

Centre for Health and Disability Assessments

Operated by MAXIMUS

Registered Physiotherapist New Entrant Revised WCA Academy

Modified Learning Sets and Physical Examination Session

Schizophrenia, Bipolar Disorder and Continence

Day 5 (Delivered Centrally)

Facilitator Notes

MED-RPNEWCAAC~001(c)

Date: 1ST September 2015



Foreword

This training has been produced as part of a training programme for Healthcare Professionals (HCPs) who conduct assessments for The Centre for Health and Disability Assessments on behalf of the Department for Work and Pensions.

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

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

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

Thus, although the training module may be of interest to non-medical readers, it must be remembered that some of the information may not be readily understood without background medical knowledge and an awareness of the other training given to HCPs.

Document control

Superseded documents

Version history

Version	Date	Comments
6 Final	1 st September 2015	Final Doc
6a Draft	19 August 2015	Updated as part of general review of Training Academy
5 Final	30 March 2015	Rebranded to CHDA
4 Final	23 April 2014	Signed off by HWD and CMMS
4a draft	21 March 2014	Updated following TTT by Medical Training & Development
3 Final	12 th June 2013	Signed off by HWD and CMMS
3b draft	10 th May 2013	Insertion of peer review comments
3a draft	10 April 2013	Updated following changes to WCA Regulations
2 Final	3 April 2012	Signed off by HWD and CMMS

Changes since last version

Foreword updated

Terms attendee and participant updated to trainee for consistency

Reference to SharePoint updated to the internal online learning portal and links removed

Author updated to Clinical Learning and Development

Reference to support group updated to LCWRA

Term patient updated to individual where appropriate

DVLA link updated

NICE guidelines on Schizophrenia updated

SIGN guideline on schizophrenia added

NICE guidelines on urinary incontinence added

DWP medical guide document name and link updated

Modified learning set on schizophrenia – information updated to reflect DSM-5 diagnostic criteria, with additional information added for trainer for the various activities.

Modified learning set on bipolar disorder – information updated to reflect DSM-5 diagnostic criteria, with additional information added for trainer for the various activities.

Physical examination session – facilitators notes updated to refer to physiotherapists being able to assess any neurological condition

Name of DANE pre-course reading material updated to be consistent with new document title

Outstanding issues and omissions

Updates to Standards incorporated

Issue control

Author: Clinical Learning and Development

Owner and approver: Clinical Director

Signature: **Date:**

Distribution:

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Introduction

These Learning Sets are designed to form part of the training within the Registered Physiotherapist WCA Academy to prepare them for Work Capability Assessments (WCA). On this day there are 3 Learning Sets to complete:

- Schizophrenia
- Bipolar Disorder
- Continence

Because the Physiotherapists are new entrants to the ESA process, the activities are mainly trainer-led and therefore the Learning Sets are termed 'modified'. The trainees will be expected to complete preparatory reading prior to attendance at each learning set. The trainees must demonstrate knowledge of the topic and fully participate in all discussions during the Learning Set. The trainer must sign off participation for each trainee. A participation form is provided within the documentation for each of the learning sets that the trainer must complete for each trainee. This can be found in Appendix D of each section of this document for the relevant Learning Set.

Any trainee failing to demonstrate adequate knowledge must undertake further personal study on the topic and demonstrate competency to the Clinical Manager prior to proceeding with live Stage 3.

The aims and objectives for each Learning Set will be provided within this document.

Following completion of the learning sets, a session has been included to allow further MSO (musculoskeletal overview) practice and discussion on functional neurological assessment to prepare trainees for the later stages of their academy.

Learning Set Process

The trainer is responsible for ensuring the following process is adhered to:

Running the Learning Set		
Organisation of the set	The trainer to be made aware of details of trainees for each event	Clinical Managers will ensure communication of the learning aims to all trainees, to allow appropriate preparatory reading. Information on the topics to be covered will be provided in the trainee's WCA Academy Welcome document.
Following completion of event	Trainees complete an Individual Learning Set Review Form (see Appendix C of each Learning Set) for their own personal development	
Following completion of event	The trainer will complete a "Participation Form" to show that each Physiotherapist has participated fully in the Learning Set and demonstrated knowledge of the subject. (see Appendix D of each Learning Set)	
Following completion of event, in cases where trainees have not been signed off by the trainer	If a trainee fails to demonstrated knowledge or active participation in the Learning Set, they will be required to undertake further learning and demonstrate that learning to the Clinical Manager.	

Recommendations for Learning Set Activities

It is important that the assembled team make best use of the time devoted to each Learning Set. The activities will ensure that the team holds an interest in the outcomes and also confidence that they will gain either knowledge or skill during the experience.

The purpose of each Learning Set is not to repeat the salient points which emerge at individual study. The Sets are designed so that the team can share and expand on the information and ideas that flow out of their individual preparation/study/experiences. There will be extensive knowledge and differing experiences within a team, and through interactive exercises this can enrich the team as a whole.

Opening the Learning Set

It is essential that the Learning Set achieves the learning aims and covers the essential content. Preparation by all those participating is a key contributor to this, as is a positive and encouraging opening of the session.

It is recommended that all trainees are reminded of the purpose of the Learning Sets, informed about the responsibilities of all those present, and that the learning aims reinforced.

It is important to remind everyone of the process relating to the Learning Set initiative, if necessary referring to the Learning Set Process in this document.

Advice on selection of activities

The Learning Sets are designed to last 2 hours. Anything longer is likely to undermine the learning for this type of development tool.

The following pages specify guidance for Learning Set activities.

Modified Learning Set 1

Schizophrenia

Schizophrenia Learning Set

This Learning Set is designed to encourage the competency-based study of Schizophrenia.

This topic will include the exploration of:

- 1. Defining schizophrenia; ‘positive’ and ‘negative’ symptoms**
- 2. Diagnosis and treatment options**
- 3. Impact the condition can have on function and prognosis**

The learning aims are defined in this document and the trainer is encouraged to ensure that these are kept prominently to the fore throughout the event, in view of all trainees. In this way they will serve to maintain a focus in discussions. It is essential that trainees be informed of the learning aims and essential content well in advance of the Learning Set to ensure they focus their self-directed preparation for the event. Details of the full process are given on the following page.

To avoid intrusive use of PowerPoint during the Learning Set the learning aims are provided in A4 format (see Appendix E).

This pack provides guidance on activities to be used during the Learning Set. The absolute requirements are that the essential content is adhered to and the Learning Set aims achieved.

Advice is provided on the gathering of suitable documentation to facilitate and confirm both individual and team participation. The trainer will complete an evaluation form to show that each Physiotherapist has participated fully in the Learning Set and demonstrated knowledge of the subject (see Appendix D) If a trainee has not demonstrated knowledge or actively participated in the Learning Set, they will be required to undertake further learning and demonstrate that learning to the Clinical Manager. This will allow verification that the learning aims have been satisfied.



Learning Aims

- To consider trainee's knowledge of schizophrenia through trainer-led presentations, team discussions and question and answer sessions
- To establish and understand the clinical features of Schizophrenia ('positive' and 'negative' symptoms)
- To consider treatment options
- To consider the disabling effects and prognosis of Schizophrenia
- To consider Schizophrenia in the context of benefit claims
- To provide individuals with the opportunity for reflective practice



Suggestions for Study

The following references and texts will help the trainees prepare for this event. In addition, other relevant individual textbook and journal preferences are acceptable:

- Any suitable up-to-date textbook of medicine
- Suitable journal articles for example:
 - *The contribution of hypersalience to the "jumping to conclusions" bias associated with delusions in schizophrenia.* Speechly W.J, Whitman J.C, Woodward T.S, Journal of Psychiatry and Neuroscience 2010; 35 (1): 7-17
 - *A translational research approach to poor treatment response in patients with schizophrenia: clozapine- antipsychotic polypharmacy.* Honer W.G, Procyshyn R.M, Chen E.Y.H, MacEwan G.W, Barr A.M Journal of Psychiatry and Neuroscience 2009; 34 (6): 433-42
- The Royal College of Psychiatrists: <http://www.rcpsych.ac.uk>
- Clinical reviews, for example- the Cochrane Database
- NICE Guideline: Psychosis and Schizophrenia in adults: treatment and management. CG178. <https://www.nice.org.uk/guidance/cg178>
- SIGN Guidelines – SIGN 131 – Management of Schizophrenia - <http://www.sign.ac.uk/guidelines/fulltext/131/index.html>
- The British National Formulary (BNF)
- The Electronic Medicine Compendium (eMC) contains online information about UK licenced medicines at the following address:

<http://www.emc.medicines.org.uk/>

- DWP — Medical guidance for DLA and AA Decision Makers (adult cases):
staff guide -<https://www.gov.uk/government/publications/medical-guidance-for-dla-and-aa-decision-makers-adult-cases-staff-guide>

All trainees are advised to document their learning sources using an Individual Learning Set Review form (see Appendix C). Portfolio activity should be based upon reflection on usual practices and work based evidence, to show when new learning has been implemented to improve those standards.

