2022

Issue control

Author: T&D

Owner and approver: T&D

Signature: **Date:**

Distribution:

Contents

Foreword

This module has been produced as part of an Independent Assessment Services (IAS) training programme for Health Professionals (HP's) who will be completing Disability Assessments.

All Health Professionals undertaking PIP assessments must be registered medical practitioners, registered nurses, paramedics, occupational therapists or physiotherapists who, in addition, have undergone training in disability assessment medicine and specific training in PIP Assessment. The training includes distance learning modules, theory training in a classroom setting, supervised practical training, and a demonstration of understanding as assessed by quality audit. The PIP Assessment Guide which forms an integral part of that training has been provided by the Department of Work and Pensions (DWP) and is referred to throughout the training provided by IAS.

There are areas in the training where it is useful to revise diagnostic or assessment principles, and where appropriate, these have been included for the relevant HPs.

In addition, the training module is not a stand-alone document, and forms only a part of the training and written documentation that a health professional receives. The DWP "PIP Assessment Guide" must be read in conjunction with IAS training material, as it provides information on the DWP's scope and intention for each of the twelve PIP Activities and corresponding Descriptors in each activity area. As disability assessment is a practical occupation, much of the guidance also involves verbal information and coaching.

Thus, although the training module may be of interest to non-medical readers, it must be remembered that some of the information may not be readily understood without background medical knowledge and an awareness of the other training given to Health Professionals. Some Health Professionals from these professional groups may find it a useful revision and are welcome to use these resources for reflective practice purposes if they wish.

PIP Clinical Director

August 2022

Introduction

This workbook is part of the ongoing training programme for Disability Analysts. This Workbook is designed as a learning tool to consolidate Health Professions understanding of Bipolar Disorder and the functional impact of the disease.

The focus for this training will be on Bipolar Disorder and the impact the condition and symptoms can bring to the individual. It will also discuss the possible impact it can have on a person's functional ability.

This training will cover the following topics:

- What is Bipolar Disorder
- Symptoms of Bipolar Disorder
- Treatments in Bipolar Disorder and their side effects
- Functional impact of Bipolar Disorder, it's symptoms and the effects of its medications
- Bipolar Disorder at Initial Review
- Bipolar Disorder at Consultation

There will be three competency assessments:

- Mid module assessment – 10 True/False questions
- End of module assessment – 10 True/False questions
- End of module scenario based upon a claimant with Bipolar Disorder – Choose appropriate descriptors.

The above will be reviewed by the HP's Clinical Support Lead [CSL].

Overall Aim
To improve understanding of the condition of Bipolar Disorder including typical symptoms treatments and how these may impact upon claimant function. Additionally to enhance understanding of how this diagnosis may impact on case handling within the front and back office roles of the PIP process.

Design / Format

- This participant pack contains the relevant articles required through your training. It is important that you go through the Module independently and as prompted by your CSL, failure to do this may result in misinterpretation of the information provided.

1. Bipolar Disorder Clinical Overview

What is Bipolar Disorder

Bipolar disorder is a mental health problem that can cause a person's mood to swing from one extreme to another. These extremes are called episodes of mania and depression, and a single episode can last for several days or longer. It is possible to have only 1 or 2 episodes of bipolar disorder a year or fewer and be well the rest of the time. However, some people have many episodes each year, or do not get well between episodes.

Bipolar Disorder is also called Bipolar Affective Disorder and used to be known as Manic Depression. The peak age of onset is 15–19 years, and there is often a substantial delay between onset and first contact with mental health services. The lifetime prevalence of bipolar I disorder (mania and depression) is estimated at 1% of the adult population, and bipolar II disorder (hypomania and depression) affects approximately 0.4% of adults.

(https://www.nice.org.uk/guidance/cg185 and https://cks.nice.org.uk/topics/bipolar-disorder/)

Pathology

Although bipolar disorder is diagnosed based on the patient's history and clinical course, laboratory studies may be necessary to rule out other potential causes of the patient's signs and symptoms.

A robust clinical history is taken and the person's mental state is assessed. This assessment would typically include:

- Appearance
- Affect/mood
- Thought content
- Perception
- Suicide/self-destruction
- Homicide/violence/aggression
- Judgment/insight
- Cognition

The cause of bipolar affective disorder has not been determined however, twin, family, and adoption studies all indicate that bipolar disorder has a significant genetic component.

BPI occurs equally in both sexes; however, rapid-cycling bipolar disorder (≥4 episodes/y) is more common in women than in men. The incidence of BPII is higher in females than in males. Most studies report a nearly equal male-to-female ratio in the prevalence of bipolar

disorder; however, most studies also report an increased risk in women for BPII/hypomania, rapid cycling, and mixed episode.

A number of factors contribute to bipolar affective disorder including genetic, biochemical, psychodynamic, and environmental factors.

Genetic factors:

First-degree relatives of people with BPI are approximately 7 times more likely to develop BPI than the general population. Remarkably, offspring of a parent with bipolar disorder have a 50% chance of having another major psychiatric disorder. One longitudinal study found that subthreshold manic or hypomanic episodes were a diagnostic risk factor for the development of subsequent manic, mixed, or hypomanic episodes in the offspring of parents with bipolar disorder. High-risk offspring, compared with offspring of parents without bipolar disorder, also had higher rates of ADHD, disruptive behaviour disorders, anxiety disorders, and substance use disorders.

Twin studies demonstrate a concordance of 33-90% for BPI in identical twins. As identical twins share 100% of their DNA, these studies also show that environmental factors are involved, and there is no guarantee that a person will develop bipolar disorder, even if they carry susceptibility genes.

(https://emedicine.medscape.com/article/286342-overview#a4)

Physical factors:

Multiple biochemical pathways likely contribute to bipolar disorder, which is why detecting one particular abnormality is difficult. A number of neurotransmitters have been linked to this disorder, largely based on patients' responses to psychoactive agents as in the following examples. Drugs used to treat depression and drugs of abuse (eg, cocaine) that increase levels of monoamines, including serotonin, norepinephrine, or dopamine, can all potentially trigger mania, implicating all of these neurotransmitters in its etiology.

Hormonal imbalances and disruptions of the hypothalamic-pituitary-adrenal axis involved in homeostasis and the stress response may also contribute to the clinical picture of bipolar disorder.

There is the risk that antidepressant treatment may propel the patient into a manic episode.

(https://emedicine.medscape.com/article/286342-overview#a4)

Psychological and Environmental factors

Although studies of identical twins indicated that there is a genetic disposition studies where there has been adoption show that environment does also seem to impact on developing the condition.

A study by Barnett et al found that personality disturbances in extraversion, neuroticism, and openness are often noted in patients with bipolar disorder and may be enduring characteristics.

