Ailment Guide, Decision tables and Typical Outcome Tables (TOT's)

Contents

Anxiety/Phobias

Conditions covered

General anxiety disorder

Panic disorder

Specific phobias (e.g. fear of spiders)

Social phobia

Agoraphobia

Medical Criteria Questions

1. Health Care Involvement

People with mild Anxiety Disorders may self treat and are likely to either have no health care involvement or be under the care of their general practitioner [GP]

Management of moderate Anxiety Disorders is likely to be achieved by specific referral to an individual member of the community mental health team who may either be attached to the GP's practice or hospital based. This includes counsellors, CPN's [Community Psychiatric Nurses], psychologists and occupational therapists.

Management of severe Anxiety Disorders is likely to be achieved by specialist referral, for example to the community mental health team, and commonly includes an assessment by a psychiatrist. People who are severely disabled will be unable to leave their homes and are therefore likely to require assessment by a psychiatrist in their own home. It should be noted however, that CPN's routinely visit patients at home, in contrast to GPs and psychiatrists, so CPN home assessment is not a reliable marker for severe disability.

The community mental health team provides a multidisciplinary team approach. The team will include psychiatrists, community psychiatric nurses, occupational therapists and social workers working in close collaboration with social service departments. One member of the team may co-ordinate the care and is known as the Care Co-ordinator.

2. Day centre or day hospital attendance

Attendance at a day centre [not on hospital site] or psychiatric day hospital [on hospital site] is likely to indicate severe disability.

These are therapeutic environments for evaluation, diagnosis and treatment of patients with mental health problems. They are staffed by psychiatric nurses, and there is input from all other members of the community mental health team. Attendance presents an alternative for patients whose condition requires intensive treatment, but do not need to be hospitalised

In patient treatment in the last year indicates a severe disability.

Failure to attend hospital or day centre is likely to be the result of the illness and is likely to indicate a severe disability. Some may be discharged from the clinic as their illness is resistant to treatment. In both these cases the criterion should be considered as 'severe'.

Treatment

Generalised Anxiety Disorder

Psychological treatments include counselling, relaxation training, group work and Cognitive Behavioural Therapy [CBT]

In the early stages of Generalised Anxiety Disorder, simple methods of counselling are often effective. Some people with more severe or persistent Generalised Anxiety Disorder respond to counselling, but others need either CBT or medication.

Counselling

Counselling for people with Anxiety Disorders should emphasise a clear plan of management agreed with the person or relative, an explanation of the nature of the disorder and reassurance that any physical symptoms of anxiety are not caused by physical disease with provision of an information leaflet, problem solving or help to adjust to problems and advice to reduce the intake of caffeine as people with Anxiety Disorders are more sensitive to the anxiety effects of caffeine.

Relaxation training

If practiced regularly, relaxation can reduce anxiety in mild and moderate Generalised Anxiety Disorder. Practice in a group sometimes improves motivation and some people do better when relaxation is part of a programme of yoga exercises.

Cognitive behavioural therapy

Cognitive therapy explores how thoughts can alter feelings and behaviour. Therapy consists of identifying automatic negative thought patterns such as the general concerns about the effect of being anxious [fear of fear], concerns about specific symptoms such as palpitations [fear of symptoms] and concerns that other people will react unfavourably to the person [fear of negative evaluation] and teaching the patient to recognise and challenge them. The aim is to enable the patient to counter the negative thoughts with alternative rational thoughts.

Cognitive therapy for Generalised Anxiety Disorder is combined with relaxation therapy

Drug treatment

Anxiolytic medication refers to any medication prescribed to reduce symptoms of anxiety.

Medication should be used selectively for Generalised Anxiety Disorder. It can be used to bring symptoms under control while the effects of psychological treatments are awaited. Medication is also helpful in patients with severe anxiety related disability who do not improve with psychological treatments. There are a number of groups of drugs available.

Benzodiazepines

These are indicated for the short-term relief of severe anxiety but are not usually prescribed for more than 3 weeks at a time because of the risk of dependence and abuse. If they have been prescribed for long-term use, they have to be withdrawn slowly because of the risk of withdrawal symptoms. However, a proportion of people are prescribed benzodiazepines in the long term, often due to concern over the potential for withdrawal symptoms.

Benzodiazepines in current use include:

Diazepam [Valium]

Chlordiazepoxide [Librium]

Chlorazepate [Tranxene]

Lorazepam [Ativan]

Oxazepam

Commoner side effects include drowsiness, light headedness, confusion, unsteadiness, amnesia and muscle weakness

Buspirone

Buspirone is as effective as the benzodiazepines in the short-term management of Generalised Anxiety Disorder. It is unlikely to cause dependence and abuse. It is licensed for short-term use only but psychiatrists occasionally use it for several months.

Commoner side effects include nausea, dizziness, headache, nervousness, light-headedness and excitement

Beta-blockers

These do not affect psychological symptoms such as worry, fear and tension but do reduce physical symptoms such as palpitations and tremor.

The commoner prescribed beta blockers include:

Propranolol [Inderal, Half-Inderal]

Oxprenolol [Trasicor, Slow -Trasicor]

Side effects include slowing of the pulse rate, low blood pressure, breathlessness, dizziness, nausea, fatigue, sleep disturbance and impotence.

Antidepressants

Most antidepressants have anxiety reducing as well as antidepressant effects. They act more slowly than benzodiazepines and Buspirone but their effect is equivalent or greater and they are much less likely to cause dependence than benzodiazepines. There is a tendency to use an antidepressant with more sedative effects, such as Amitriptylline or Trazadone, but Imipramine seems to be just as effective. Of the newer antidepressants, Venlafaxine appears to be effective.

Antidepressants in current use include:

SSRI antidepressants [serotonin reuptake inhibitors]

Citalopram [Cipramil]

Escitalopram [Cipralex]

Fluoxetine [Prozac]

Fluvoxamine [Faverin]

Paroxetine [Seroxat]

Sertraline [Lustral]

Side effects include; nausea, diarrhoea, headache, insomnia, agitation and sexual dysfunction. Some of these medicines may cause adverse effects if suddenly stopped.

Tricyclic antidepressants

Amitriptylline [Lentizol]

Amoxapine [Asendis]

Clomipramine [Anafranil]

Dosulepin/Dothiepin [Prothiaden]

Doxepin [Sinequan]

Imipramine [Tofranil]

Lofepramine [Gamanil]

Nortriptylline [Allegron, motipress, motival]

Trimipramine [Surmontil]

Side effects include; irregularity of heart rhythm, low blood pressure, drowsiness, convulsions, hence dangerous in overdose and can cause death.

Can also cause blurred vision, dry mouth, constipation and urinary retention.

All of these can reduce compliance with treatment.

Drowsiness and blurred vision may be dangerous for those who drive, operate machinery or work at heights.

Related antidepressants

Venlafaxine [Efexor, Efexor XL]

Reboxetine [Edronax]

Mirtazapine [Zispin]

Moclobemide [Manerix]

Mianserin

Maprotiline [Ludiomil]

Trazodone [Molipaxin]

Flupenthixol/flupentixol [Fluanxol]

Panic disorder

SSRI antidepressants are now the first-line treatment for panic disorder. Benzodiazepines have a complementary role in the first few weeks of treatment. The drug treatments can provide a window of opportunity for effective treatment with relaxation, exposure or cognitive behaviour treatments.

Simple phobias

Simple phobias can be treated by graded exposure therapy. The person exposes themselves to their feared stimulus or cue in a gradual and controlled way, and gradually acquires desensitisation to it. Feelings of anxiety become much less intense and normal functioning can be restored. Exposure treatment can be very effective in achieving cure in 80% of cases.