Essential Content

This subject is complex; therefore the overall Learning Set will cover the following:

- The clinical aspects of Schizophrenia
- The general and clinical management of people with Schizophrenia
- Potential disability in people with schizophrenia and how this affects work and benefit claims

Activity 1: To explore the clinical features of schizophrenia

This activity will be predominantly trainer-led. It will include discussions on:

1. Defining Schizophrenia
2. Possible causes of Schizophrenia
3. Signs and symptoms of Schizophrenia ('positive and 'negative')

Discussion should also ensure trainees are aware of the 'NICE' and 'SIGN' guidelines.

1) Defining Schizophrenia

The facilitator should direct the trainees to discuss possible definitions for Schizophrenia. The facilitator should write the definitions on a whiteboard/flip chart and discuss.

The Royal College of Psychiatrists offer the following definition:

"A disorder of the mind which affects how you think, feel and behave"

According to the revised fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5.), to be diagnosed with schizophrenia at least two of the following five symptoms are required, with at least one symptom from the first three:

- Delusions
- Hallucinations
- Disorganized speech
- Disorganized or catatonic behaviour
- Negative symptoms

Symptoms should each be present for a significant portion of time during a 1 month period (or less if successfully treated).

Social/occupational dysfunction: For a significant portion of the time one or more major areas of functioning such as work, interpersonal relations, or self-care, are markedly below the level achieved prior to the onset.

Duration: Continuous signs of the disturbance persist for at least six months. This six-month period must include at least one month of symptoms (or less, if symptoms remitted with treatment.)

The Schizophrenia subtypes of 'paranoid', 'disorganised', 'catatonic', 'undifferentiated' and 'residual' have been removed from DSM-5 because of their limited diagnostic stability, clinical utility, reliability and validity.

Schizophrenia is believed to affect around 1 in every 100 people over the course of their life. It affects men and women equally and tends to start between the age of 15 and 35; however men tend to be diagnosed at a slightly younger age than women.

2) Possible causes of Schizophrenia

The facilitator should ask the whole group to brainstorm the possible causes of Schizophrenia, for 5 minutes while the facilitator acts as scribe on the white board / flip chart. This will enable the trainees to recall the knowledge they obtained in their professional practice and/or personal study before the Learning Set.

The following information is designed to support the facilitator in this process:

The cause for schizophrenia is still not clear. Some believe that it is due to a combination of factors such as genetics, brain abnormalities and environmental factors while others believe it is a group of different disorders.

Possible causes include:

Genetics: 1 in 100 people develop Schizophrenia, but about 1 in 10 people with Schizophrenia have one parent with the illness. In identical twins, there is a 1 in 2 chance of developing schizophrenia, while for non identical twins, there is a 1 in 8 chance of developing schizophrenia if one twin has the condition.¹

Brain abnormalities: Some studies have shown structural or physical differences on brain scans of individuals with schizophrenia. However these have not been found in all cases. This may be due to injury or damage even within the prenatal period.

Dopamine: Some evidence suggests that an increase in dopamine may be involved in the development of schizophrenia however the mechanism is still not clear and the evidence is still not conclusive.

Drugs and alcohol: Alcohol, amphetamines and cannabis seem to precipitate Schizophrenia.

Stress: A sudden traumatic or stressful event or long term stress can trigger or exacerbate schizophrenia. Stressful events may include unemployment, homelessness, poverty, social isolation, bereavement, abuse of any kind, etc.

Childhood factors: As with other mental health disorders, schizophrenia is thought to be more likely if there was deprivation, or in situations of physical or sexual abuse in childhood.

¹ <http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/schizophrenia/schizophrenia.aspx>

3) Signs and symptoms of schizophrenia

The facilitator should then ask the groups to consider the 'positive' and 'negative' symptoms. Firstly, the group should be given the information that 'positive' symptoms can be seen as excess or distortion of normal function. Ask a member of the group to be a scribe, for the open discussion of the possible positive symptoms that one might expect to see.

The following information is designed to support the facilitator in this process.

Positive symptoms of schizophrenia:

- Hallucinations (perceptions in a conscious and awake state in the absence of external stimuli which have qualities of real perception, in that they are vivid, substantial, and located in external objective space.)
- Delusions (false beliefs based on incorrect inference about external reality that is firmly sustained despite what almost everybody else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person's culture or subculture.)
- Disorganised behaviour
- Inappropriate affect
- Formal Thought Disorder – specifically, the presumed disruption in the flow of conscious verbal thought that is inferred from spoken language. Examples include thought blocking, flight of ideas, perseveration (the contextually inappropriate and unintentional repetition of a response or behavioural unit), tangential thinking, thought insertion or withdrawal

The group can then be directed to consider the negative symptoms. Negative symptoms can be defined as evidence of a decrease or loss of normal function.

Negative symptoms:

- Poverty of thought and speech
- Impaired volition
- Blunt affect and anhedonia
- Social withdrawal
- Impaired attention

The trainer needs to ensure the trainees understand that the typical course of schizophrenia is acute episodes of hallucination, delusions and florid disorganisation of thought; superimposed on a persistent disorder of the initiation and organisation of thought and behaviour.

Exploring hallucinations in more detail

Hallucinations are common in schizophrenia and are unusual experiences. The trainer will ask the group to consider the following, in relation to hallucinations:

- What kind of hallucinations may be experienced?
- What do the 'voices' sound like?
- How do people react to them?
- Where do the voices come from?
- Can people with other kinds of mental illness experience 'voices' or is it unique to people with schizophrenia?

The following information is intended to support the trainer in this process, but is not intended exhaustive:

- **What kind of hallucinations may be experienced?** Seeing, hearing smelling or tasting things, which are not there. Some people feel things 'touching' their body. The commonest reported is hearing voices
- **What do the 'voices' sound like?** To the person hearing them they sound entirely real. They usually seem to come from somewhere outside the body, often from a particular place or an object. Voices can talk directly to the person or – more commonly - the person may feel he has overheard a conversation about him. The voices can be pleasant, but are often rude or abusive
- **How do people react to them?** People respond in a variety of ways, for example, shouting at them, ignoring them or trying to converse with them. People may feel a need to obey the voices even if they know the action is wrong
- **Where do the voices come from?** They are created in the mind. It is thought that the brain mistakes the inner monologue for voices coming outside the body
- **Can people with other kinds of mental illness experience 'voices' or is it unique to people with schizophrenia?** In some cases of severe depression, people can hear a voice – usually a critical second person - which may repeat a word or phrase over and over again. The voices would not usually interfere in the person's life, may come and go, and usually do not require any kind of treatment. People with sensory impairment, such as vision or hearing, may also experience visual or auditory hallucinations in the absence of any mental function condition.

Exploring delusions in more detail

The following definition is taken from The Royal College of Psychiatrists:

“A delusion happens when you believe something – and are completely sure of it – while other people think you have misunderstood what is happening. It's as though you see things in a completely different way from everyone else. You have no doubts, but other people see your belief as mistaken, unrealistic or strange. If you do try to talk about your ideas with someone, your reasons don't make sense to them, or you can't explain – you 'just know'. It's an idea, or set of ideas, that can't be explained as part of your culture, background or religion”

The trainer will ask the group to consider the following, in relation to delusions:

- What are the criteria for a delusion?
- What types of delusions may be experienced?
- The following information is intended to support the trainer in this process, but is not intended exhaustive:
- What are the criteria for a delusion? – The noted Psychiatrist and Philosopher Karl Jaspers described the criteria required for a delusion:
 - **Certainty** – the person believes the delusion absolutely
 - **Incorrigibility** – the belief cannot be shaken
 - **Impossibility** – the delusion is, without doubt, untrue

Delusions can vary in strength over time.

(The above information has been taken from the following: Spitzer, M; On Defining Delusions. Compr Psychiatry. 1990 Sept-Oct; 31 (5): 377-97)

What types of delusions may be experienced? –

- Monothematic – delusions only relating to one particular topic
- Polythematic – a range of delusional topics (which is seen in people with Schizophrenia)
- Delusions can also be classified as:
 - Primary – occur in the mind, fully formed, with no preceding reasons (strongly suggestive of schizophrenia)
 - Secondary – an example would be in the depressed person believing that they are worthless

Discuss with trainees the following example which may be a feature of schizophrenia:

Grandiose delusions where there is a belief of exaggerated self worth.

Diurnal Patterns

The trainer will then discuss the effect that disruption of diurnal patterns may have on quality of life and ability to function. The person may report being unable to sleep at night and therefore spends the day asleep (turning night into day). The consequence is usually that they are active throughout the night which can be difficult and distressing for both the person and the family.