In some instances, the cycle may be directly linked to external stresses or the external pressures may serve to exacerbate some underlying genetic or biochemical predisposition. For example, pregnancy is a particular stress for women with a manic-depressive illness history and increases the possibility of postpartum psychosis.

Because of the nature of their work, certain individuals have periods of high demands followed by periods of few requirements. For example, a landscaper and gardener who was busy in the spring, summer, and autumn became relatively inactive during the winter, except for ploughing snow. Consequently, he appeared manic for a good part of the year, and then he would crash and hibernate during the cold months.

(https://emedicine.medscape.com/article/286342-overview#a4)

Symptoms Overview

Bipolar affective disorder is characterized by periods of deep, prolonged, and profound depression that alternate with periods of an excessively elevated or irritable mood known as mania.

Mania

Manic episodes are feature at least 1 week of profound mood disturbance, characterized by elation, irritability, or expansiveness (referred to as gateway criteria). At least 3 of the following symptoms must also be present:

- Grandiosity
- Diminished need for sleep
- Excessive talking or pressured speech
- Racing thoughts or flight of ideas
- Clear evidence of distractibility
- Increased level of goal-focused activity at home, at work, or sexually
- Excessive pleasurable activities, often with painful consequences

During an episode of mania the person may feel very happy and energetic. They can become so overexcited that they're not able to control what they're doing. They may also feel much more confident than usual and take risks that they wouldn't normally take. The person often doesn't realise that they're ill during an episode of mania.

Having moods of mania that change to moods of depression, and then back to mania, is known as bipolar I (pronounced 'bipolar one') disorder.

Hypomania

Hypomanic episodes are characterized by an elevated, expansive, or irritable mood of at least 4 consecutive days' duration. At least 3 of the following symptoms are also present:

- Grandiosity or inflated self-esteem
- Diminished need for sleep
- Pressured speech
- Racing thoughts or flight of ideas
- Clear evidence of distractibility
- Increased level of goal-focused activity at home, at work, or sexually
- Engaging in activities with a high potential for painful consequences

In hypomania there are usually no symptoms of psychosis. Having moods of hypomania that change to moods of depression, and then back to hypomania, is known as bipolar II (pronounced 'bipolar two') disorder.

Depression

Major depressive episodes are characterized as, for the same 2 weeks, the person experiences 5 or more of the following symptoms, with at least 1 of the symptoms being either a depressed mood or characterized by a loss of pleasure or interest:

- Depressed mood
- Markedly diminished pleasure or interest in nearly all activities
- Significant weight loss or gain or significant loss or increase in appetite
- Hypersomnia or insomnia
- Psychomotor retardation or agitation
- Loss of energy or fatigue
- Feelings of worthlessness or excessive guilt
- Decreased concentration ability or marked indecisiveness
- Preoccupation with death or suicide; patient has a plan or has attempted suicide

During an episode of depression the person feels very 'low' and stops enjoying things they used to like doing. They may not feel like spending time with family and friends and feel very alone and isolated. They may also feel tired all the time, and sometimes think about harming themselves or suicide.

(https://www.nice.org.uk/guidance/cg185 and https://emedicine.medscape.com/article/286342-overview#a4)

Types of Bipolar disorder:

Bipolar I Disorder

- A person with Bipolar I will have one or more manic episodes or mixed episodes and at least one major depressive episode.

Bipolar II Disorder

- A person with Bipolar II will have one or more major depressive episodes with at least one hypomanic episode. There are no manic or mixed episodes. It is common for those with Bipolar II to not remember their hypomanic episodes.

Cyclothymia

- Changing low level depression along with periods of hypomania. The symptoms will be present for at least two years for a diagnosis and there is likely to be symptom free periods.

Rapid Cycling Bipolar

- A person may be diagnosed with rapid cycling Bipolar if they have four or more depressive, manic, mixed or hypomanic episodes in a twelve month period. It affects more women than men.

Mixed Bipolar State

- It is possible to experience symptoms of mania and depression at the same time. There are feelings of depression such as sadness and hopelessness but at the same time feelings of mania such as being very energised.

Bipolar with seasonal pattern

- This means that the time of year or seasons regularly affect mood episodes.

Unspecified bipolar

- Where symptoms don't fit the diagnostic criteria for other types of bipolar disorder.

(https://www.mind.org.uk/information-support/types-of-mental-health-problems/bipolar-disorder/types-of-bipolar/ and https://www.rethink.org/advice-and-information/about-mental-illness/learn-more-about-conditions/bipolar-disorder/

Related conditions

In an illness where psychosis is experienced, such as schizophrenia and bipolar disorder, the risk of suicide is estimated to be over 5%. It is more likely that a person would try to take their own life during depressive episodes of bipolar disorder.

There is also research which suggests a person is more likely to self-harm if they suffer from bipolar disorder and that this is particularly likely if they experience symptoms of mania.

(What are the signs and symptoms of bipolar disorder? (rethink.org))

People with bipolar disorder have a higher rate of physical illnesses such as diabetes and heart disease than the general population. NICE recommends a physical health check every year.

Treatments in Bipolar Disorder

There are medications that can help to treat mania. These medications are often called mood stabilizers. The National Institute of Health and Care Excellence (NICE) that recommends the treatment for bipolar disorder call them “antimanic medications” and “prophylactic medication”.

Antimanic medication is used to treat symptoms of mania. Prophylactic medication is used to prevent symptoms of mania and to keep you stable. Doctors can use the same medications as both antimanic and prophylactic medication. They will use different dosages and combinations.

Commonly prescribed medications are listed below.

- Lithium
- Sodium Valproate/Semi Sodium Valproate
- Olanzapine
- Quetiapine
- Risperidone

A Psychiatrist may prescribe antidepressants to treat depressive symptoms however antimanic medication should also be prescribed because antidepressants on their own can cause mania.

(https://www.rethink.org/advice-and-information/about-mental-illness/learn-more-about-conditions/bipolar-disorder/)

Side effects:

Medication for bipolar disorder can sometimes cause people to gain weight, and if they have depression too, they may not feel like being very active. This can lead to health problems such as diabetes, so they should be offered advice and support to help maintain a healthy weight

An annual health check with the GP should:

- measure weight
- ask about eating and exercise
- check blood sugar and cholesterol levels
- check the liver is working normally
- where Lithium is prescribed check that your kidneys are working normally

A person who has high blood pressure (hypertension), high cholesterol (lipid) levels, diabetes, are overweight or have signs of diabetes, or are at risk of having a heart problem or stroke (cardiovascular disease) should be offered the appropriate treatment recommended by NICE.

(https://www.nice.org.uk/guidance/cg185)

Psychological therapy

As well as medication Bipolar Disorder symptoms can be managed with psychosocial treatments. Psychosocial treatments include one of the following explained below.