Social phobias

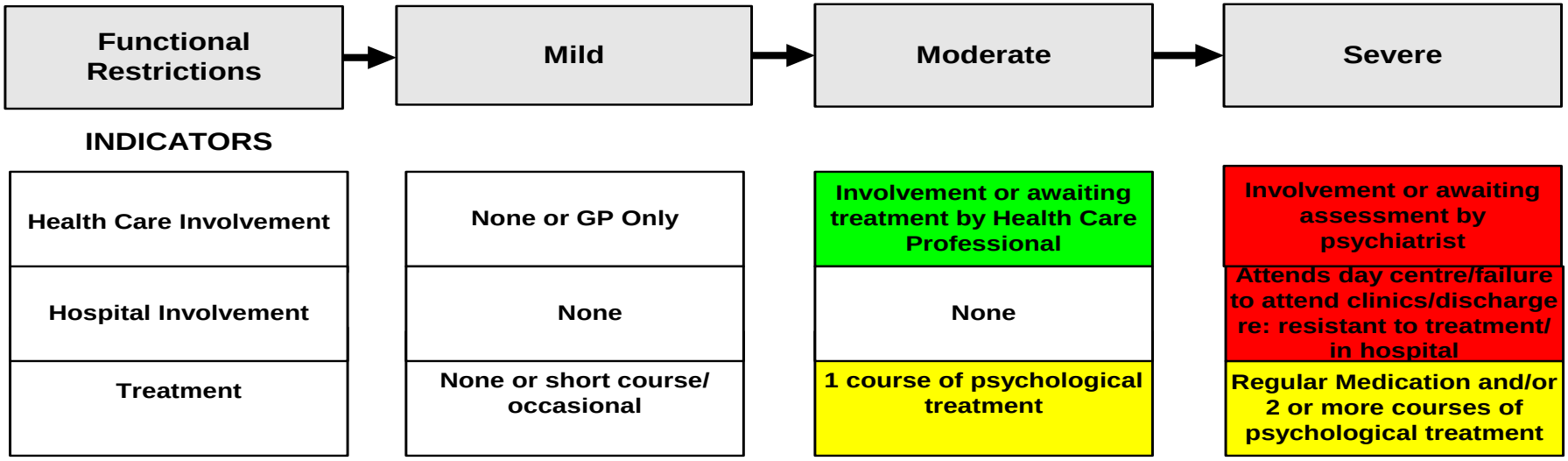
Social phobia can be treated with a number of psychotherapeutic techniques including cognitive-behaviour therapy and graded exposure therapy. Various medications are also used. Benzodiazepines such as diazepam reduce the anxiety symptoms, but can lead to the risk of dependency, if used long term. Betablockers such as propranolol or atenolol help to control palpitations and tremor. Some antidepressant drugs (specific serotonin re-uptake inhibitors) such as sertraline, paroxetine and fluoxetine have been shown to be effective in the condition.

Agoraphobia

Agoraphobia is treated with various types of psychotherapy, and in some cases with medication. The person is encouraged to return to the anxiety provoking situation (graded exposure treatment). Cognitive behaviour therapy is also used with good effect, often to prevent relapse after an initial good response to graded exposure therapy.

Benzodiazepines such as diazepam, alprazolam may be prescribed to help people with agoraphobia. People may use them on a one-off or intermittent basis when it is necessary to confront the anxiety provoking situation. These drugs have a risk of dependency if used long-term. Antidepressant drugs may also be helpful, even in those people whose agoraphobia is not part of a concurrent depressive disorder. The following drugs may be used in this way – imipramine, clomipramine, citalopram, fluvoxamine, paroxetine, sertraline, and fluoxetine. Prescription of such medications may often be found as an adjunct to psychotherapeutic techniques, when panic attacks are frequent and/or severe. In such cases medication may be prescribed for long term.

Anxiety



Combinations and Weights

= severe

+ = moderate

Anxiety TOT

ACTIVITY	MILD	MODERATE	SEVERE
1. Sitting			
2. Standing			
3. Rising			
4. Walking/Stairs			
5. Bending/Kneeling			
6. Reaching			
7. Lifting/Carrying			
8. Manual Dexterity			
9. Vision			
10. Hearing			
11. Speech			
12. Seizures			
13. Finance			c
14. Personal Care			
15. Daily Routine			
16. Awareness danger			
17. Navigation outdoors		b (M)	a
18. Coping with change			
TOTAL SCORE		**15 (M)**	**25**

Notes:

1. Activity groups

   Lower limb/back function

   Upper limb/neck function

   Sensory functions

   Maintaining control

   Mental health

2. Scoring descriptors (M = mobility)

Asthma

Conditions covered

Extrinsic asthma
Intrinsic asthma
Atopic asthma
Occupational asthma

Criterion 1 – TREATMENT PLAN

Step 1	Step 2	Step 3	Step 4	Step 5
Asthma with intermittent symptoms. Up to 28% of UK asthma patients.	Patients needing short acting relievers more than once a day. Up to 47% of UK asthma patients.	Patients needing greater therapy to get control, than at Step 2. Up to 11% of UK asthma patients.	Up to 5% of UK asthma patients.	Up to 1% irreversible asthma

1. Occasional use of short-acting bronchodilators (“relievers”) (B2 agonist).	1. Regular inhaled steroids (anti-inflammatory agents). 2. Short-acting relievers as in Step 1. 3. Anti-inflammatory such as a cromone could be used instead on inhaled steroids.	1. Short-acting bronchodilators as required. 2. High dose inhaled steroids OR Low-dose inhaled steroid, plus a long-acting inhaled bronchodilator 3. Theophylline or Cromone may be added.	1. High-dose inhaled steroid <u>Plus one or more of (in order).</u> 2. Inhaled log-acting bronchodilator and/or Theophylline (sustained release) and/or Inhaled anti-cholinergices and/or Sustained action oral bronchodilators and/or High dose inhaled short acting broncholdilator (B2 agonist Cromones).	**8**Daily use of oral Steroid or frequent use of daily steroid (6 per year). 2. High dose inhaled steroid. 3. Continuous/daily use of oxygen.

Criterion 2 – PEAK FLOW AND SPIROMETRY RESULTS

PEAK EXPIRATORY FLOW RATE (PEFR)

This is the maximum rate of air breathed out as hard as possible through a measuring device called a peak flow meter, (after a full breath taken in). See appendix B1.

The reading is measured in litres/minute (l/min). Three readings are taken and the best of three is recorded.

The average range for an adult for peak flow lies between 450 and 600 l/min, but because the peak flow depends on age, gender, race and height, the measured result is compared to that predicted for a person's age, gender and height, using special charts and the measurement is compared with what would be expected. **However, for decision making refer to guideline figures.** A measured peak flow of less that 80% predicted, indicates that airways obstruction is present, but the diagnosis of asthma cannot be made on a single peak flow measurement; also, having a normal one-off peak flow reading does not exclude asthma.

Peak flow measurement is done very commonly, and many patients test their peak flows on a daily basis, having their own peak flow meters. They then may record the reading in a graph form, which then easily highlights any change especially morning and evening. It is a very easy test to do. GP's and Specialist Asthma Nurses can do an on-the-spot reading, to quickly check a patient's status.

SPIROMETRY (FEV and FVC measurement)

Spirometry measures the volume of air blown out against time, and gives more specific information about lung function. This is done by a special technician, or a specialist, using a machine, into which the patient's age, gender, and height have been entered, so that a predicted value has already been made. The patient blows out into a mouthpiece connected to the machine, as fully and as long as possible, after a deep breath in. Various readings can then be taken.

In asthma, the readings will be reduced, returning to normal between episodes, and again, the recorded result would be compared with what is predicted, (according to age, height and gender, by the machine), and the results are then printed out.