Distraction and thought disorder

The trainer will now ask the trainees to consider the impact distraction and thought disorder can have on daily living:

- Difficulty keeping up with studies at College / University
- Difficulty keeping focused on a task at work, for example
- Difficulty finishing an article in a newspaper or watching a TV programme to the end

People with distractibility and muddled thinking find their thoughts wander and flit from one unconnected idea to another (flight of ideas). They may also find it difficult to recall things they were thinking about a few moments earlier. Other examples are “word salads” - speech that is incoherent because, though individually the words are real, the manner in which they are strung together results in gibberish, e.g. the question "How did you get here today?" elicits a response such as "I started off twirling in a box, the elephant is broken, isn't rain sad?" – and knight's-move thinking, where thoughts slip off the topic on to another which is obliquely related or unrelated.

This can create difficulties for those who are trying to follow the speaker's train of thought.

The trainer will then ask the group whether they agree with the following viewpoint:

“Schizophrenics are often violent and are likely to murder people in a psychotic rage”

The trainer will ask the group why they agree/disagree with the above viewpoint, which is commonly held in the general public.

Tip

The importance here is to emphasise that **a few people** with schizophrenia do become violent but are much more likely to harm themselves than others. The risk of suicide is higher in schizophrenia, with a lifetime risk of suicide of 10% in individuals with schizophrenia. Rarely, however, they may hurt other people.

This may be as a result of feelings of persecution, or hearing voices which are telling them to do it, but more often it is a combination of both these elements. Misuse of drugs or alcohol makes violent behaviour much more likely. However, it should be emphasised that violence in schizophrenia is the exception rather than the rule.

Activity 2: Discussion around treatment options for people with schizophrenia

The trainer should emphasise that the earlier a person seeks help for their symptoms, then the better the outlook. Early intervention also reduces the likelihood that hospital treatment will be required. Someone who is newly diagnosed with schizophrenia will probably see a Psychiatrist and Community Mental Health Team (CMHT) to plan treatment at home, in the Primary care setting. Some may need hospitalisation, but only until they are stable and well enough to go home.

A range of pharmacological and psychological interventions may be employed to treat the person with schizophrenia.

Schizophrenia is commonly associated with other conditions affecting mental function, such as depression, anxiety, post traumatic stress disorder, personality disorder and substance misuse. Management options would need to consider any other co-morbidity.

Drugs are used for treatment of acute episodes and the prevention of relapse. Psychosocial interventions are used to prevent relapse and disability. Typical antipsychotic medications are more effective in treating the positive symptoms of schizophrenia while the atypical antipsychotics are effective in reducing the both positive and negative symptoms.

The facilitator should split the main group into smaller groups before asking them to consider firstly:

1. The type of medication employed (and the potential side effects)
2. Why medication is employed as **part of the treatment** of schizophrenia.

The groups should then feedback their thoughts to the group as a whole, reflecting on the differing viewpoints which are likely to emerge.

The following information is designed to support the facilitator in this process.

Antipsychotic medications- These are used to help weaken any delusions or hallucinations. They may help the person to think more clearly and improve their ability to self care. In most people it is possible to control symptoms but treatment is not curative. Antipsychotics should be taken regularly, even if the person starts to feel better. Older antipsychotic medications had multiple side effects including tremor and restless legs. New generation antipsychotics work on different neurotransmitters and have fewer side effects. Symptoms usually return within 3 - 6 months of medication being stopped.

The choice of antipsychotic medication will depend on the main symptoms present, any other co-morbidity, individual preference due to risk of side effects from the different medication, any contraindications to use of any of the medication and any response to previous medication.

Clozapine is the most effective of the 2nd generation (atypical) antipsychotic drugs, but is reserved for use in those who are resistant to other treatment options because of the risk of agranulocytosis and myocarditis. Frequent monitoring of blood tests is required throughout treatment.

The facilitator should then build on this exercise, by asking the groups to go on and think about other possible interventions which are used as part of the treatment and recovery process.

The following questions will be posed to the group for open discussion and reflection:

[REDACTED]

The following notes are designed to help the facilitator in stimulating informative discussion:

[REDACTED]

Tip

This is an important exercise, as it will encourage the group to think about the role medication plays, as part of the treatment of schizophrenia, rather than being the sole solution. Taking and responding to medication is an important step for a person with schizophrenia and facilitate access other kinds of help and support.

Furthermore, the group should be challenged to think about interventions that are in place to support the person with schizophrenia. Some people may need more support than others, and others may remain unstable, even with support in place.

These are important considerations for practitioners involved in carrying out assessments, since they will be required to evaluate the level of input as part of the process of determining the likely level of disability.

Prognosis

Within 5 years the clinical course becomes established. The trainer should use a white board/flip chart to discuss prognosis.

The following notes are designed to support the facilitator in this process:

In most cases the course follows one of four broad patterns:

- Complete remission (22%)
- Episodic remission (35%)
- Episodic with stable deficit (8%)
- Episodic with progressive deficit (35%)

Death rates in schizophrenia are at least twice as high as the general population

The leading cause of death amongst schizophrenic individuals is suicide. The lifetime risk of this is about 10%.

Individuals who have had several psychotic episodes usually require life-long maintenance antipsychotic medication.

Persistent moderate to severe disability is present in 40% of males and 25% of females with schizophrenia.

Supported employment programmes have been shown to be effective in increasing the rates of competitive employment.

Activity 3: Case Study Presentation

This activity will be predominantly trainer - led. The trainer will present a case study to the group. This case may be one they have personally seen, or it may be a case they have reviewed at audit. The anonymity of the claimant must be protected. The trainer must ensure that the focus of the case is on broad-based function only, rather than on the descriptors.

After the case presentation, the trainees should be split into groups of an approximate size, to discuss the functional problems associated with the condition. The trainees can feed back their findings to the rest of the group and the trainer. This will allow the trainees to think about the nature of the condition, and, through discussion of the case, will be inspired to consider the functional impact that the condition and medications may have on the claimant with schizophrenia. The purpose of exploring the case study is to think about the impact of having schizophrenia on a claimant's benefit claim. The trainee's personal knowledge, preparatory reading and Modified Learning Set activities will have highlighted the difficulties faced by people with schizophrenia.

In order to support the facilitator, the following is an example of a case which may be used in this exercise if a case from personal experience is not available.

Case example:



Activity 4: Question and answer session

A number of “True/False” questions have been devised. The depth of the subject, including severity, psychological effects and disabilities lends itself very well to a team question and answer session.

This can be completed by a divided team that "compete" to achieve the best outcome.

The aim is to allow individual team members to confirm that their study has successfully increased their knowledge of the subject to a level equivalent of their peers.

The trainer may choose to use some of their own questions or modify the questions, however must ensure the learning aims are satisfied.

The facilitator will be prepared to summarise the key facts and ensure all the trainees have equal understanding of the principles covered in the questions.

Activity 4: Question and answer session (continued)

The following questions are designed to reflect the key principles of the learning set. Following individual study of the questions the group will then explore the answers, with time allocated for group discussion.



Activity 4: Question and answer session - Answers



Closing the Learning Set

As with the opening of the Learning Set, the closing set should be a positive and encouraging element. Refocus attention on the learning aims and ask if everyone is satisfied, that through individual preparation/study and participation during the Learning Set the aims have been achieved. An attendance sheet will be completed by the trainer to ensure trainees have completed this part of the academy.

An Individual Learning Set Review Form, contained at Appendix C of this document, will be given to all trainees. This form is designed to provide the basis for self-reflection and is for the individual's use. It is, therefore, optional whether the individual uses it or not. However, it is recommended that for revalidation or continued registration or appraisal purposes, reflective practice is used.

Appendix A - Schizophrenia Modified Learning Set Event Fact Sheet

Date		Time	
Venue			



Learning Aims

- To consider trainee's knowledge of schizophrenia through trainer-led presentations, team discussions and question and answer sessions
- To establish and understand the clinical features of Schizophrenia ('positive' and 'negative' symptoms)
- To consider treatment options
- To consider the disabling effects and prognosis of Schizophrenia
- To consider Schizophrenia in the context of benefit claims
- To provide individuals with the opportunity for reflective practice



Suggestions for Study

The following references and texts will help the trainees prepare for this event. In addition, other relevant individual textbook and journal preferences are acceptable:

- Any suitable up-to-date textbook of medicine
- Suitable journal articles for example:
 - *The contribution of hypersalience to the "jumping to conclusions" bias associated with delusions in schizophrenia.* Speechly W.J, Whitman J.C, Woodward T.S, Journal of Psychiatry and Neuroscience 2010; 35 (1): 7-17
 - *A translational research approach to poor treatment response in patients with schizophrenia: clozapine- antipsychotic polypharmacy.* Honer W.G, Procyshyn R.M, Chen E.Y.H, MacEwan G.W, Barr A.M Journal of Psychiatry and Neuroscience 2009; 34 (6): 433-42
- The Royal College of Psychiatrists: <http://www.rcpsych.ac.uk>
- Clinical reviews, for example- the Cochrane Database

- NICE Guideline: Psychosis and Schizophrenia in adults: treatment and management. CG178. <https://www.nice.org.uk/guidance/cg178>
- SIGN Guidelines – SIGN 131 – Management of Schizophrenia - <http://www.sign.ac.uk/guidelines/fulltext/131/index.html>
- The British National Formulary (BNF)
- The Electronic Medicine Compendium (eMC) contains online information about UK licenced medicines at the following address:
<http://www.emc.medicines.org.uk/>
- DWP — Medical guidance for DLA and AA Decision Makers (adult cases): staff guide -<https://www.gov.uk/government/publications/medical-guidance-for-dla-and-aa-decision-makers-adult-cases-staff-guide>

All trainees are advised to document their learning sources using an Individual Learning Set Review form (see Appendix C). Portfolio activity should be based upon reflection on usual practices and work based evidence, to show when new learning has been implemented to improve those standards.