- Cognitive Behavioural Therapy (CBT) – this is mainly recommended for the depressive episodes of bipolar disorder.
- Psycho education – this involves learning about your illness, your treatment and how to recognise signs of becoming unwell again so you can prevent a full episode. Psycho education may also be helpful for anyone who is supporting you, such as family, a partner or a trusted colleague.
- Family therapy – this works on family relationships to improve how you feel. This can help reduce any problems in the family which add to, or are because of, your symptoms.

NICE recommends long term preventative treatment because bipolar disorder is a recurring illness and it is possible to manage symptoms with treatment, even if they are severe.

However, sometimes the treatment might not be helping you and different combinations of medication may be tried in conjunction with talking therapy to help.

Managing Care

People with complex mental health conditions, such as Bipolar, may be entered into a treatment process known as a care programme approach (CPA). CPA is essentially a way of ensuring the person receives the right treatment for their needs and that the health professionals and other agencies involved work together in a coordinated way.

There are four stages to a CPA:

- **assessment** – health and social needs are assessed
- **care plan** – a care plan is created to meet health and social needs
- **care coordinator appointed** – a care coordinator, sometimes known as a key worker, is usually the person the Service User sees most often. The role of Care Co-coordinator is often carried out by a Social Worker, Occupational Therapist or Nurse. This person is the first point of contact with other members of the team who help deliver care
- **reviews** – the care plan and treatment will be regularly reviewed and, if needed, changes to the care plan can be agreed

Not everyone is cared for under CPA, some people may be cared for by their GP, while others may be under the care of a specialist.

(Adapted from https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/)

The Mental Health Act

The Mental Health Act 1983 is the law which sets out when a person can be admitted, detained and treated in hospital against their wishes. This is only done if the person is putting their own safety or someone else's at risk and they have a mental disorder.

The Mental Health Act [MHA] defines the term 'mental disorder' as 'any disorder or disability of mind'. It includes mental health conditions such as:

- Bipolar Disorder
- Schizophrenia
- Depression
- Obsessive Compulsive Disorder
- Eating Disorders
- Personality disorders

This list is not exhaustive.

Because the Mental Health Act has different sections, it is commonly known as being 'sectioned'. The Mental Health Act covers what rights the person has, how they can leave hospital and what aftercare they can expect to get. The Act applies in England and Wales. .

- For the Mental Health Act to be used certain people must agree that the individual has a mental disorder that requires a stay in hospital
- Treatment can sometimes be given even if the person doesn't want it.
- Rights under the Mental Health Act include the right to appeal and the right to get help from an advocate.
- Section 117 aftercare is free aftercare provided once following discharge from a hospital stay under certain sections.
- There 'civil' sections and 'forensic' sections, forensic sections involve criminal law.

(https://www.rethink.org/living-with-mental-illness/mental-health-laws/mental-health-act-1983
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2. Bipolar Disorder - Mid Module Assessment

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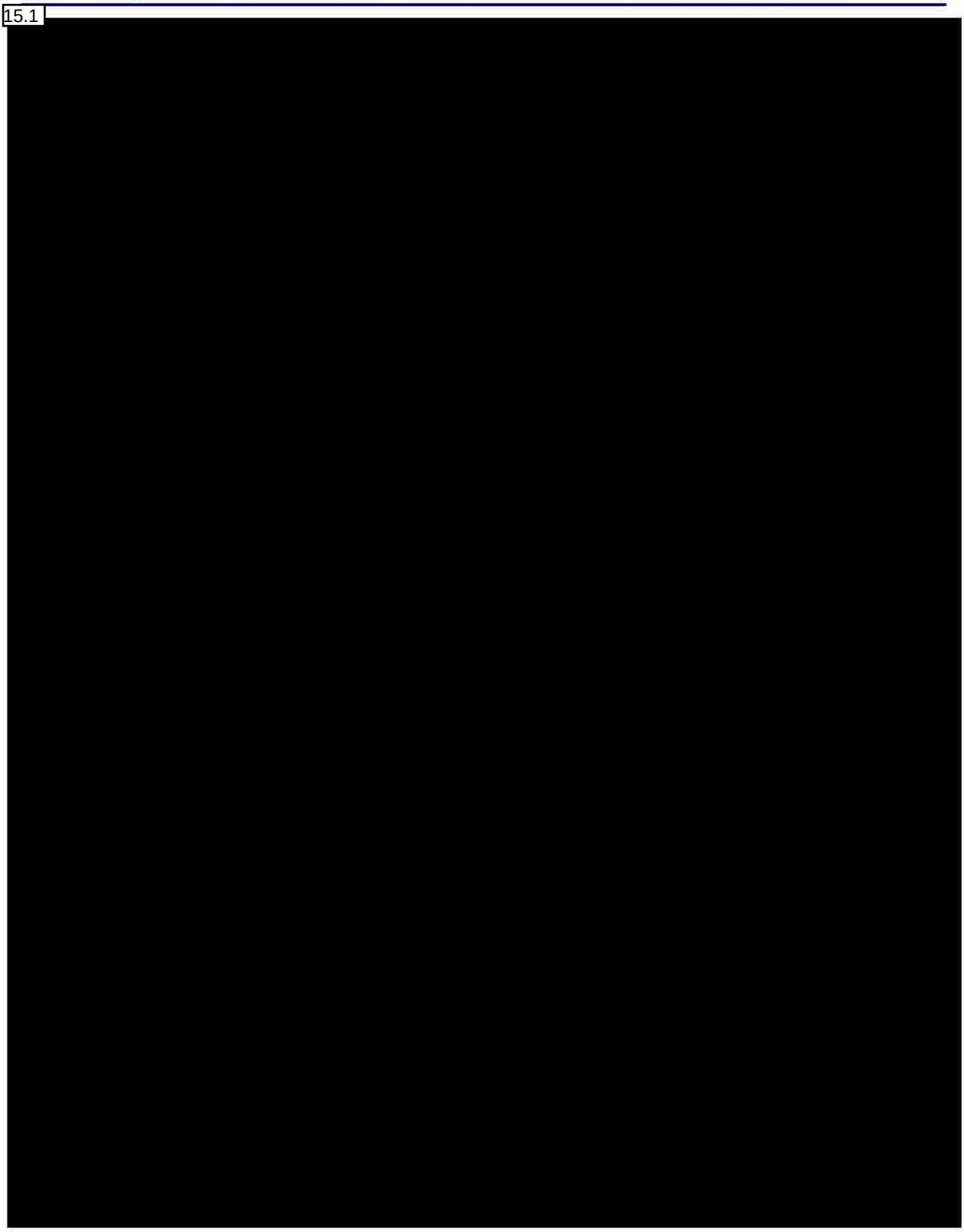

3. Bipolar Disorder and Process

Impact of a diagnosis of Bipolar on Back Office Process

If a diagnosis of Bipolar is identified at initial review the claimant is considered to have Additional Support Needs and every effort should be made to gather further evidence before calling to assessment.