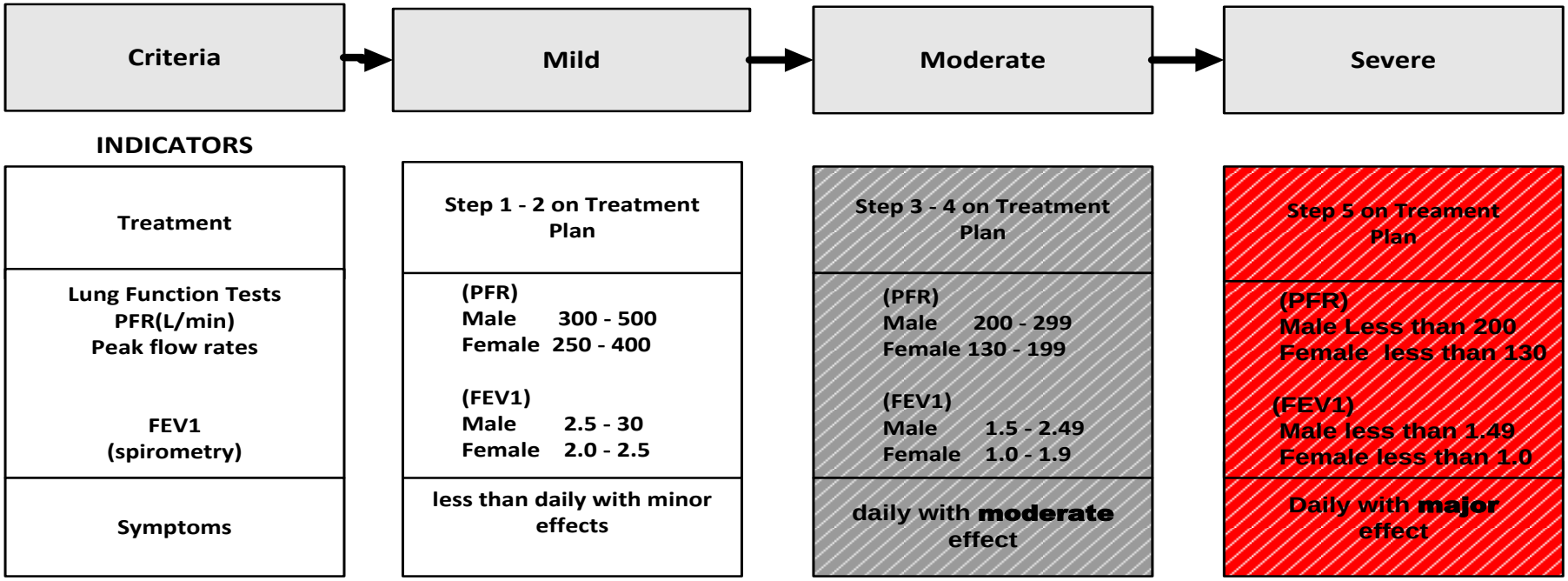
Criterion 3 – SYMPTOMS

Mild Does not have symptoms every day. Symptoms intermittent, may not last a full day and have only minor limitations on functioning.

Moderate Has symptoms daily but only has a moderate effect on strenuous daily activities e.g. walking briskly up hill.

Severe Daily severe symptoms which severely affect exercise tolerance. Breathless on minimal exertion, breathless talking, dressing.

ASTHMA



Combinations and Weights

Any 2 red = severe

Any 1 red and any grey = severe

Any 2 grey = moderate

Read in conjunction with Asthma Criteria

Asthma TOT

ACTIVITY	MILD	MODERATE	SEVERE
1. Sitting			
2. Standing			
3. Rising			
4. Walking/Stairs		**e**	**c(m)**
5. Bending/Kneeling			**b**
6. Reaching			**c**
7. Lifting/Carrying			
8. Manual Dexterity			
9. Vision			
10. Hearing			
11. Speech			
12. Seizures			
13. Finance			
14. Personal Care			
15. Daily Routine			
16. Awareness danger			
17. Navigation outdoors			
18. Coping with change			
TOTAL SCORE	**0**	**3**	**33(m)**

Notes:

1. Activity groups

   Lower limb/back function

   Upper limb/neck function

   Sensory functions

   Maintaining control

   Mental health

2. Scoring descriptors (M = mobility)

Back Pain

Conditions covered

Mechanical back pain
Lumbgo
Lumbar spondylosis
Sciatica
Disc desiccation
Slipped disc
Sciatica
Spinal stenosis
Cauda equina syndrome
Ankylosing spondylitis

Medical Criteria Questions

1. Surgery

Mild back conditions such as MBP do not require spinal surgery. Severe back conditions may require Orthopaedic or Neurosurgical intervention.

These major operations include:

- Spinal decompression
- Laminectomy
- Discectomy
- Microdiscectomy

Procedures which are not included as spinal surgery are:

- Spinal injections
- Nerve blocks
- Facet joint injections

To satisfy this criterion the person must be on a waiting list or had spinal surgery in the last 6 months

2. Signs

Muscle wasting and neurological signs are a feature of the more severe types of back pain and are not found in mild conditions such as the vast majority of people with Mechanical Back Pain (MBP).

When present, these signs usually indicate compression of a nerve root in the lower back, typically causing “Sciatica”.

Wasting of the thigh and sometimes the calf muscles on the affected side often follows. One leg only is usually affected.

Neurological signs may include:

- Reduced or absent reflexes
- Loss of muscle power
- Specific sensory changes in the region of the leg supplied by the nerve root
- Foot drop.

Group 1

Two of the following:

- No significant neurological signs in either leg.
- No significant muscle wasting
- No significant muscle weakness
- No significant restriction of SLR (i.e. in excess of 75°)

Group 2

Two of the following:

- Evidence of below knee neurological signs in one leg (reduced reflexes, sensory disturbance, muscle wasting)
- Evidence of muscle weakness in affected leg (e.g. reduction of dorsiflexion (upward movement) of the hallux (big toe), or reduced ability to perform resisted SLR
- SLR restricted to 50°

Group 3

Two of the following:

- Gross neurological signs in at least one leg (absent or nearly absent reflexes, extreme numbness and loss of sensation, severe muscle wasting)
- Marked muscle weakness in affected leg[s] (absent or nearly absent dorsiflexion of the hallux or ability to perform resisted SLR)
- SLR restricted to 25°on affected side
- Foot drop
- Loss of bowel/bladder control

3. Assistive equipment

For any aid to be considered under this criterion it must be prescribed by a health care professional

Minor aids

These may include:

- sock aids
- raised toilet seat
- long handled shoe horn)
- walking stick

- pick up stick

Major aids/adaptations

In addition to that used in moderate column these may include:

- stair lift, hoist
- foot drop orthosis (support to prevent foot dropping)
- wheelchair
- architectural adaptations

4. Treatment

Table 1

Irregular use of one of the analgesics listed in this section

Mild (simple) analgesics **Available to the public over the counter**	
Drug	***Dose***
Paracetamol 500mg	500 – 1000mg 4 hourly
Low dose co-codamol 8/500mg (codeine + paracetamol)	2 tablets 4 hourly
Low dose Ibuprofen 200mg	200 – 400mg 6 hourly
Aspirin 300mg	300 – 600 mg 4 hourly

Table 2

Regular daily use of the analgesics listed in this section

Moderate analgesics Available on prescription only	
Drug	***Dose***
Co – codamol 15/500mg (Codeine + paracetamol)	2 tablets 4 hourly