Appendix B - Schizophrenia Essential Content

This subject is complex; therefore the overall Learning Set will cover the following:

- The clinical aspects of Schizophrenia
- The general and clinical management of people with Schizophrenia
- Potential disability in people with schizophrenia and how this affects work and benefit claims

Appendix C - Schizophrenia Individual Learning Set Review Form (To be completed by the learner to aid reflective practice)

Name	
Learning Set Title	
Date attended	
Learning Set Preparation What did I do to prepare for the Learning Set? What source(s) of information did I use/access? How useful were these?	
Learning Set Participation To what extent did I participate? What value did my participation bring to me and other trainees? Could I have brought more value, if so what and how?	

<p>Learning Achieved</p> <p>What were the key points of learning for me?</p> <p>What impact will this learning have on my performance?</p>	
<p>Application of Learning</p> <p>How will I show that I have implemented this new learning in my every day role?</p>	
<p>Any Other Reflections?</p>	

Appendix D “Participation Form” for Learning Set Attendance – Schizophrenia

Registered Physiotherapist WCA Academy Schizophrenia Learning Set Participation Form	
Name of Trainee:	Date of Learning Set:
Did the HCP demonstrate adequate knowledge of the topic? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Please provide comments:	
Did the HCP fully participate and bring value to the Learning Set? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Please provide comments:	
Does the HCP need to complete further reading and demonstrate Knowledge to Clinical Manager? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Please provide comments:	
Trainer name	Date

Appendix E – Schizophrenia Learning Set Aims

Schizophrenia - Learning Aims

- To consider trainee's knowledge of schizophrenia through trainer-led presentations, team discussions and question and answer sessions
- To establish and understand the clinical features of Schizophrenia ('positive' and 'negative' symptoms)
- To consider treatment options
- To consider the disabling effects and prognosis of Schizophrenia
- To consider Schizophrenia in the context of benefit claims
- To provide individuals with the opportunity for reflective practice

Modified Learning Set 2

Bipolar Disorder

Modified Learning Set 2 – Bipolar Disorder (Day 5 of Academy)

This topic includes the exploration of:

- 1) Bipolar Type I, II , Rapid Cycling and Cyclothymia**
- 2) Diagnosis and classification**
- 3) Treatment and prevention of relapse**
- 4) Impact the condition can have on function and prognosis**

The Learning Aims defined in this document and the trainer is encouraged to ensure that these are kept prominently to the forefront throughout the event, keeping them in view of all trainees. In this way they will serve to maintain a focus on discussions. It is essential that trainees be informed of the learning aims and essential content well in advance of the Learning Set to ensure they focus their self directed preparation for the event. Details of the full process are given on the following page.

To avoid intrusive use of PowerPoint apparatus during the Learning Set the learning aims are provided in A4 format (see Appendix E of each learning set).

This pack provides guidance on activities to be used during the Learning Set. The absolute requirements are that the essential content is adhered to and the Learning Set aims achieved.

Advice is provided on the gathering of suitable documentation to facilitate and confirm both individual and team participation. The trainer will complete an evaluation form to show that each Physiotherapist has participated fully in the Learning Set and demonstrated knowledge of the subject see Appendix D. If a Physiotherapist has not demonstrated knowledge or actively participated in the Learning Set, they will be required to undertake further learning and demonstrate that learning to the Clinical Manager. This will allow verification that the learning aims have been satisfied.

This is essential to establish the status and quality of the Learning Set should Healthcare Professionals decide to make use of the reflective practice data for revalidation or continuing registration purposes.



Learning Aims

- To consider trainee's knowledge of Bipolar Disorder through trainer-led presentations, team discussions and question and answer sessions.
- To confirm / assure understanding of the clinical features of Bipolar Disorder (Types I, II, Rapid Cycling and Cyclothymia)
- To consider the disabling effects and prognosis of Bipolar Disorder
- To consider Bipolar Disorder in the context of benefit claims
- To provide individuals with the opportunity for reflective practice.



Suggestions for Study

The following references and texts will help the trainees prepare for this event. In addition, other relevant individual textbook and journal preferences are acceptable:

- Any suitable up-to-date textbook of medicine
- Suitable journal articles:
 - What can we conclude from studies on psychotherapy in bipolar disorder? Dominic Lam *The British Journal of Psychiatry* (2006) 188: 321-322
 - Psychological process in bipolar affective disorder: negative cognitive style and reward processing Emma Van der Gucht *The British journal of Psychiatry* (2009) 194: 146-151
- The Royal College of Psychiatrists: <http://www.rcpsych.ac.uk>
- Clinical reviews for example - the Cochrane Database
- SIGN guideline 82 'Bipolar Affective Disorder: A national clinical guideline' can be found using the following address: <http://www.sign.ac.uk/pdf/sign82.pdf>
- NICE Guideline - Bipolar disorder: the assessment and management of bipolar disorder in adults, children and young people in primary and secondary care - <http://www.nice.org.uk/guidance/cg185>
- The British National Formulary (BNF)
- The Electronic Medicine Compendium (eMC) contains online information about UK licensed medicines at the following address: <http://www.emc.medicines.org.uk/>

- DWP — Medical guidance for DLA and AA Decision Makers (adult cases): staff guide - <https://www.gov.uk/government/publications/medical-guidance-for-dla-and-aa-decision-makers-adult-cases-staff-guide>

All trainees are advised to document their learning sources using an Individual Learning Set Review form (see Appendix C).

Essential Content

This subject is complex; therefore the overall Learning Set will cover the following:

- The clinical aspects of Bipolar Disorder Types I, II, Rapid Cycling and Cyclothymia
- The general and clinical management of individuals with Bipolar Disorder
- Potential disability in individuals with Bipolar Disorder and how this affects work and benefit claims

Activity 1: To explore and understand clinical features and classification of Bipolar Disorder

This activity will be predominantly facilitator-led and will cover the following:

- 1) Signs and symptoms of depression (brief overview)**
- 2) Signs and symptoms of mania (brief overview)**
- 3) Types of Bipolar Disorder**
- 4) Brief discussion of the DSM and ICD criteria for diagnosis**

Discussion should also ensure trainees are aware of the “SIGN”/”NICE” guidelines.

The facilitator will direct the trainees to offer their understanding of some of the signs and symptoms of both depression and mania. Answers can be recorded on a whiteboard or flipchart. Participation of all group members should be encouraged wherever possible. Once the group has reflected on their lists the facilitator can supplement the answers with further information and guidance if required.

The following information is designed to support the facilitator and is not exhaustive.

Bipolar disorder is characterised by marked mood swings from mania and hypomania to depression. It usually starts between the age of 15 – 19 and men and women are equally affected. About 1 in every 100 adults has bipolar disorder at some point in their life.

60% of individuals with bipolar disorder will have psychotic symptoms at some point. Co-morbidity with other mental health conditions is common and 50% of individuals with bipolar disorder will attempt suicide at some point. Long term poor psychosocial functioning is present in up to 60% of individuals with bipolar disorder.

Signs and symptoms of depression:

- Feeling sad, empty or unhappy
- Thoughts of suicide
- Unable to think positively
- Sleeping too much, or unable to sleep
- Changes in appetite and unintended weight loss/gain

- Loss of pleasure in activities including sex (anhedonia)
- Loss of interest in activities
- Difficulty making decisions
- Feelings of worthlessness, hopelessness, loss of self esteem
- Lack of concentration

Signs and symptoms of Mania:

- Feels more happy than usual
- Exercises poor judgement
- Unrealistic beliefs in one's abilities and powers
- Feeling full of exciting ideas, with flight of thoughts
- Little need for sleep
- Extreme irritability
- Denial of symptoms or that anything is wrong
- Feeling full of energy
- Engaging in risky behaviour

This exercise allows the trainees to make the distinction between mania and depression, before examining the types of bipolar disorder.

The group will be asked to name the types of bipolar disorder, before exploring the terms in more detail with the facilitator in open discussion.

Once again, the following notes are designed to support the facilitator in this process:

Types of bipolar disorder:

Bipolar Type I - There has been at least one manic episode, which has lasted for longer than one week. Person may only have manic episodes, although most people will also have periods of depression.

Bipolar Type II - There has been more than one episode of severe depression but only mild manic episodes (hypomania).