Impact of Bipolar diagnosis on consultation

The focus of this section will be on how the assessor approaches the consultation and key points to consider ensuring a fair and balanced report is produced.

However, it will also cover history and observed behaviour. In your role as a Disability Analyst assessing Mental Health cases, the importance of careful and focused history-taking, recording of observed behaviour and specific mental state examination [MSE] cannot be overstated.

It is always important to consider all pieces of evidence obtained in the light of what is medically reasonable. Your opinion must be fully justified and supported by evidence and any inconsistencies between pieces of evidence must always be addressed.

By the end of this section, you will be aware of:

- History taking in mental health cases
- Observed behaviour in mental health cases
- Principles of a robust MSE
- The importance of valuing the input of carers, advocates and other health care professionals

History taking in mental health cases

- Throughout the Condition History establish variability and the frequency and duration of all mood states including times when the person has a stable mood.

NOTE: In many conditions variability can change day to day. In Bipolar the fluctuations in mood tent to be longer lasting. It can be helpful to look at the last 12 months as a predictor for the following. It is possible to see a person at assessment who is well but they typically are only well for 3 months of the year with the first 5 months spent in a depressive state and the last 4 months spent in a manic state in which case they are functionally restricted for the majority of the time.

- Establish symptoms in all mood states experienced
- Ask if there has been admission to hospital and if this was voluntary or under the MHA as this will help to inform on insight and risk
- Look at the level of involvement from formal agencies but consider that many of the required support needs are met through charities such as Mind, Rethink, DISC, Richmond Fellowship and not all is delivered through the NHS services such as Community Mental Health Teams [CMHT] or Assertive Outreach Teams [AOT]. A person may have a high level of functional restriction but minimal NHS involvement particularly if risk is low
- Look at the level of informal support, insight may be an issue and the person may perceive that their level of function is higher than it is. Informal support will often be picked up by friends, family members or neighbours ask about their involvement.
- Consider reliability with medication, maintaining regular taking of medication can be a particular issue in this condition as insight, particularly when mood is high, can be poor and the person may believe they do not need medication.

Social and Occupational

- Is the person working, did they used to or have they stopped and was this as a consequence of their condition?
- If they are working is this a supported work placement or have adaptations been made, is their job adapted according to their mood state?
- Consider housing, is there support, is it an assisted living accommodation?
- Consider hobbies, clubs and activities, how they fill their day may help to give information on if the mood is high or low.
- Is there service provision during the day, Mind and other charities run groups and day centres which the person may attend to build life and employability skills?
- Were they accompanied to assessment, was any encouragement necessary, how did they get to the centre, this will add to the information gathered for activity 11.

4. Functional implications of Bipolar Disorder

A comprehensive account of the functional history is essential. Areas of particular importance may include (and are not limited to):

- **Activity 1** – The ability to concentrate as well as the motivation to cook may be impacted upon by a high mood, the person may be too busy with other activities that are perceived as more important. In a low mood lack of motivation becomes an issue. How does the person cope in the kitchen? What kinds of meals are being cooked? Are fresh ingredients being used? Is there support, from whom and how often? Support may often be informal, friends, families and neighbours. Have there been any accidents or incidents to suggest a risk?
- **Activity 3** – There may be a lack of insight, not only may medications have unwanted side effects when the mood is normal or elevated the person may not believe they are needed. Is medication being taken reliably in all mood states? How much support is in place to ensure this and what support, formal or informal?
- **Activities 4 and 6** – In a low mood lack of motivation to self-care to an acceptable standard is an issue. Consider how have standards changed? Is there support and if so by whom and how often? Who was involved in getting the claimant to the assessment? If the support was not there what would happen? In a high mood again the person may be too busy with other activities that are perceived as more important to wash and dress to an acceptable standard. Inappropriate clothing choices may also be an issue, provocative clothing or being aware of circumstances in which to remain clothed should be considered.
- Activity 9 – In a low mood the person is likely to be avoiding social contact and prompting may be needed however in a high mood the person may be friendly, forthcoming and be appearing to socialize very well. In this situation it is imperative to remember to consider vulnerability as if there are risky behaviours in interactions with others the person may require social support.
- Activity 10 – A symptom of a high mood is over spending, often many debts are accrued in hypomanic or manic phases, prompting would be needed to manage a budget. When the mood is low prompting may still be needed to deal with the debts accrues in the previous mood state or due to the lack of motivation to act on mail. Are bills getting paid on time? What the property is like and how much responsibility does the person have, if it is not much why is that? Is there support with looking after the property or paying bills?
- Activity 11 – Do they drive; use public transport or walk when going out? How often do they go out and is this independently or are they prompted? Is prompting always successful and if not how often is it unsuccessful? Are they safe when they are out or

is there risk to themselves or to others? Is there evidence of OPD impacting on setting off, planning or following journeys?

- **Throughout the Functional History establish variability and ensure that although the areas where a functional restriction may be expected are discussed above robust positive evidence is needed for all 12 activities.**

Observed behaviour in mental health cases

Observed behaviour remains a cornerstone of Disability Analysis. As always, it is important to observe and record relevant informal observed behaviour. Where a claimant has a mental health condition the relevance of sitting, standing, rising, use of arms and walking is limited unless there is a comorbid physical health condition. However there are still many relevant informal observations which can be made.

If the person was accompanied how much input did that person have into the assessment, what was the rapport with the accompanying person like compared to the rapport with you?

Principles of a robust MSE

As part of a robust MSE the HP should be looking at completing much more than the basic detail from the Behaviour, Appearance, Speech, Mood, Insight and Cognition (general) sections of the MSE desk aid for a person with Bipolar. All the other areas of the MSE should be considered and if present/relevant added to the basic MSE.

Consider speech, was it fast, pressured, or multiple topic changes and it was difficult to keep the assessment on track, were there inappropriate comments, was there irritability or restlessness that would suggest a high mood?

Look at the appearance, are they well turned out, maybe a little overdressed for the occasion, is the makeup overstated for day wear or is the clothing inappropriate and is this indicating the mood is high? On the other hand are they poorly kept, is there other signs indicating a current depressed state.

Valuing the input of carers, advocates and other health care professionals

Carers, relatives and friends of people with Bipolar are important both in the process of assessment and engagement and their opinion should not be discounted. Be aware they may not be comfortable to contradict the person so utilise observational skills of their body language and question sensitively where there is suggestion of a contradiction. The importance of applying logical reasoning to all of the pieces of evidence obtained during the assessment cannot be overstated. As always, your justification should address any inconsistencies between various pieces of evidence.