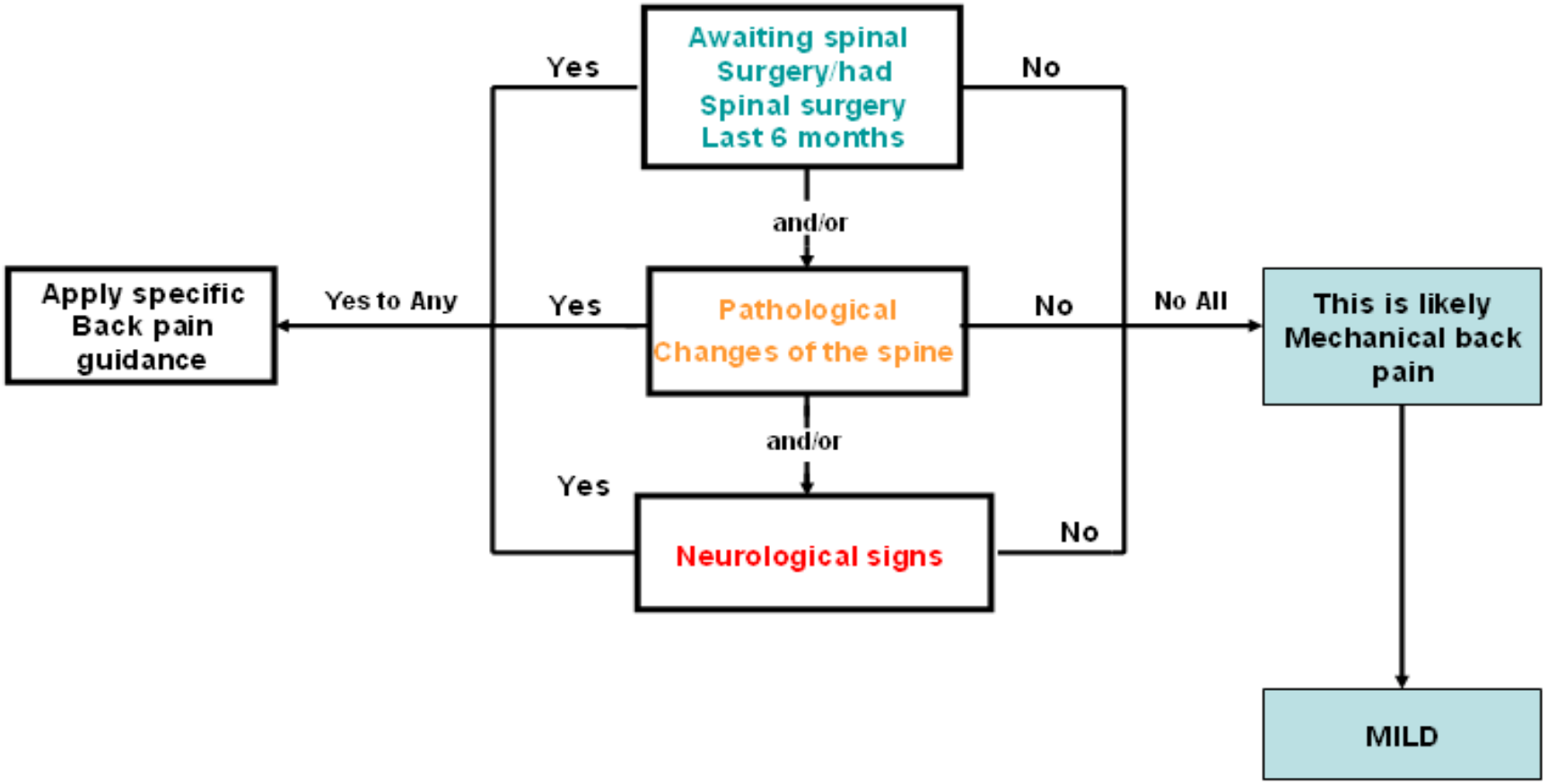
Co – dydramol 10/500mg (Dihydrocodeine + paracetamol)	2 tablets 4 hourly
Co – dydramol 20/500mg (Dihydrocodeine + paracetamol)	2 tablets 4 hourly
Co – proxamol 32.5/325mg (Dextropropsyphene + paracetamol)	2 tablets 4 hourly
Codeine 15mg and 30mg	15 – 30mg 4 hourly

Table 3

Regular use of the analgesics listed in this section

Strong analgesics Available on prescription only	
Drug	***Dose***
Co – codamol 30/500mg	2 tables 4 hourly
Co – dydramol 30/500mg	2 tablets 4 hourly
Dihydrocodeine 30mg	30 – 60mg 4 hourly
Codeine 60mg	60mg 4 hourly
Tramadol 50mg	50 – 100mg 4 hourly
Morphine Preparations	10 – 50mg 4 hourly
Buprenorphine	200 – 400mg microgram 4 hourly
Pethidine	50 – 150mg 4 hourly

BACK PAIN I


Awaiting spinal Surgery/had Spinal surgery Last 6 months
Yes
No
and/or
Apply specific Back pain guidance
Yes to Any
Yes
Pathological Changes of the spine
No
No All
This is likely Mechanical back pain
and/or
Yes
Neurological signs
No
MILD

Guidelines for Determining Officers

Specific Back Pain

Functional Restrictions	Mild	Moderate	Severe
INDICATORS			
Surgery	None	None	Yes
Signs	No Significant Signs	Any 2 from Group 2	Any 2 from Group 3
Assistive Equipment	N/A	Type A Minor	Type B Major
Treatment	Mild Treatment Table 1	Frequent use of Moderate Analgesics described in Treatment Table 2	Strong Treatment Table 3

Combinations and Weights

= Moderate

= Severe

+ = Severe

+ = Moderate

Read in conjunction with Back Pain Criteria

Back Pain TOT

ACTIVITY	MILD	MODERATE	SEVERE
1. Sitting		**d/N/A**	**b**
2. Standing		**c/N/A**	**b**
3. Rising			**b**
4. Walking/Stairs		**e/N/A**	**c/(m)**
5. Bending/Kneeling			**a/b**
6. Reaching			
7. Lifting/Carrying			
8. Manual Dexterity			
9. Vision			
10. Hearing			
11. Speech			
12. Seizures			
13. Finance			
14. Personal Care			
15. Daily Routine			
16. Awareness danger			
17. Navigation outdoors			
18. Coping with change			
TOTAL SCORE	**0**	**0 – 12**	**51 – 60(m)**

Notes:

1. Activity groups

   Lower limb/back function

   Upper limb/neck function

   Sensory functions

   Maintaining control

   Mental health

2. Scoring descriptors (M = mobility)

Depression

Conditions covered

Depression
Seasonal affective disorder

Not included

Bipolar disorder (manic depression)

Medical Criteria Questions

1a. Accommodation

People with a depressive illness may live in accommodation with varying levels of support. The greater the level of disability, the greater the level of support that is likely to be provided.

A person with a mild or moderate depressive illness is likely to live in their own home, either with or without support from another individual.

A person with severe depressive illness is likely to live in residential accommodation, either supported or supervised.

Home

This is defined in this context as a house, bedsit or flat.

Residential accommodation

This is defined in this context as accommodation provided by an external agency where there are arrangements for either intermittent support or regular supervision, and includes:

Supported Group home

Lives with 3 - 10 or more people, often with different mental health disorders, where support workers visit several times a week or daily, but are not present at night. Sometimes a warden may live on site but would only be called on at night in an emergency.

Residential accommodation with 12 to 24 hours supervision

Lives in a group home or hostel where support workers are present throughout the day. In addition, the support workers either sleep in at night [they would expect to be called if the residents needed attention at night or an emergency occurred] or are present at night [because the residents may exhibit disturbed behaviour at night that would require intervention from trained staff]

1b. Care plan

People with moderate and severe depressive illness, under the care of the community mental health team are likely to be under a Care Programme Approach (CPA). The care plan is a written document which brings together information about social care, a medical treatment plan, domestic support, names of the professionals involved in care and actions to be taken in the event of changing circumstances. Copies of the plan are given to the patient/customer, carer, care co-ordinator and others involved. Plans are of two types depending on the level of support required – standard and enhanced. People with severe depressive illness are likely to have an enhanced Care Programme Approach. The plans are reviewed every three to six months, when a revised plan will be completed.

2. Delivery of health care

Treatment of moderate and severe depressive illness is most effective with a multidisciplinary team approach usually co-ordinated through a community mental health team. The team will include psychiatrists, community psychiatric nurses, occupational therapists and social workers working in close collaboration with social service departments. One member of the team may co-ordinate the care and is known as the Care Co-ordinator. People with milder forms of depressive illness may be solely under the care of their general practitioners.

3. Treatment

Mild, moderate and severe depressive illnesses are treated in similar ways and the principal decision is whether to treat with antidepressant drugs or a talking therapy i.e. counselling etc.

Drug treatment

Drug treatment is usually effective in moderate and severe episodes of depressive illness. Approximately 60 % of patients will respond to the first antidepressant prescribed.

There is a wide and increasing range of antidepressant drugs available, varying in their side effects.

Non-compliance with antidepressants may reach 50%. Reasons for non-compliance include side effects encountered, perceived lack of effectiveness, lack of motivation and limited insight into illness.

Current recommendations are that antidepressant treatment should be continued for 6 months following remission; however emerging evidence suggests continuing treatment for 9-12 months following remission. Following this antidepressants should be withdrawn gradually over 3 months.

In those with onset of a severe depressive episode after 50 years of age, or with three previous episodes of depressive illness, it is recommended that antidepressant medication is continued indefinitely.

There are a number of different drugs available. The choice of drug depends upon the preference of the individual doctor, taking into account factors such as side effects and cost. The individual drugs are listed below [trade name in brackets] together with some of the more common side effects.

Citalopram [Cipramil]

Fluoxetine [Prozac]

Fluvoxamine [Faverin]

Paroxetine [Seroxat]

Sertraline [Lustral]

Side effects include; nausea, diarrhoea, headache, insomnia, agitation and sexual dysfunction. Some of these medicines may cause adverse effects if suddenly stopped.