Cyclothymia - The mood swings are less severe, but very often last longer.

Rapid Cycling - More than four mood swings occurring in a 12 month period. This affects around 1 in 10 people with bipolar disorder and can occur in both bipolar types I and II.

Discussion should conclude by reviewing the ICD and DSM clinical assessment criteria for diagnosing Bipolar Disorder. Discuss the differences with the group.

DSM - The Diagnostic and Statistical Manual for Mental Disorders is published by the American Psychiatric Association and provides diagnostic criteria for mental disorders. The manual covers all mental health disorders for both children and adults. It also lists known causes of these disorders, statistics in terms of gender, age at onset, and prognosis as well as some research concerning the optimal treatment approaches.

ICD - International Classification of Diseases is published by the World Health Organization (WHO) and is used worldwide. The WHO began work in 1983 on categorizing diseases and signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases. It also tracks many new diagnoses and procedures.

DSM-5 has removed the 'mixed episode' diagnosis for bipolar disorder and instead added a new specified 'with mixed features' which can be used when features of mania/hypomania are present with features of depression. DSM-5 also has amended the primary criteria for diagnosis of mania and hypomania to include a change in activity and energy and not just a change in mood.

Activity 2: To explore treatment strategies for Bipolar Disorder

This activity will be predominantly facilitator-led, but is designed to be interactive to recognise that trainees may already have a good grasp of the concepts. This follows on from Activity 1 which covered the clinical features and classification.

The facilitator will ask the group to consider the treatment interventions employed in clinical practice to address acute episodes of depression and mania and to prevent relapse. The facilitator will discuss the following factors with trainees.

The information provided is designed to support the facilitator in discussions with the group

- ☐ **Specialist input for managing Bipolar Disorder:** Mental Health Team, Psychiatrist, Psychologist, Community Psychiatric Nurse
- ☐ **Acute Treatment for depression and mania:** Antidepressants, antipsychotics, benzodiazepines, ECT, anti-manic drugs, mood stabilisers
- ☐ **Pharmacological and psychosocial relapse prevention:** Use of Lithium, Carbamazepine, Valproate Acid Salts, Lamotrigine, antipsychotics and antidepressants. Then consider Cognitive Behavioural Therapy, Behavioural Family Therapy, Group Psychotherapy and Interpersonal and Social Rhythm Therapy
- ☐ **Possible side effects of medication:** With Lithium, for example, side effects can include feeling thirsty, passing more urine than usual, weight gain and less commonly blurred vision, fine tremor of the hands. The person on Lithium treatment will have close monitoring of their blood levels as the medication can be toxic with the potential of death occurring.
- ☐ **Reproductive health issues:** E.g. Contraception (for example dose adjustment and warning of reduced efficiency due to enzyme induction effect of medications), preconception counselling and drugs in counselling
- ☐ **Substance misuse:** Drug and alcohol misuse (can be misused in an attempt to cope with the symptoms of condition)

Activity 3: Case Study Presentation

This activity will be predominantly facilitator-led. The facilitator will present a case study to the group. This case may be one they have personally seen, or it may be a case they have reviewed at audit. **They must ensure the case is fully anonymised.** In addition the trainer should discuss how bipolar disorder impacted on the client's functional ability. Avoid discussing specific descriptors, as trainees are new to Disability Analysis and will not have knowledge of specifics such as descriptors.

After the case presentation, the trainees should be split into groups of an approximate size, to discuss further the functional problems associated with the condition. The trainees can feedback their findings to the rest of the group and the facilitator. This will allow the trainees to think about the nature of the condition, and through discussion of the case will be inspired to consider the functional impact and prognosis the condition and medications may have on the client with bipolar disorder. The purpose of exploring the case study is to think about the impact of having bipolar disorder on the claimant's ability to function. The trainee's personal knowledge, preparatory reading and Modified Learning Set activities will have highlighted the difficulties faced by people with bipolar disorder.

In order to support the facilitator, the following is an example of a case which may be used in this exercise if a case from personal experience is not apparent.



Activity 4: Question and answer session

A number of “True/False” questions have been devised. The depth of the subject, including severity, psychological effects and disabilities lends itself very well to a team question and answer session.

This can be completed by a divided team that "compete" to achieve the best outcome.

The aim is to allow individual team members to confirm that their study has successfully increased their knowledge of the subject to a level equivalent of their peers.

The trainer may choose to use some of their own questions or modify the questions, however must ensure the learning aims are satisfied.

The facilitator will be prepared to summarise the key facts and ensure all the trainees have equal understanding of the principles covered in the questions.

Activity 4: Question and answer session (continued)

The following questions are designed to reflect the key principles of the learning set. Following individual study of the questions the group will then explore the answers, with time allocated for group discussion.



Activity 4: Question and answer session - Answers:



Closing the Learning Set

As with the opening of the Learning Set, the closing set should be a positive and encouraging element. Refocus attention on the learning aims and ask if everyone is satisfied, that through individual preparation/study and participation during the Learning Set the aims have been achieved. An attendance sheet will be completed by the trainer to ensure trainees have completed this part of the academy.

An Individual Learning Set Review Form, contained at Appendix C of this document, will be given to all trainees. This form is designed to provide the basis for self-reflection and is for the individual's use. It is, therefore, optional whether the individual uses it or not. However, it is recommended that for revalidation or continued registration or appraisal purposes, reflective practice is used.

Appendix A - Bipolar Disorder Modified Learning Set Event Fact Sheet

Date		Time	
Venue			



Learning Aims

- ☐ To consider trainee's knowledge of Bipolar Disorder through trainer-led presentations, team discussions and question and answer sessions
- ☐ To confirm/ assure understanding of the clinical features of Bipolar Disorder (Types I, II, Rapid Cycling and Cyclothymia)
- ☐ To consider the disabling effects and prognosis of Bipolar Disorder
- ☐ To consider Bipolar Disorder in the context of benefit claims
- ☐ To provide individuals with the opportunity for reflective practice



Suggestions for Study

The following references and texts will help the trainees prepare for this event. In addition, other relevant individual textbook and journal preferences are acceptable:

- Any suitable up-to-date textbook of medicine
- Suitable journal articles:
 - What can we conclude from studies on psychotherapy in bipolar disorder? Dominic Lam *The British Journal of Psychiatry* (2006) 188: 321-322
 - Psychological process in bipolar affective disorder: negative cognitive style and reward processing Emma Van der Gucht *The British journal of Psychiatry* (2009) 194: 146-151
- The Royal College of Psychiatrists: <http://www.rcpsych.ac.uk>
- Clinical reviews for example - the Cochrane Database
- SIGN guideline 82 'Bipolar Affective Disorder: A national clinical guideline' can be found using the following address:
<http://www.sign.ac.uk/pdf/sign82.pdf>

- NICE Guideline - Bipolar disorder: the assessment and management of bipolar disorder in adults, children and young people in primary and secondary care - <http://www.nice.org.uk/guidance/cg185>
- The British National Formulary (BNF)
- The Electronic Medicine Compendium (eMC) contains online information about UK licensed medicines at the following address: <http://www.emc.medicines.org.uk/>
- DWP — Medical guidance for DLA and AA Decision Makers (adult cases): staff guide - <https://www.gov.uk/government/publications/medical-guidance-for-dla-and-aa-decision-makers-adult-cases-staff-guide>

All trainees are advised to document their learning sources using an Individual Learning Set Review form (see Appendix C).

Appendix B- Essential Content

This subject is complex; therefore, the overall Learning Set will cover the following:

- ☐ The clinical aspects of Bipolar Disorder Types I, II, Rapid Cycling and Cyclothymia
- ☐ The general and clinical management of individuals with Bipolar Disorder
- ☐ Potential disability in individuals with Bipolar Disorders and how this affects work and benefit claims

Appendix C - Individual Learning Set Review Form (To be completed by the learner to aid reflective practice)

Name	
Learning Set Title	
Date attended	
Learning Set Preparation What did I do to prepare for the Learning Set? What source(s) of information did I use/access? How useful were these?	
Learning Set Participation To what extent did I participate? What value did my participation bring to me and other trainees? Could I have brought more value, if so what and how?	

<p>Learning Achieved</p> <p>What were the key points of learning for me?</p> <p>What impact will this learning have on my performance?</p>	
<p>Application of Learning</p> <p>How will I show that I have implemented this new learning in my every day role?</p>	
<p>Any Other Reflections?</p>	

Appendix D “Participation Form” for Learning Set Attendance – Bipolar Disorder

Registered Physiotherapist WCA Academy Bipolar Learning Set Participation Form	
Name of Trainee:	Date of Learning Set:
Did the HCP demonstrate adequate knowledge of the topic? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Please provide comments:	
Did the HCP fully participate and bring value to the Learning Set? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Please provide comments:	
Does the HCP need to complete further reading and demonstrate Knowledge to Clinical Manager? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Please provide comments:	
Trainer name	Date

Appendix E – Bipolar Learning Set Aims

Bipolar Disorder - Learning Aims

- To consider trainee's knowledge of Bipolar Disorder through trainer-led presentations, team discussions and question and answer sessions.
- To confirm/ assure understanding of the clinical features of Bipolar Disorder (Types I, II, Rapid Cycling and Cyclothymia)
- To consider the disabling effects and prognosis of Bipolar Disorder
- To consider Bipolar Disorder in the context of benefit claims
- To provide individuals with the opportunity for reflective practice

Modified Learning Set 3

Continence

Modified Learning Set 3 – Continence (Day 5 of Academy)

This is a relatively complex subject area, encompassing aspects of urinary continence and faecal continence. The Modified Learning Set is designed to encourage the physiotherapists to consider existing knowledge and then apply it to the practice of Disability Analysis.