5. Bipolar Disorder - End of module Assessment

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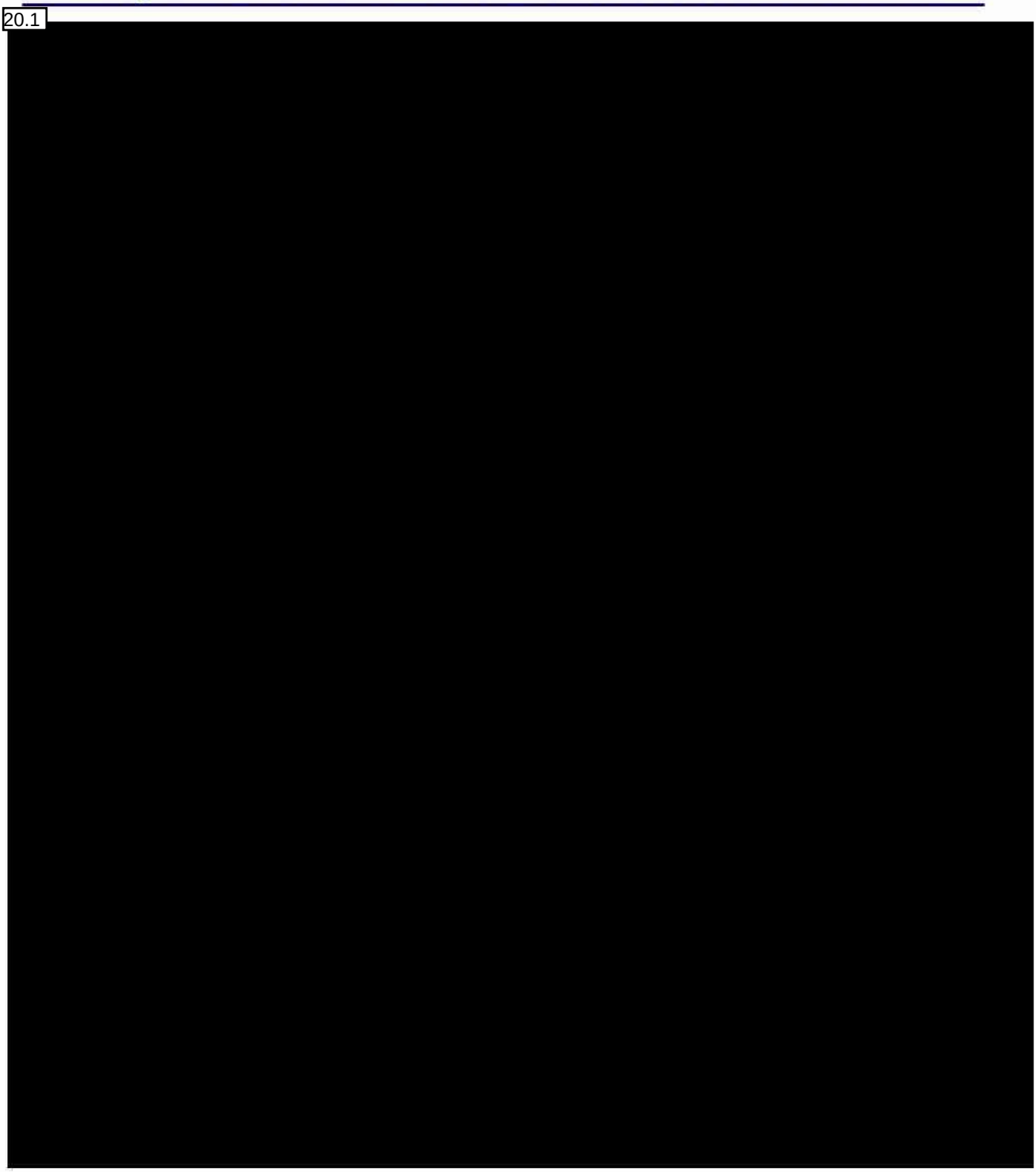

6. Test Case Competency Check (BO version)

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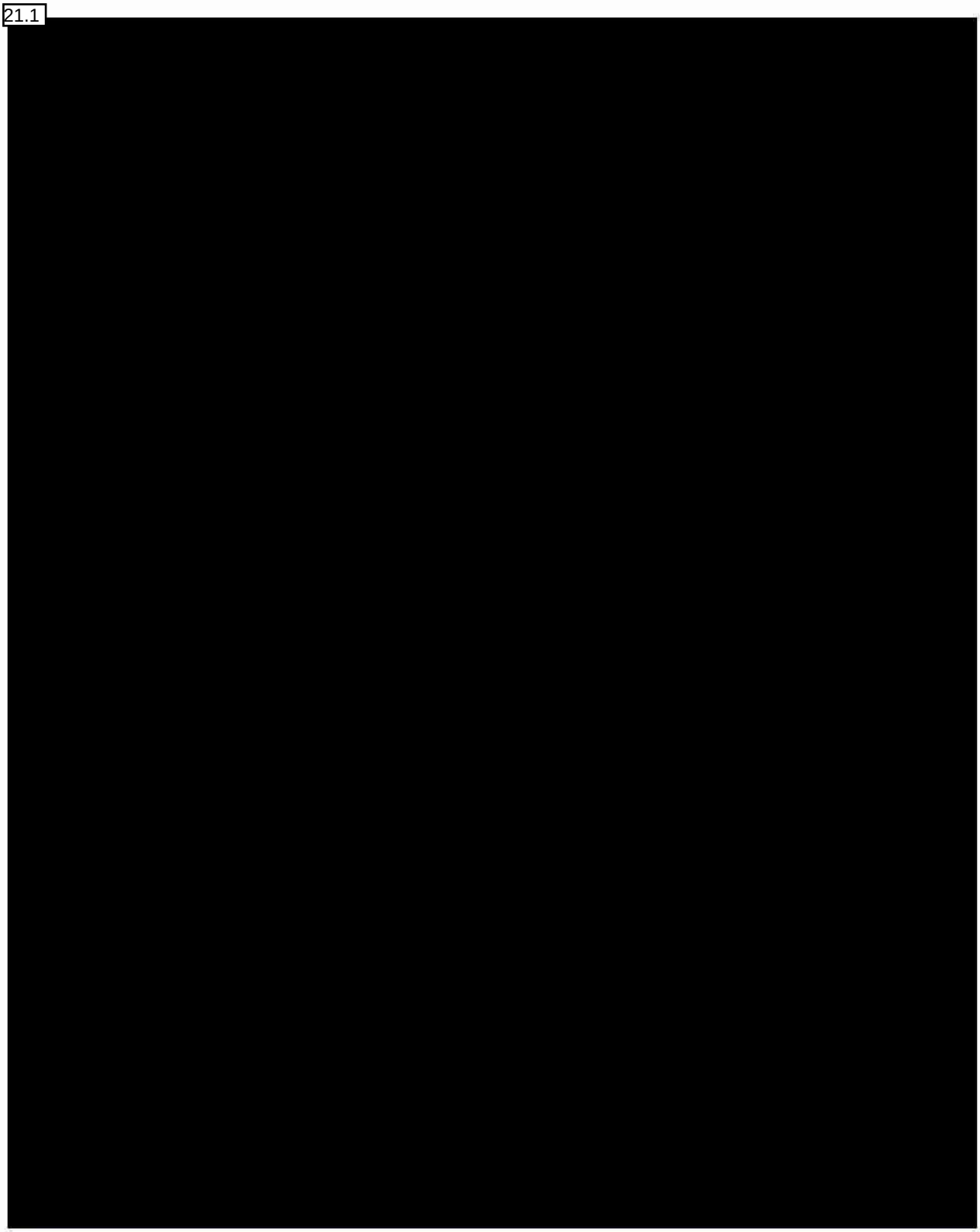