Amitriptylline [Lentizol]

Amoxapine [Asendis]

Clomipramine [Anafranil]

Dosulepin/Dothiepin [Prothiaden]

Doxepin [Sinequan]

Imipramine [Tofranil]

Lofepramine [Gamanil]

Nortriptylline [Allegron, motipress, motival]

Trimipramine [Surmontil]

Side effects include; irregularity of heart rhythm, low blood pressure, drowsiness, convulsions, hence dangerous in overdose and can cause death.

Also can cause blurred vision, dry mouth, constipation and urinary retention.

All of these can reduce compliance with treatment.

Drowsiness and blurred vision may be dangerous for those who drive, operate machinery or work at heights.

More recently introduced medicines include the following:

Venlafaxine [Efexor, Efexor XL]

Reboxetine [Edronax]

Mirtazapine [Zispin]

Moclobemide [Manerix]

Brofaromine

Cimoxatone

Toloxatone.

Mianserin

Maprotiline

Trazodone [Molipaxin]

Flupenthixol/flupentixol [Fluanxol]

Tryptophan [Optimax]

Can only be prescribed by hospital specialists for people with severe and disabling depressive illness of more than 2 years duration and only after an adequate trial of standard antidepressant medication, due to potential severe blood disorder that can result from taking the drug.

Lithium

The evidence for using lithium in unipolar depressive illness is less clear than in bipolar disorders. It can be effective as an added medicine when other measures have failed, e.g. in people who have not responded to a standard antidepressant drug by itself.

Non drug treatment

Electro Convulsive Therapy (ECT)

ECT entails administrating an electric charge to the head of a patient under a general anaesthetic in order to produce a generalised convulsion. A normal course is 6–12 treatments at a rate of 2 per week.

ECT is reserved for cases of resistant depressive illness unresponsive to drug treatment, especially those with psychotic symptoms.

ECT produces a more rapid resolution of depressive illness compared to antidepressant medication and may be lifesaving in severe depressive illness. However antidepressant medication should be continued following a successful course of ECT.

4. Clinical features

List A:

Loss of weight

Early morning wakening

Diurnal variation of mood [Worse in morning]

Hopelessness

Unreasonable guilt

List B:

Psychomotor retardation

[Includes poverty of speech]

Psychotic symptoms

Severe and persistent agitation

Active suicidal thoughts

People with depressive illness may exhibit a number of features. The features present in any individual patient are determined by the severity of the illness. Doctors are able to assess the severity of the illness by means of eliciting a history combined with a structured “mental state examination.”

Biological symptoms

The following are often referred to as biological symptoms or “biological features.” They are features of moderate and severe depressive illness.

Sleep disturbance

Diurnal variation of mood [worse in the morning]

Loss of appetite

Loss of weight

Constipation

Loss of libido [sexual drive]

Amenorrhoea [cessation of periods]

People with depressive illness may demonstrate any of the following, depending upon the severity of the illness:

Appearance

Unkempt.

Neglected dress and grooming.

Poor self-care and personal hygiene – often dirty clothing.

Depressed facial appearance, perhaps with turning down of the corners of the mouth.

Tearfulness.

“Knitted brow” – furrowing of the centre of the forehead, between the eyebrows.

Downward gaze – poor eye contact and reduced rate of blinking.

But some people may maintain a smiling exterior while depressed. These people are often referred to as “smiling or masked depressives”

Weight loss.

Reduced gestures.

Shoulders bent and head inclined forwards.

Speech

Poverty [lack] of speech and/or speaking in a monotone.

Slow and hesitant – long delay before questions are answered.

Mood

Low and sad – often one of misery.

“Autonomous” – i.e. mood does not react in response to circumstance.

Anxiety, irritability and agitation may occur.

Morbid / pessimistic thoughts

Concerned with the past – often taking the form of unreasonable guilt and self-blame about minor matters, e.g. feeling guilty about past trivial acts of dishonesty [such as taking home an office pencil many years ago]. Such minor misdemeanours may be exaggerated out of all proportion and used as “proof” that the patient is “evil” and does not deserve his current status in life.

Concerned with the present

Pessimism – the patient sees the unhappy side of every event.

He thinks he is failing in everything he does and that other people see him as a failure.

Low self-esteem - he no longer feels confident, and discounts any success as a chance happening for which he can take no credit.

Concerned with the future [which seems bleak]

Ideas of hopelessness and helplessness – the patient expects the worst.

Often accompanied by the thought that life is no longer worth living for and that death would come as a welcome release.

May progress to thoughts of, and plans for, suicide.

Homicidal thoughts may occasionally occur – e.g. a depressed mother may decide the future is equally bleak for her children and plan to kill them before committing suicide; or a depressed elderly man may persuade his wife to enter into a suicide pact.

Poverty of thought

Few thoughts – these lack variety and richness, and seem to move slowly through the mind.

Intellect and memory

Impaired attention and concentration.

Poor memory – not permanent, as is often feared by the patient.

In the elderly, depressive pseudodementia may occur i.e. the patient exhibits the features of dementia, but this is due to the depressive illness.

Sleep disturbance

Early morning wakening 2 – 3 hours before the patient's usual time. Often occurs in more severe depressive illness.

Initial insomnia – difficulty and delay in falling asleep. May occur in less severe depressive illness.

Some young depressed people sleep excessively – but still feel unrefreshed on waking.

Intractable sleep disturbance is common in the elderly.

Change in appetite

Characteristically loss of appetite, less commonly increased appetite.

Change in weight

Characteristically loss of body weight [at least 5% in a month], less commonly increased weight.

Change in psychomotor activity

Common in the elderly.

Characteristically psychomotor retardation [slowed up].

Sometimes agitation.

Diurnal variation of mood

Characteristically worse in the morning – people wake up feeling very depressed and possibly suicidal.

Their mood gradually lifts during the day, but is sometimes worse again in the evening.

Some people, often with less severe depressive illness, may not feel depressed on waking but may become more depressed as the day progresses.

Anhedonia

Total lack of interest in and enjoyment of hobbies / pleasure activities.

Reduced energy and drive

Causing fatigue / tiredness and reduced activity.

Loss of [or markedly reduced] libido [sexual drive]

Change in bowel habit

The patient may complain of constipation.

Change in menstrual cycle

Amenorrhoea may occur in females i.e. periods cease

Physical Symptoms

These are more common in the elderly

Aching discomfort anywhere in the body.

Increased complaints about any pre-existing physical disorder.

Psychotic Features

Delusions [False beliefs that are unshakeable]

Concerning themes of worthlessness, guilt, ill health [especially cancer] or poverty.

Concerning persecution [e.g. that others are going to take revenge on him]; the supposed persecution is often accepted as having been brought on himself.

Hallucinations

Usually compatible with depressed mood i.e., derogatory auditory hallucinations – voices addressing repetitive words and phrases to the patient,

confirming his ideas of worthlessness [e.g. “You are an evil sinful man; you should die”], making derisive comments or urging suicide.

A few people experience visual hallucinations, such as scenes of death and destruction.

Other psychiatric symptoms include:

Anxiety

Hypochondriasis – these [and other somatic complaints] are common in old age.

Depersonalisation i.e. person feels unreal and detached from his own experience

Self harm

Self-harm includes self-injury [e.g. Self inflicted wounds,] and self poisoning with drugs

It should be noted that suicide is a rare event and that fleeting thoughts of suicide are common in people with many mental disorders. The current suicide rate for the general population is 10 per 100,000 per year. 6% of those suffering from a mood disorder will die by suicide.

The following are associated with increased risk of suicide:

- Low socio-economic status
- Low educational status
- Unmarried, separated, divorced, widowed
- Living alone, homeless
- Unemployed, retired, insecure employment
- Certain occupations – vets, farmers, doctors, dentists, pharmacists
- Adverse life events
- Co – morbid psychiatric illness – depressive illness, personality disorders, alcohol related disorders, psychotic illness

Significant means that the person had a desire to die. Factors that increase the likelihood of this, that are required to be taken into account by a Health Care Professional when assessing suicidal risk include the following:

- Planning and preparation, e.g. buying equipment or collecting medication
- Precautions taken to avoid discovery, e.g. doors locked, the act timed to avoid disturbance or carried out in isolation
- No help sought after the act
- A violent method attempted, e.g. hanging, electrocution, shooting, jumping or drowning

- A final act was performed, e.g. making a will or leaving a suicide note

- Regret for not having died and still wanting to die.