Essential areas to be covered will include:

- ☐ A review of urinary incontinence in relation to definition, main causes, investigation and treatment
- ☐ A review of faecal incontinence in relation to definition, main causes, investigation and treatment
- ☐ The physical, social and psychological implications of continence issues
- ☐ A review of treatment guidelines
- ☐ Consideration of the issue of incontinence in relation to ESA and work related considerations

The Modified Learning set will be delivered in a combination of facilitator led presentations, group discussions and feedback. This approach is intended to encourage participation from all the group members therefore maximising the retention of learning.

The Learning Aims are defined in this document and the trainer is encouraged to ensure that these are kept prominently to the fore throughout the event, keeping them in view of all trainees. In this way they will serve to maintain a focus in discussions. It is essential that trainees be informed of the learning aims and essential content well in advance of the Learning Set to ensure they focus their self- directed preparation for the event. Details of the full process are given on the following page.

To avoid intrusive use of PowerPoint apparatus during the Learning Set the learning aims are provided in A4 format (see Appendix E).

This pack provides guidance on activities to be used during the Learning Set. The absolute requirements are that the essential content is adhered to and the Learning Set aims achieved.

Advice is provided on the gathering of suitable documentation to facilitate and confirm both individual and team participation. The trainer will complete an evaluation form to show that each Physiotherapist has participated fully in the Learning Set and demonstrated knowledge of the subject (see Appendix D). If a Physiotherapist has not demonstrated knowledge or actively participated in the Learning Set, they will be required to undertake further learning and demonstrate that learning to the Clinical Manager. This will allow verification that the learning aims have been satisfied.



Learning Aims

- ☐ To compare the definitions of the terms 'continence' and 'incontinence'
- ☐ To consider the aetiology of continence issues and relevant investigations
- ☐ To consider current management and treatment guidelines of faecal and urinary incontinence
- ☐ To consider Disability Analysis in adults with continence issues, in relation to claims to ESA benefit
- ☐ To consider the issue of work in relation to incontinence and the effects of one on the other



Suggestions for Study

The following references and texts will help the trainees prepare for this event. In addition, other relevant individual textbook and journal preferences are acceptable:

- ☐ Any suitable up-to-date textbook of medicine
- ☐ Clinical reviews for example - the Cochrane Database
- ☐ SIGN guideline 79 - Management of urinary incontinence in primary care: A national clinical guideline -
<http://www.sign.ac.uk/guidelines/fulltext/79/index.html>
- ☐ NICE guidelines:

CG 49 - Faecal incontinence: The management of faecal incontinence in adults - <http://www.nice.org.uk/guidance/cg49>

CG 171 - Urinary incontinence: the management of urinary incontinence in women - <https://www.nice.org.uk/Guidance/CG171>
- ☐ The British National Formulary (BNF)
- ☐ The Electronic Medicine Compendium (eMC) contains online information about UK licensed medicines
<http://www.emc.medicines.org.uk/>
- ☐ DWP — Medical guidance for DLA and AA Decision Makers (adult cases): staff guide -
<https://www.gov.uk/government/publications/medical-guidance-for-dla-and-aa-decision-makers-adult-cases-staff-guide>

All trainees are advised to document their learning sources using an Individual

Learning Set Review form (see Appendix C). Any presentations or other exercises used by trainees in the Learning Set must include references to the source documents. Portfolio activity should be based upon reflection on usual practices and work based evidence, to show when new learning has been implemented to improve those standards.

Essential Content

This is a relatively complex subject area, encompassing urinary incontinence and faecal incontinence. The Modified Learning Set is designed to encourage the physiotherapists to consider existing knowledge and then apply it to the practice of Disability Analysis.

Essential areas to be covered will include:

- ☐ A review of urinary incontinence in relation to definition, main causes and treatment
- ☐ A review of faecal incontinence in relation to definition, main causes and treatment
- ☐ The physical, social and psychological implications of continence issues
- ☐ A review of treatment guidelines
- ☐ Consideration of the issue of incontinence in relation to ESA and work related considerations

The Modified Learning set will be delivered in a combination of facilitator led presentations, group discussions and feedback. This approach is intended to encourage participation from all the group members therefore maximising the retention of learning.

Activity 1: To explore the definition of incontinence and consider urinary incontinence

In order to appreciate the difficulties some claimants may face in relation to incontinence, it is essential that trainees have a clear grasp of the definitions of 'continence' and 'incontinence' before considering the impact of urinary and faecal incontinence.

The activities will firstly consider urinary and then faecal incontinence.

The following information is designed to support the facilitator in this process.

Activity:

Ask the group to offer their own definitions of what they understand by the terms 'continence' and 'incontinence.'

Put simply, urinary incontinence can be defined as an involuntary leakage of urine. It can range from a small 'dribble' to large 'floods' of urine.

It is estimated that 4 in every 100 people are regularly incontinent of urine, which is about 3 million people in the UK.

The facilitator should introduce discussion about the causes of urinary incontinence. The trainees will have some existing knowledge and perhaps professional experience in this field, so the facilitator should use the following information for reflection with the group as a whole.

The facilitator can use either flip chart or whiteboard to explore with the group the possible causes of urinary incontinence. **The list below is intended to support the facilitator in this process:**

- ☐ Increased age in men and women
- ☐ Previous prostate surgery
- ☐ Pregnancy (increased maternal age, parity, high birth weight babies)
- ☐ Childbirth (traumatic delivery such as forceps)
- ☐ Increased BMI
- ☐ Menopause
- ☐ Men or women who previously experienced day time wetting or nocturnal enuresis as a child
- ☐ Abdominal surgery
- ☐ Neurological disorders

The trainees will now be asked to refer back to the lists they made on the possible causes of urinary incontinence. This exercise is designed to build on this, and allow trainees to consider the terms below, which are commonly used to describe incontinence:

- ☐ Stress incontinence
- ☐ Urge incontinence
- ☐ Enuresis (bedwetting)
- ☐ Mixed incontinence
- ☐ Overflow incontinence

The following information is designed to support the facilitator in this process.

Stress incontinence - This is the most common type. It occurs when the pressure in the bladder becomes too great for the bladder outlet to withstand. It usually occurs when the pelvic floor muscles are weakened. Urine leakage tends to occur when laughing, coughing, or during exercise. Usually small amounts of urine may be passed, however, in some cases there may be greater loss of control. The most common cause of stress incontinence is childbirth. Women who have had several children may have further increased risk. The risk becomes greater with increased age.

Urge incontinence (overactive or unstable bladder) - this is the next commonest cause. The individual feels an increased urge to pass urine and sometimes the urine leaks before the person can make it to the toilet. In essence the bladder muscle contracts too early and a degree of normal control is lost. The bladder signals to the brain that it is fuller than it actually is. The cause of this is not always known (idiopathic). Also common in individuals with neurological disorders such as Parkinson's, Stroke, Multiple Sclerosis, acquired brain injury and other brain disorders.

Nocturnal Enuresis - bedwetting in children and occasionally in adults.

Mixed incontinence - a mixture of both stress and urge incontinence.

Overflow incontinence- where there is an obstruction to the outflow of urine. The obstruction stops the bladder from emptying normally and instead a pool of urine sits in the bladder and cannot be emptied. The urine can sometimes leak past the obstruction from time to time. One example of this is an enlarged prostate in men, where removal of the prostate solves the problem. Also common in neurological disorders where sphincter control is lost.

Tip

The groups should be allowed time to discuss the definitions above and consider people who may be affected. The facilitator can then write the suggestions on a white board or flip chart and reflect on the groups choices. It is important that the trainees understand the differences.

Claimants may be unsure how to describe their symptoms and the skill of the HCP is “recognising” what symptoms they are describing, the degree of functional loss and the impact of this loss on the claimant’s abilities day to day or at work.