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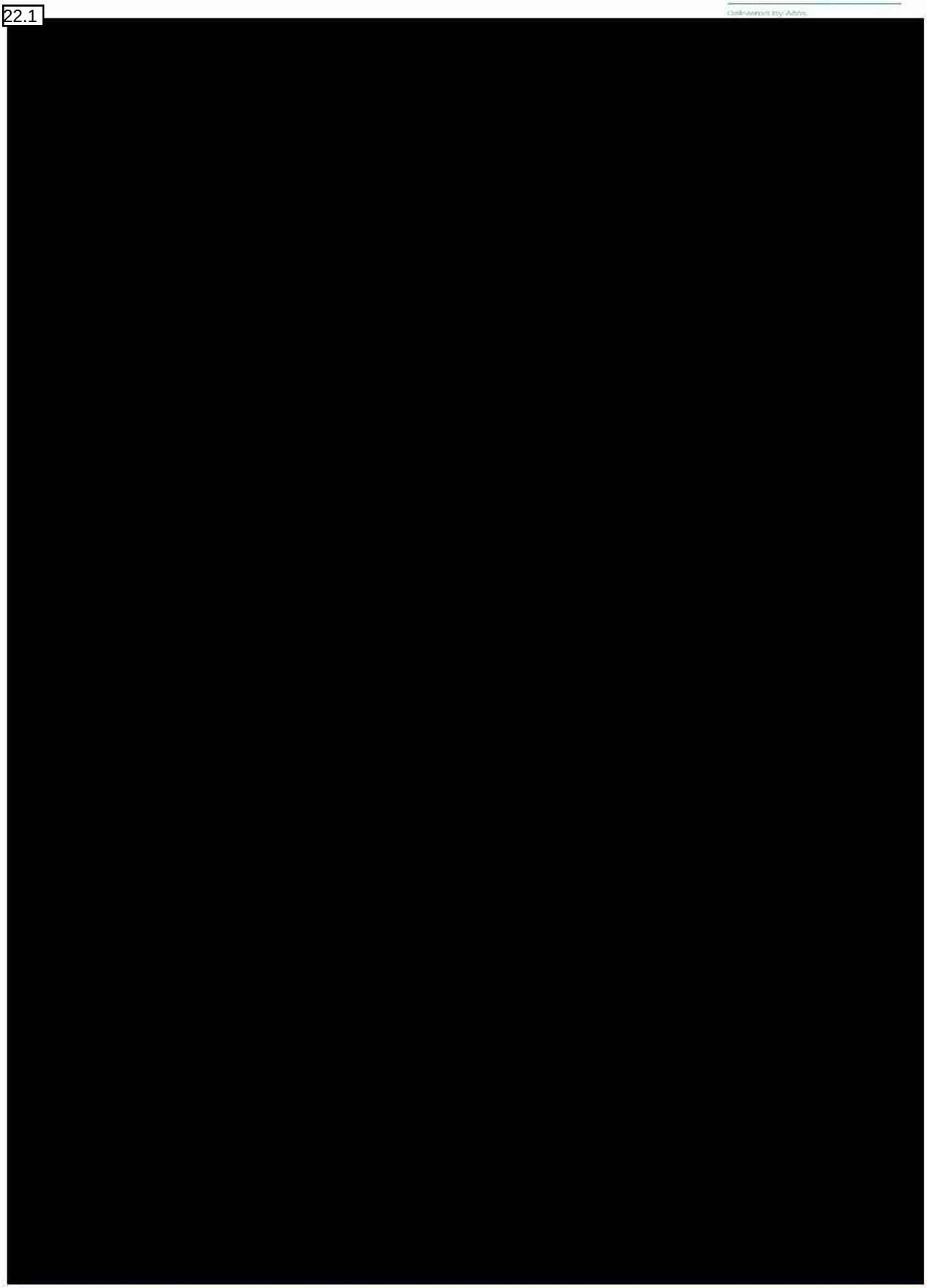

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7. Test Case Competency Check (FO version)

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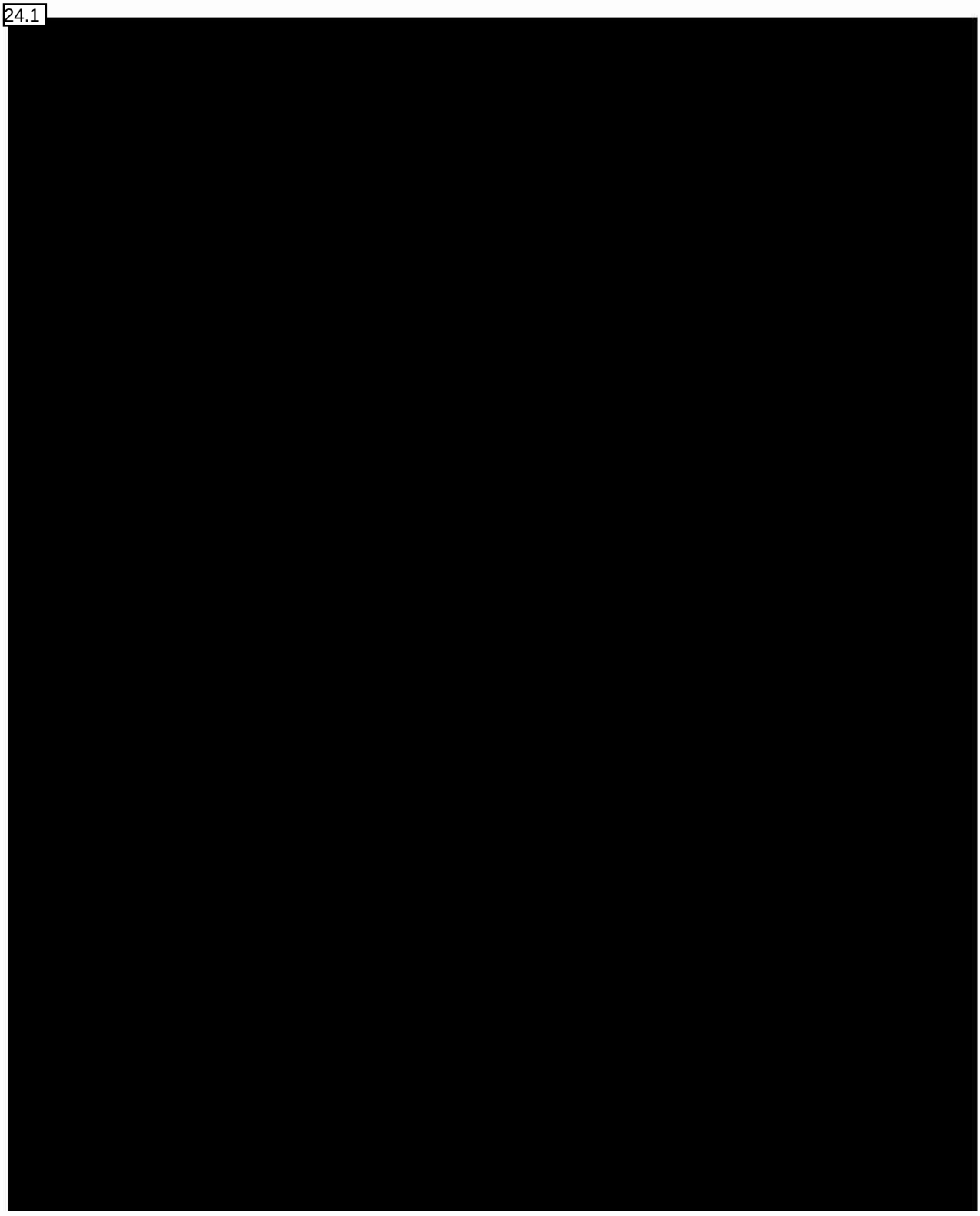