In depressive illness, although there is an increased risk of suicide, continuous supervision should not be necessary as:

- The onset of depressed mood is rarely sudden
- Continuous supervision can usually only be reliably provided on a 24-hour basis in a hospital setting and is therefore not practical in the home situation.
- Patients with psychomotor retardation are at greater short-term risk of suicide once their symptoms begin to improve – when they develop the energy to carry out the act of suicide.

However, the risk of suicide diminishes with successful treatment and hence is not likely to be an ongoing problem in the majority of cases.

5. Previous episodes

The average length of a depressive episode is about 6 months but about 25% of people have episodes lasting more than a year and about 10-20% develop a chronic unremitting course

Guidelines for Determining Officers

Depression

Functional Restrictions	Mild	Moderate	Severe
INDICATORS			
Accommodation	Own Home	Home	Residential
Management	GP Only	Psychiatric Outpatient	Psychiatric Day Hospital Treatment
Symptoms	Minimal	List Type A	List Type B
Medication	None/low dose antidepressants	Mood modifying drugs for more than 4 months	ECT or severe medication - antipsychotics
Episodes in last 12 months	1	2 or 3	More than 3 episodes or continuous over the last 12 months.

2 x = severe

1 x + 1 x = severe

1 x or 1 x + 1 x = moderate

2 x = moderate

Read in conjunction with Depression Criteria

Depression TOT

ACTIVITY	MILD	MODERATE	SEVERE
1. Sitting			
2. Standing			
3. Rising			
4. Walking/Stairs			
5. Bending/Kneeling			
6. Reaching			
7. Lifting/Carrying			
8. Manual Dexterity			
9. Vision			
10. Hearing			
11. Speech			
12. Seizures			
13. Finance		c	b
14. Personal Care			a/b
15. Daily Routine		d	b
16. Awareness danger			b/c
17. Navigation outdoors			c
18. Coping with change			
TOTAL SCORE	**0**	**0-10**	**65-80**

Notes:

1. Activity groups

   Lower limb/back function

   Upper limb/neck function

   Sensory functions

   Maintaining control

   Mental health

2. Scoring descriptors (M = mobility)

General Osteoarthritis Lower

Conditions covered

Osteoarthritis
Degenerative arthritis
Arthritis (unless clear it is an autoimmune arthritis such as rheumatoid)

Not included

Autoimmune arthritis (e.g. rheumatoid)
Where diagnosis is only back pain – use back pain guidance

Medical Criteria Questions

1. Surgery

Awaiting surgery for a replacement of major lower limb joint(s). This criterion considers whether one (moderate) or two (severe) joints are awaiting replacement. Major joint means:

- Hip
- Knee
- Big toe.

There will be cases where although joint replacement is clinically necessary and has been recommended by a specialist is cannot be carried out. This may be due to for example:

- The person refuses surgery
- There is a contraindication to surgery for example other medical conditions

In these circumstances this criterion will apply i.e. treat as if awaiting the joint(s) replacement.

2. Signs

This considers the range of movements, swelling and deformity in the lower limb joints.

<u>List A (mild)</u>

- No/mild swelling or deformity and no significant loss of movement

<u>List B (moderate)</u>

One or more of the following:

- Persistent moderate swelling and/or deformity of one or both knee joints
- moderate restriction of hip and/or knee movements.
- Instability of knee joint on one side
- Moderate swelling and deformity of toes (must include big toe)

List C (severe)

One or more of the following:

- Gross swelling or deformity of knee joint(s)

- Fixed flexion deformity of hip(s)
- Severe restriction of hip or knee movements
- Knee instability both knees
- Gross swelling and deformity of toes (must include big toes)
- Bow legged or knock-kneed
- Significant muscle wasting of lower limb(s)

3. Symptoms

Need to consider whether the person reports:

- Pain only on moving affected joint(s) (moderate)
- Persistent pain day and/or night reducing sleep quality or duration (severe)

4. Back

At least one of the following would indicate severe functional restrictions:

- Awaiting Lumbar Spinal Surgery
- Significant neurological signs in lower limbs arising from lower back

Significant neurological signs means at least two of the following:

- Gross neurological signs in at least one leg (absent or nearly absent reflexes, extreme numbness and loss of sensation, severe muscle wasting)
- Marked muscle weakness in affected leg[s] (absent or nearly absent dorsiflexion of the hallux or ability to perform resisted SLR)
- SLR restricted to 25°on affected side
- Foot drop
- Loss of bowel/bladder control

Guidelines for Determining Officers

General Osteoarthritis Lower

Functional Restrictions	Mild	Moderate	Severe
INDICATORS			
Surgery	None	Awaiting 1 joint replaced	Awaiting 2 joints replaced
Signs	Mild/None	Moderate loss of movements	Severe restrictions movement (2 joints)
Low Back	None	None	Awaiting spinal surgery, neuro signs etc.,

Combinations and Weights

1 x  = severe

1 x  + 1 x  = severe

1 x  = moderate

1 x  = moderate

Read in conjunction with Osteoarthritis Criteria

General OA Lower TOT

ACTIVITY	MILD	MODERATE	SEVERE
1. Sitting		**d**	**c**
2. Standing		**b/c**	**b**
3. Rising		**b**	**b**
4. Walking/Stairs		**d**	**c(m)**
5. Bending/Kneeling		**b**	**a**
6. Reaching			
7. Lifting/Carrying			
8. Manual Dexterity			
9. Vision			
10. Hearing			
11. Speech			
12. Seizures			
13. Finance			
14. Personal Care			
15. Daily Routine			
16. Awareness danger			
17. Navigation outdoors			
18. Coping with change			
TOTAL SCORE	**0**	**36-45**	**51(m)**

Notes:

1. Activity groups

   Lower limb/back function

   Upper limb/neck function

   Sensory functions

   Maintaining control

   Mental health

2. Scoring descriptors (M = mobility)

General Osteoarthritis Upper

Conditions covered

Osteoarthritis
Degenerative arthritis
Arthritis (unless clear it is an autoimmune arthritis such as rheumatoid)

Not included
Autoimmune arthritis (e.g. rheumatoid)
Where diagnosis is only back pain – use back pain guidance

Medical Criteria Questions

1. Surgery

Awaiting surgery for a replacement of major upper limb joint(s). This criterion considers whether one (moderate) or two (severe) joints are awaiting replacement. Major joint means:

- Shoulder
- Elbow
- Wrist
- Thumb

There will be cases where although joint replacement is clinically necessary and has been recommended by a specialist is cannot be carried out. This may be due to for example:

- The person refuses surgery
- There is a contraindication to surgery for example other medical conditions

In these circumstances this criterion will apply i.e. treat as if awaiting the joint(s) replacement.

2. Signs

This considers the range of movements, swelling and deformity in the upper limb joints.

<u>List A (mild)</u>

- No significant loss of movement, joint swelling or deformity

<u>List B (moderate)</u>

One or more of the following:

- Moderate swelling or deformity of fingers or thumb
- Moderate restriction of movement of shoulder or elbow or thumb or fingers.

List C (severe)

One or more of the following:

- Severe restriction of movement of shoulder or elbow or thumb or fingers
- Gross swelling of shoulder, elbow or thumb or fingers
- Gross deformities of shoulder or elbow or thumb or fingers
- Significant muscle wasting of shoulder girdle or upper arm.