Activity 2: Investigating urinary incontinence

Each type of urinary incontinence is treated differently, so the first step is to determine which type the individual has, using a number of techniques. The facilitator should discuss the following with the group:

Investigations may include:

- ☐ **Clinical history** - medication, urinary symptoms, bowel habit, sexual dysfunction, intercurrent medical problems and ability to access toilet facilities
- ☐ **Urinalysis** - dipstick test for blood, protein and infection
- ☐ **Residual volume test** - measures the amount of urine left in the bladder after it has been emptied. May be done with ultrasound, or a catheter passed into the bladder
- ☐ **Vaginal and anal examination** - this assesses the strength and tone of pelvic floor muscles. Can also detect pelvic organ prolapse in women and assess the size of the prostate gland in men
- ☐ **Urodynamics** - usually done in hospital to test the flow of urine. Used particularly when the cause of incontinence is not clear.
- ☐ **Diary** - This can be used to assess the frequency of micturition, how much urine is passed, and whether the individual has any other urine leakage
- ☐ **Specialist referral** - if clarification of the cause of incontinence is needed.

Activity 3: Managing urinary incontinence

The management will depend on the type of incontinence. There are 2 main therapies which may be employed - physical and pharmacological.

The facilitator should ask the group if they are aware of any physical therapies which may be employed and discuss. The following notes are designed to help the facilitator in this process:

Physical therapies:

- ☐ **Pelvic floor exercises** - can be used for women and men (such as men who are about to undergo radical prostatectomy)

The facilitator should then be prepared to discuss the additional tools that may be used to assist pelvic floor rehabilitation and medication that may be used:

- ☐ **Bladder training** - may be used to improve symptoms of urge incontinence
- ☐ **Alarm systems** - can be used to improve nocturnal enuresis
- ☐ **Lifestyle changes** - losing weight where appropriate and changing how much liquid is drunk (intake may need to be increased if it is inadequate, and decreased if it is excessive. Alcohol and caffeine can also affect the bladder)
- ☐ **Surgery** - sometimes used to treat incontinence, especially stress incontinence

Medication:

- ☐ **In stress incontinence** - Oestrogens, adrenoceptor agonists, combined noradrenaline and serotonin reuptake inhibitors may be used in some cases
- ☐ **Detrusor over-activity and urge incontinence** - antimuscarinics such as Tolterodine and Oxybutynin may be used

Devices to support management:

- ☐ Urostomy
- ☐ Catheter
- ☐ Pads

Activity 4: Practical aspects of living with urinary incontinence

In the field of disability analysis, claimants may present at various stages of condition onset, investigation, diagnosis and treatment. Some claimants may be using devices or strategies to help them manage their condition. This however, can pose some claimants with additional difficulties which may become apparent when taking the history.

Activity

The facilitator should ask the group (or may split into smaller groups if wished) to discuss and write down some of the possible practical aspects of managing urinary incontinence, For instance:

- ☐ What are the likely challenges for someone managing a Urostomy?
- ☐ What are the likely challenges for someone with a catheter?
- ☐ Consider possible difficulties with body image and sexuality for the person with a urine collection device, or pad
- ☐ Consider the impact of self-catheterisation

The group(s) may wish to write lists of their thoughts, or may prefer to use a mind-map to explore each of the considerations above.

The facilitator should be prepared to discuss and where appropriate, expand on the ideas reported by the group(s).

Activity 5: Exploring causes of faecal incontinence

So far, the Modified Learning Set has considered urinary incontinence. Now the facilitator will guide the group towards exploring faecal incontinence.

Between 1% and 10% of the adult population has had faecal incontinence and 0.5%-1.0% of adults experience regular faecal incontinence, which affects their quality of life.

Activity

The facilitator should split the trainees into smaller groups and provide them with the list of specific groups outlined below, who may be at risk of developing faecal incontinence:

- ☐ People with neurological or spinal disease/injury (e.g. stroke, spina bifida, multiple sclerosis, spinal cord injury)
- ☐ Hospitalised patients who are acutely unwell and who develop acute faecal loading and associated incontinence
- ☐ Learning Difficulties
- ☐ Severe or terminally ill
- ☐ Acquired brain injury
- ☐ People with cognitive or behavioural issues
- ☐ People with limited mobility
- ☐ People with faecal loading or constipation
- ☐ Frail older people
- ☐ People who have undergone pelvic radiotherapy
- ☐ People who have undergone colonic resection or anal surgery
- ☐ Women who have undergone childbirth (particularly following 3rd and 4th degree obstetric injury)

Once the group has considered the list, the facilitator should ask them to consider and discuss any potentially reversible causes of faecal incontinence. The group could be directed to use a flip chart/ whiteboard to record thoughts.

The facilitator should be looking for responses to follow the outline below, which are provided to support the facilitator:

- ☐ Faecal loading
- ☐ Potentially treatable causes of diarrhoea (e.g. infective, Inflammatory bowel disease)
- ☐ Warning signs of lower gastrointestinal cancer
- ☐ Rectal prolapse or 3rd degree haemorrhoids

The facilitator must discuss:

- ☐ Symptoms of Irritable Bowel Syndrome (IBS)
- ☐ Whether IBS causes faecal incontinence

The trainer should be prepared to supplement answers as required.

Tip

This is a useful exercise as it illustrates the wide variety of people who are at risk of developing faecal incontinence, some of which may be as a result of a potentially treatable condition.

It is worth reiterating to the group that faecal incontinence is NOT a diagnosis, but is instead a sign or symptom of an underlying problem.

The facilitator should be prepared to summarise, covering any key learning points which may have been missed.

Activity 6: Possible treatments for faecal incontinence

Treatment for individuals with bowel incontinence will usually start with the least intrusive treatments.

Activity

The group will now explore the following possible treatments

- ☐ Dietary measures
- ☐ Medication
- ☐ Physical therapy
- ☐ Surgery

The facilitator should now ask the group to write down and discuss the following **dietary considerations**, before reflecting their findings back to their fellow trainees:

- ☐ **The possible dietary triggers of diarrhoea** (for example; spicy and fatty foods and some dairy products)
- ☐ **Foods which may help diarrhoea** (for example; starchy foods such as bread and pasta and protein such as chicken or fish)
- ☐ **Foods which may help constipation** (for example; fruit, vegetables, nuts and whole grains)
- ☐ **The importance of fluid intake** (at least 1.5 litres of water a day is recommended)

The information in brackets can be used to support the facilitator in this activity.

Activity:

The facilitator can reflect with the group on their awareness of the **medicines** which may be used;

- ☐ **Anti-diarrhoeals** - for example; Loperamide
- ☐ **Bulk-forming laxatives to treat constipation** - for example; ispaghula husk, methylcellulose and sterculia. All these laxatives require the individual to drink plenty of water.
- ☐ **Enema's** - where a special solution is used to wash out the anus in cases of impaction where other methods have failed.

Activity

The facilitator can reflect with the group on their awareness of the **physical therapy** which may be used:

- ☐ **Pelvic floor muscle training** (range of exercises used to treat bowel incontinence after childbirth where muscles have been stretched or weakened. People should notice improvement after about 6-8 weeks)
- ☐ **Bowel retraining** (for people with reduced sensation in rectum due to nerve damage, or those with recurring episodes of constipation. Includes dietary modifications, establishing a routine for emptying bowels and stimulating bowel movements)
- ☐ **Biofeedback** (a type of bowel retraining which involved placing a small electrode into rectum. The individual then performs a range of exercises designed to improve bowel function. The sensor checks they are carried out correctly)

Activity

There are a number of operations available to individuals with faecal incontinence. It is important for the trainees to be aware of these, as claimants may present to an assessment after being referred or having undergone one of the following surgical interventions.

For each of the surgical interventions below highlighted in bold, the facilitator should inform the group what the surgery hopes to achieve. The group should then be directed to think about the possible difficulties/benefits to individuals undergoing these procedures.

The following notes are designed to support the facilitator in this process:

Sphincteroplasty - This is an operation to repair a damaged sphincter, where the damaged muscle is removed. The surgeon then overlaps the muscle edges and sews them back together. The resulting extra support for the muscles makes them stronger.

Stimulated Graciloplasty - This is an operation to replace the sphincter muscle. The surgeon uses muscle from the thigh to fashion a new sphincter. Electrodes are implanted in the new sphincter and stimulated by a pulse generator implanted in the abdomen. The hope is that the muscle will start to act like a natural sphincter muscle. (Potential problems may be infection at surgery site and problems with stimulator function).

Injectable bulking agents - This is where silicone or collagen can be injected into the muscles of the sphincter and rectum to strengthen them. (Although this is a new treatment is not widely used, it is possible some HCPs may meet individuals about to undergo, or those who have undergone this procedure)

Sacral nerve stimulation - This is used for people with weakened sphincter muscles. Electrodes are implanted under the skin in the lower back, which are attached pulse generator. This releases pulses of electricity which stimulate the sacral nerves. If successful the generator can then be implanted into abdomen.

Colostomy - This is only considered if other surgical interventions were unsuccessful. The colon is cut and brought through the abdominal wall to create a stoma. The artificial opening allows the stools to be collected in a colostomy bag.