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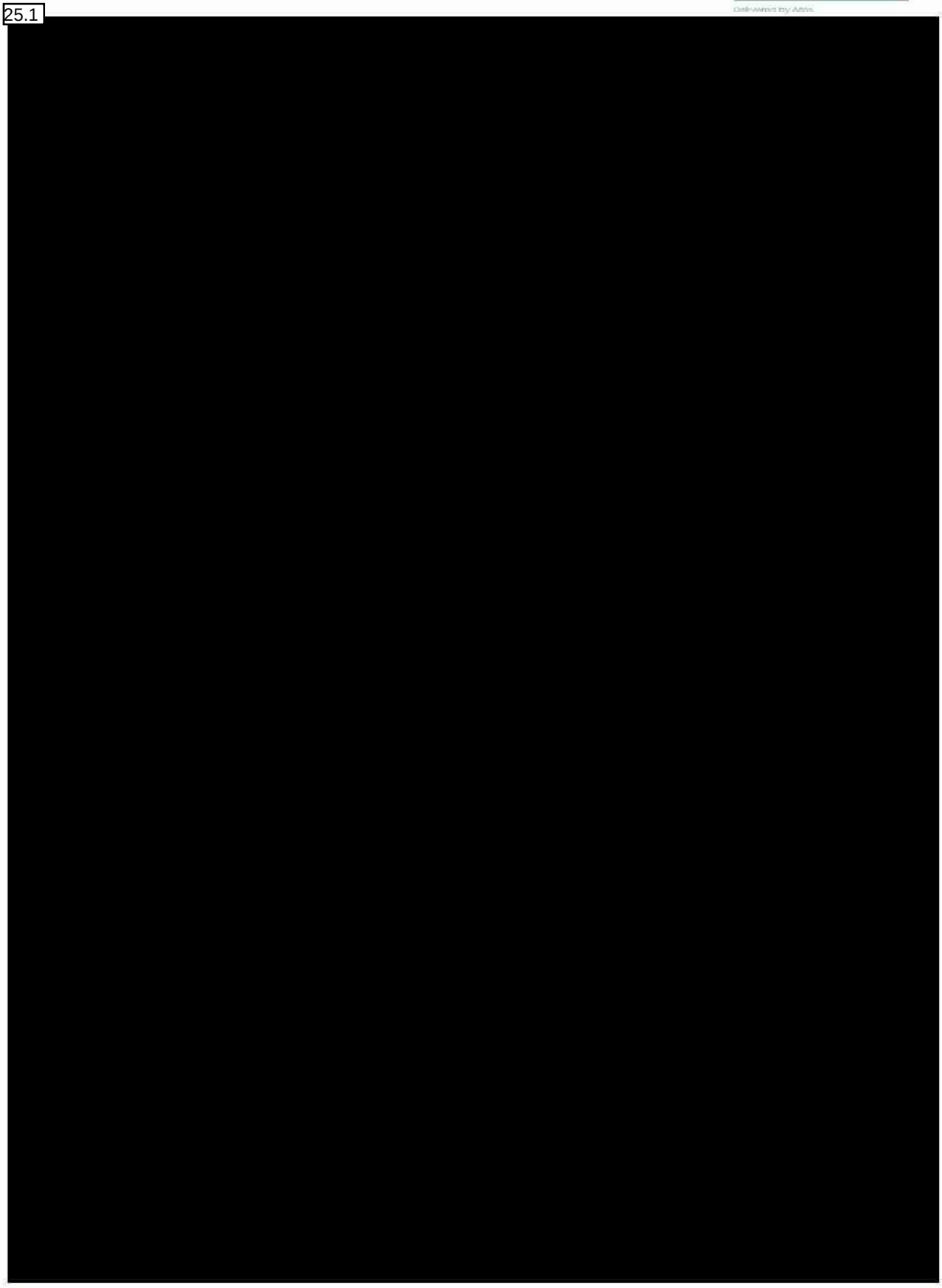