3. Symptoms

Need to consider whether the person reports:

- Pain only on moving affected joint(s) (moderate)
- Persistent pain day and/or night reducing sleep quality or duration (severe)

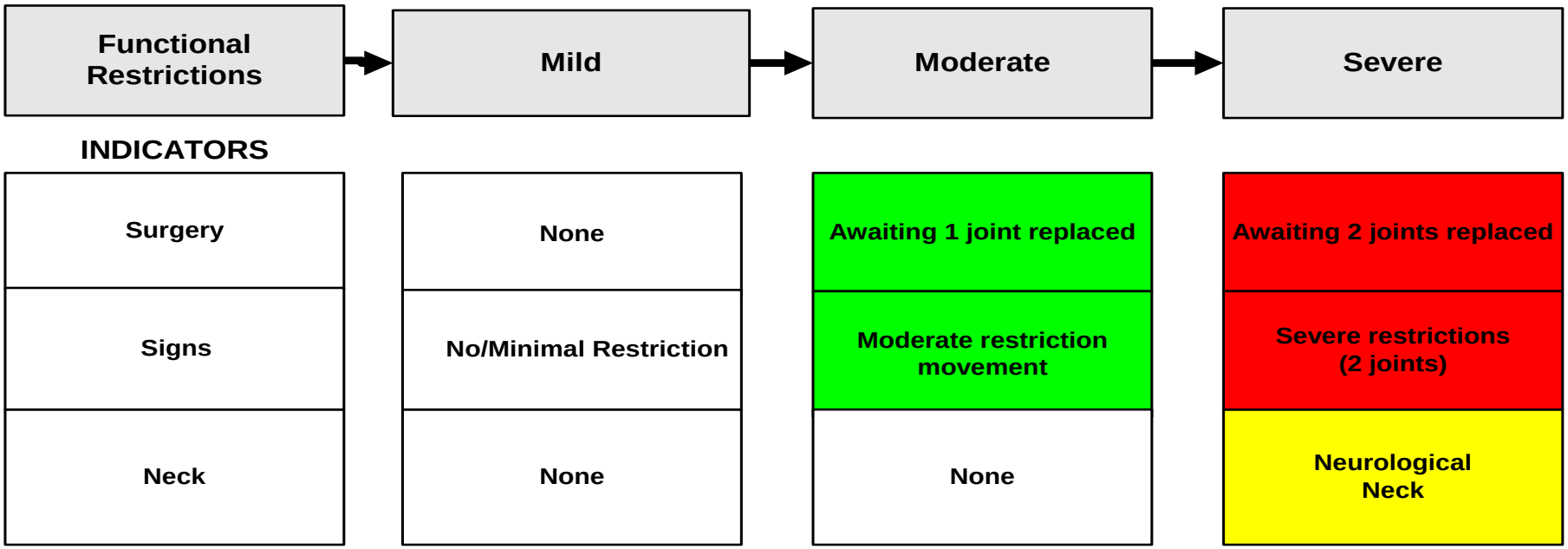
4. Neck

Pain and restricted neck movements occur with moderate and severe OA of her neck. The addition of neurological signs would indicate severe functional restrictions for this criterion. Neurological signs include:

- Muscle wasting arms and hands
- Weakness of grip
- Altered sensation
- Loss reflexes

Guidelines for Determining Officers

General Osteoarthritis Upper



Combinations and Weights

1 x [red] = severe

1 x [green] + 1 x [yellow] = severe

1 x [green] = moderate

1 x [yellow] = moderate

Read in conjunction with Osteoarthritis Criteria

General OA Upper TOT

ACTIVITY	MILD	MODERATE	SEVERE
1. Sitting			
2. Standing			
3. Rising			
4. Walking/Stairs			
5. Bending/Kneeling			
6. Reaching	**e**	**c*/d*/e**	**b*/c**
7. Lifting/Carrying[1]	**e**	**c*/d*/e**	**b*/e**
8. Manual Dexterity	**h**	**e^/h**	**a^/b^/c^/d^/h**
9. Vision			
10. Hearing			
11. Speech			
12. Seizures			
13. Finance			
14. Personal Care			
15. Daily Routine			
16. Awareness danger			
17. Navigation outdoors			
18. Coping with change			
TOTAL SCORE	**0**	**0/6 - 27**	**0/15 - 45**

[1] Only consider this function if the shoulder, elbows or wrist are affected

Notes:

1. Activity groups

   Lower limb/back function

   Upper limb/neck function

   Sensory functions

   Maintaining control

   Mental health

2. Scoring descriptors (M = mobility)

Ischaemic heart disease

Conditions covered

Angina
Angina pectoris
Coronary artery disease
Myocardial ischaemia
Prinzmetal angina (vasoplasic angina)
Coronary artery spasm

Medical Criteria Questions

Exercise test (Bruce Protocol)

Formal exercise testing is undertaken when the diagnosis of angina needs to be confirmed in suspected individuals, and indeed the severity of the coronary disease a standard treadmill or, more rarely, a bicycle ergo-meter is used and a formal exercise test (ETT) is performed. It is carried out according to a standard protocol.

The patient walks on the treadmill, which has a varying speed (which can be altered, i.e. made faster or slower) and a variable gradient (slope), which can mimic going uphill or upstairs. (The Bruce Protocol is a description of the protocol for the increments in speed and gradient in the treadmill test).

During the time of testing, continual monitoring of the patient's general condition, ECG and blood pressure take place.

A specialist must supervise, and full resuscitation facilities must be available.

The patient stops when chest pain or discomfort occurs, or when advised to, by the Specialist.

For the Full (Standard) Bruce Protocol, each stage lasts 3 minutes and the speed and gradient are increased at each stage (see the following table).

Full (Standard) Bruce Protocol

Stage	Speed (mph)	Gradient (%)	Duration (min)	Cumulative time (min)
I	1.7	10	3	3
II	2.5	12	3	6
III	3.4	14	3	9
N	4.2	16	3	12
V	5.0	18	3	15
VI	5.5	20	3	18
VII	6.0	22	3	21

For the modified Bruce Protocol, the gradient, but not the speed, is increased at each stage.

Specific ECG changes indicate myocardial ischaemia.

A modified test is used in cases where standard testing would be too strenuous for the patient. The patient may not be able to participate in exercise testing, because of co-existing problems (i.e. severe OA of the hip, or severe chronic obstructive airways disease).

About one hundred and fifty metres uphill is covered in the first 3 minutes of the test, and a further 220 metres in the second stage.

Symptoms

Minimal exertion

Sitting, eating, talking, dressing, and undressing, showering, and drying self.

Minimal

Walking on the level (2 blocks, that is, about 12 houses), keeping up with someone of the same age and gender, walking upstairs (one flight, that is, about 12 steps). Ordinary household tasks. Carrying two supermarket bags of shopping, (weighing 5lbs, or 2.5 Kg, one in each hand), a reasonable distance, on the flat.

Moderate

Walking briskly, hurrying upstairs, walking on an incline without stopping, and walking more than one flight of stairs.

Severe

Running for a bus, running upstairs, walking up a steep hill without stopping.

Walking up multiple flights of stairs. Carrying two full supermarket bags of shopping upstairs.

Medication (see help screen for further details)

GTN

GTN may be used as a prevention of angina, before planned exercise, as well as to treat it. Nitrates work by dilating (opening up) blood vessels in the body. Acute angina attacks are treated by glyceryl trinitrate under the tongue in either spray or tablet form. Typical medication includes:

Glyceryl Trinirate (GTN) in aerosol spray or in tablet form.

GTN 400 microgram spray. (Spray once under the tongue when required).

GTN 500 microgram tablets. Place one tablet under the tongue when required.

Preventatives

Four groups of medications are used to treat angina; betablockers, calcium-channel blockers, nitrates and potassium-channel activators.

Different combinations will be used as they are tailored to the individual requirements.

1) **Betablockers**: They work by reducing heart muscle oxygen demand as the heart rate is slowed down. There are numerous betablockers on the market, but the following three are recommended for use, as they appear to meet nearly all clinical needs.

- Atenolol (Trade name Tenormin) (50-100 mg per day)
- Metoprolol (Betaloc, Lopresor) (100-200 mg per day)
- Propanolol (Inderal) (40 mg twice or 3 times a day)

2) **Calcium Channel Blockers**: These work by "relaxing" the heart muscle and coronary arteries and the effect of this is to increase blood flow, and to reduce the force of contraction of the main ventricle of the heart. Generally the blood vessels are dilated. The dose may gradually be increased.
The therapeutic effects in calcium channel blockers may vary.

Commonly used medications are:

Verapamil (Trade name Cordilox, Securon Univer)

(40mg three times a day or 80mg three times a day) Diltiazem (Tildiem, Angitil and Slozem are commonly used trade names).