Activity 7: Incontinence and the WCA

At this point in the Modified Learning Set, the facilitator will explore the following considerations with trainees:

- ☐ Ways in which continence problems may present themselves when claiming for benefit
- ☐ The functional effects of incontinence
- ☐ Attitudes amongst the team about incontinence and potential disability

Activity

The facilitator should direct the group to review **the Revised WCA Handbook section 3.2.10**. Note: this will be **essential** for the next activity.

(The facilitator may wish to split the group into smaller subgroups to allow trainees to compare their ideas.)

Once the trainees have reviewed the WCA Handbook section, the facilitator should ask the group to consider and discuss the following:

- ☐ When does soiling become incontinence?
- ☐ Is 'dribbling' incontinence?
- ☐ Is odour a major problem?
- ☐ If the customer indicates loss of continence when drinking alcohol- does that count as 'incontinence' of either the bladder or bowel?
- ☐ If you wear pads and no-one else notices, is this still a problem?
- ☐ Consider the possible impact that upper limb problems, severe disorder of mood, cognitive difficulties or the client with visual impairment would have on the client's ability to use continence aids
- ☐ What constitutes "risk" of incontinence?
- ☐ If you maintain continence with intermittent self catheterisation, are you incontinent?
- ☐ If the claimant has no bowel or bladder problem but indicates incontinence due to not being able to reach the toilet in time, does this constitute a problem in the context of WCA? What if the claimant did have a problem with their bowels or bladder and in addition had problems with mobility?

Tip

Ensure the trainees have considered the practical difficulties that can be associated with, for example; stoma function, fistula, suprapubic/indwelling catheter, incontinence pad.

Furthermore, the Facilitator should highlight coping mechanisms such as 'RADAR key or toilet access card, skin care advice and emotional and psychological support. (RADAR is a disability network which offers access to 7,000 disabled toilets across the country).

Activity 8: A Case Discussion

This activity builds on the knowledge shared and gained in the process of undertaking the Modified Learning Set. The facilitator is encouraged to use their personal experience of undertaking work capability assessments, to identify and discuss a continence case with the group. The case may be a challenging case, or one which stimulated the interest of the facilitator. The facilitator must ensure they preserve the anonymity of the claimant.

If a suitable case does not emerge, then the example below is offered to assist the facilitator to formulate a case:



You should include the history of the condition and any treatments associated with it, including percentage success rates. Any relevant medication, alternative treatments and prognosis should also be included. You may wish to use this scenario and provide various different clinical histories e.g. IBS/ Ulcerative Colitis/ Neurological Diagnosis.

Activity

The facilitator should now ask the group to:

- ☐ Identify the types of questions, which the HCP may wish to use, to find out as much as possible about the claimant's past history, current condition. This should take into account any treatments not yet offered or available to the client.
- ☐ Consider the current difficulties faced by the claimant as she tries to manage her bowel incontinence
- ☐ Consider the long term benefit to the claimant overall in the event of an improvement in her health.

Tip

Direct the group to use the WCA Handbook to assist them in considering whether the claimant has a continence problem / degree of functional loss.

Activity 9: Continence Question and Answer session

A number of “True/False” questions have been devised. The depth of the subject, including severity, psychological effects and disabilities lends itself very well to a team question and answer session.

This can be completed by a divided team that "compete" to achieve the best outcome.

The aim is to allow individual team members to confirm that their study has successfully increased their knowledge of the subject to a level equivalent of their peers.

The trainer may choose to use some of their own questions or modify the questions, however must ensure the learning aims are satisfied.

The facilitator will be prepared to summarise the key facts and ensure all the trainees have equal understanding of the principles covered in the questions.

Activity 9: Question and answer session

The following questions are designed to reflect the key principles of the learning set. Following individual study of the questions the group will then explore the answers, with time allocated for group discussion.



Activity 9: Question and answer session - Answers:



Appendix A - Continence Modified Learning Set Event Fact Sheet

Date		Time	
Venue			



Learning Aims

- ☐ To compare the definitions of the terms 'continence' and 'incontinence'
- ☐ To consider the aetiology of continence issues and relevant investigations
- ☐ To consider current management and treatment guidelines of faecal and urinary incontinence
- ☐ To consider Disability Analysis in adults with continence issues, in relation to claims to ESA benefit
- ☐ To consider the issue of work in relation to incontinence and the effects of each one on the other

Suggestions for Study



The following references and texts will help the trainees prepare for this event. In addition, other relevant individual textbook and journal preferences are acceptable:

- ☐ Any suitable up-to-date textbook of medicine
- ☐ Clinical reviews for example - the Cochrane Database
- ☐ SIGN guideline 79 - Management of urinary incontinence in primary care: A national clinical guideline - <http://www.sign.ac.uk/guidelines/fulltext/79/index.html>
- ☐ NICE guidelines:

CG 49 - Faecal incontinence: The management of faecal incontinence in adults - <http://www.nice.org.uk/guidance/cg49>

CG 171 - Urinary incontinence: the management of urinary incontinence in women - <https://www.nice.org.uk/Guidance/CG171>

- ☐ The British National Formulary (BNF)
- ☐ The Electronic Medicine Compendium (eMC) contains online

information about UK licensed medicines

<http://www.emc.medicines.org.uk/>

- ☐ DWP — Medical guidance for DLA and AA Decision Makers (adult cases): staff guide -
<https://www.gov.uk/government/publications/medical-guidance-for-dla-and-aa-decision-makers-adult-cases-staff-guide>

All trainees are advised to document their learning sources using an Individual Learning Set Review form (see Appendix C).

Appendix B- Essential Content

This is a relatively complex subject area, encompassing urinary incontinence and faecal incontinence. The Modified Learning Set is designed to encourage the physiotherapists to consider existing knowledge and then apply it to the practice of Disability Analysis.

Essential areas to be covered will include:

- ☐ A review of urinary incontinence in relation to definition, main causes and treatment
- ☐ A review of faecal incontinence in relation to definition, main causes and treatment
- ☐ The physical, social and psychological implications of continence issues
- ☐ A review of treatment guidelines
- ☐ Consideration of the issue of incontinence in relation to ESA and work related considerations

Appendix C – Continence Individual Learning Set Review Form (To be completed by the learner to aid reflective practice)

Name	
Learning Set Title	
Date attended	
Learning Set Preparation What did I do to prepare for the Learning Set? What source(s) of information did I use/access? How useful were these?	
Learning Set Participation To what extent did I participate? What value did my participation bring to me and other trainees? Could I have brought more value, if so what and how?	

<p>Learning Achieved</p> <p>What were the key points of learning for me?</p> <p>What impact will this learning have on my performance?</p>	
<p>Application of Learning</p> <p>How will I show that I have implemented this new learning in my every day role?</p>	
<p>Any Other Reflections?</p>	

Appendix D “Participation Form” for Learning Set Attendance – Continence

Registered Physiotherapist WCA Academy Continence Learning Set Participation Form	
Name of Trainee:	Date of Learning Set:
Did the HCP demonstrate adequate knowledge of the topic? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Please provide comments:	
Did the HCP fully participate and bring value to the Learning Set? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Please provide comments:	
Does the HCP need to complete further reading and demonstrate Knowledge to Clinical Manager? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Please provide comments:	
Trainer name	Date

Appendix E – Continence Learning Set Aims

Continence - Learning Aims

- To compare the definitions of the terms 'continence' and 'incontinence'
- To consider the aetiology of continence issues and relevant investigations
- To consider current management and treatment guidelines of faecal and urinary incontinence
- To consider Disability Analysis in adults with continence issues, in relation to claims to ESA benefit
- To consider the issue of work in relation to incontinence and the effects of one on the other

Physical Examination Session (MSO Practice and Neurological Examination)



Aims

- ☐ To allow trainees the opportunity to have further practice of the MSO
- ☐ To discuss aspects of functional neurological examination.



Materials

White board/flip chart

Introduction to disability analysis and the revised WCA Pre-course reading

Registered Physiotherapist New Entrant Revised WCA Academy Participant Pack



Duration

50 mins



Facilitation

TOPIC	Duration	KEY POINTS	Actions (Slide/Handout/ Syndicate groups/etc.)
Introduction	2 mins	Introduce the session and explain the aims (see above)	
MSO Practice	30 mins	Remind trainees that they discussed the principles of the MSO and reviewed the DVD on day 4 of their Academy. This session provides them with further opportunity to practice the MSO. Trainer to split the trainees into pairs and practice MSO.	Remind trainees about the MSO Handout and Desk aid - Handout 2 and 3 of the Registered Physiotherapist New Entrant Revised WCA Academy Participant pack
Neurological Examination	16 mins	Discuss range of cases in ESA. Registered Physiotherapists may assess claimants with any form of neurological condition, similar to Registered Medical Practitioners. Discuss appropriate level of clinical examination. Emphasise that use of "sharps" is not permitted when assessing sensation.	Refer to Handout 5 of Registered Physiotherapist New Entrant Revised WCA Academy Participant Pack

TOPIC	Duration	KEY POINTS	Actions (Slide/Handout/ Syndicate groups/etc.)
Closure	2 mins	Close the event	

Observation form

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

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