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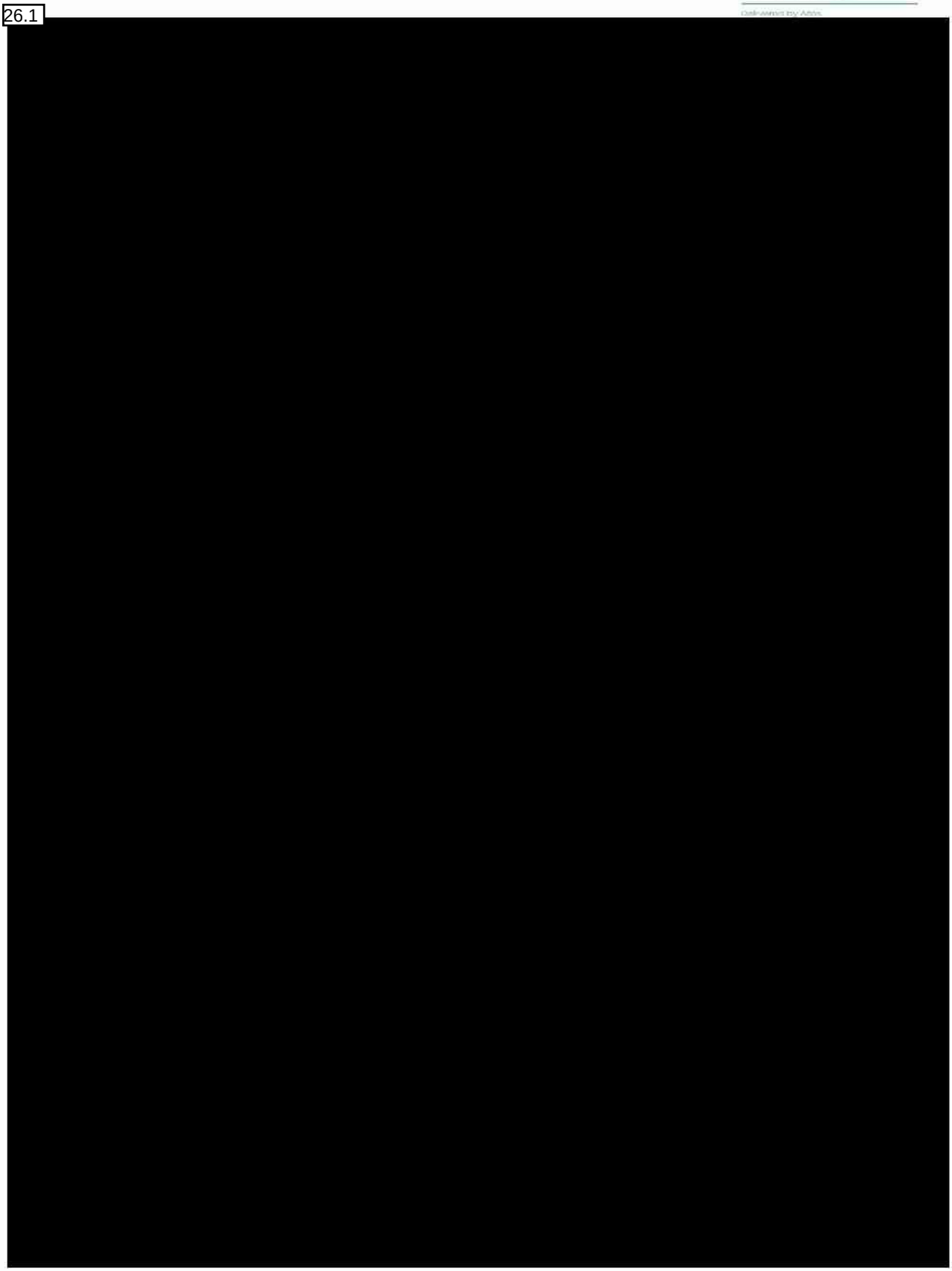

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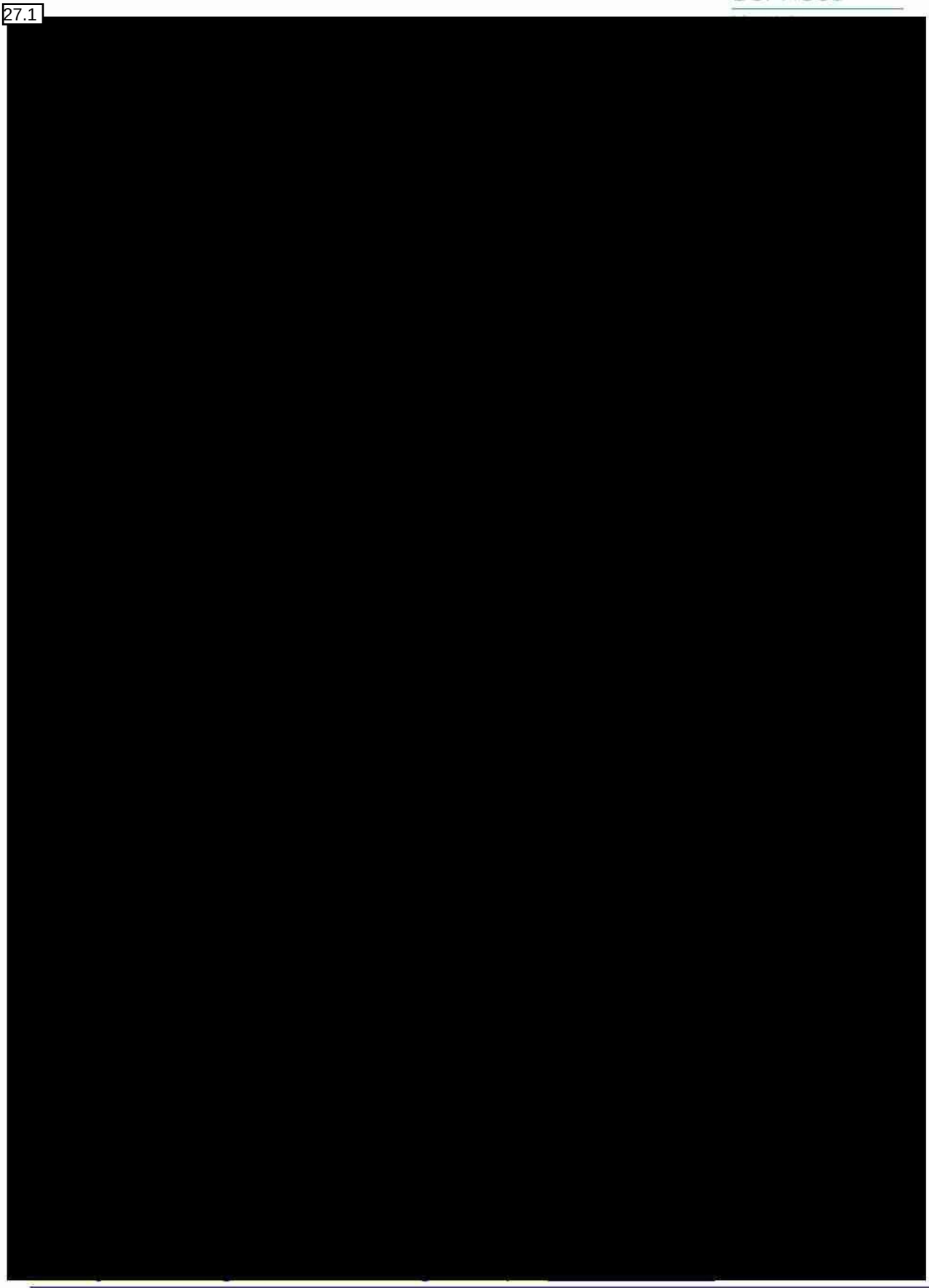

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9. Observation form

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

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