Nifedipine (Adalat, Coracten, Cardilate)

Amlodipine (Istin)

3) **Potassium Channel Activators**: They are an alternative when betablockers are contraindicated, or in persistent unstable angina. They work by increasing blood flow in the coronary arteries. They can be useful when other agents cannot be used. Example of medication:

Nicorandil (Ikorel)

4) **Long acting nitrates**:

Nitrates work by dilating (opening up) blood vessels in the body. Long acting nitrates may be taken in the form of tablets orally or as a skin patch (transdermal) form. This group of drugs include:

Isosorbide mononitrate (20-60mg once or twice a day).

Isosorbide dinitrate (10-20mg every 8 hours).

Surgery

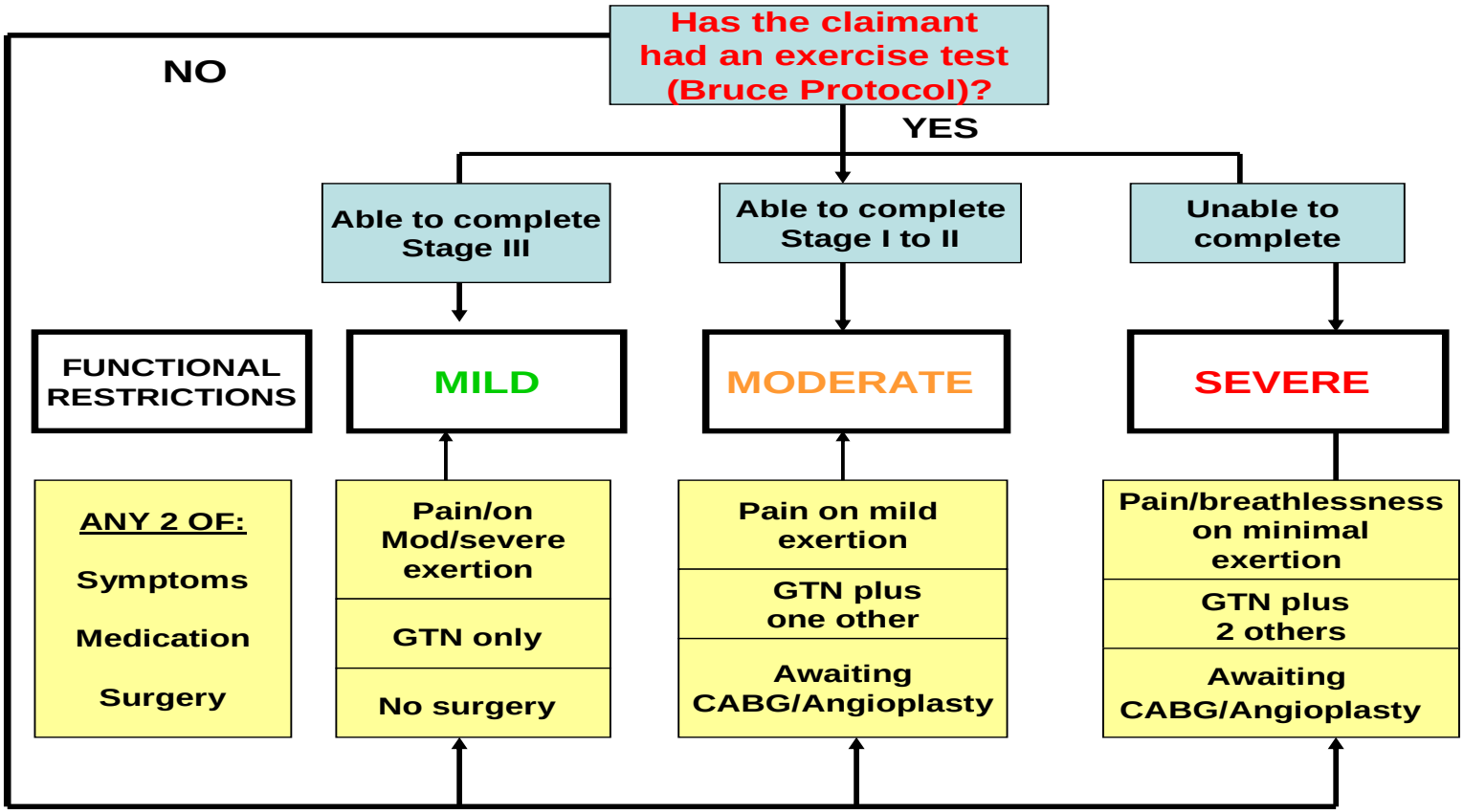
Angioplasty and coronary artery bypass grafts (CABG) are used to improve blood supply to the heart muscle and relieve angina. Differ in that angioplasty is a more minor procedure. Whereas CABG is a major operation which involves opening the chest wall, a longer recovery time in hospital, and a much longer convalescence.

Angioplasty involves the passing of a balloon (on a very thin catheter inserted through the artery in the top of the leg, or occasionally the arm) into the coronary artery with the narrowing, where it is inflated several times. This enlarges the vessel diameter by pushing against the plaque and modifying its structure. Stents – coated metallic “scaffolding” - may be used to prevent return of the narrowing and are now used in 90-95% of cases provided the artery is large enough.

CABG - as for PTCA, it is used to improve blood supply to the heart muscle, improve quality of life, and/or prognosis (life expectancy).

CABG which involves open heart surgery where a vein or artery taken from another part of the body is used to ‘bypass’ blockages in the coronary arteries is used mainly in more severe and extensive disease (i.e. when all three of the coronary arteries are affected.

Ischaemic Heart Disease



Ischaeminc Heart Disease

Ischaemic heart disease TOT

ACTIVITY	MILD	MODERATE	SEVERE
1. Sitting			
2. Standing			
3. Rising			
4. Walking/Stairs		**d/e**	**c**
5. Bending/Kneeling			**a**
6. Reaching			
7. Lifting/Carrying			
8. Manual Dexterity			
9. Vision			
10. Hearing			
11. Speech			
12. Seizures			
13. Finance			
14. Personal Care			
15. Daily Routine			
16. Awareness danger			
17. Navigation outdoors			
18. Coping with change			
TOTAL SCORE	**0**	**3-6**	**24 (M)**

Notes:

1. Activity groups

   Lower limb/back function

   Upper limb/neck function

   Sensory functions

   Maintaining control

   Mental health

2. Scoring descriptors (M = mobility)

Learning Difficulties

Conditions covered

Learning disability
Mental subnormality (old fashioned term)
Learning difficulty element of chromosome abnormalities (e.g. Downs syndrome) See DWP website
Learning difficulty element of metabolic diseases (e.g. Tay Sachs disease) See DWP website

Medical Criteria Questions

1. Intelligence Quotient (IQ)

Intelligence is a broad concept that includes the ability to reason, understand and make judgements. IQ is the psychometric test used to assess intelligence. Intelligence is distributed in the population along a normal distribution curve. The average IQ is 100. IQs of 70 and over are considered normal.

Socio-economic factors may account for a variation by up to 20 points. Low IQ is related to lower socio-economic status, poverty, poor housing and an unstable family environment.

Disease classifications divide the severity of learning difficulties into four categories:

- Mild - IQ 50-70 (accounts for 85% of people with learning difficulty)
- Moderate - IQ 35-49 (accounts for 10% of people with a learning difficulty)
- Severe - IQ 20-34 (accounts for 3-4% of people with a learning difficulty)
- Profound - IQ below 20 (accounts for 1-2% of people with a learning difficulty)

For our purposes when looking at the functional restrictions arising from learning difficulties we have divided then into 3 groups:

<u>Mild functional restrictions (IQ 50-60)</u>

People in this group may lead relatively independent lives though they may need some help in coping in more complex situations and with family responsibilities, finance, housing and employment or when under stress.

<u>Moderate functional restrictions (IQ 35-49)</u>

People in this group usually are able to acquire basic daily living skills over time but may need prompting to carry them out. Speech is usually relatively

simple and better understood by a person who knows then well. Finance and road skills generally require support.

Severe functional restrictions (IQ less than 34)

People in this group need support with most aspects of daily living activities. They may be able to undertake simple tasks and engage in limited social activity but need supervision and a clear structure to their lives. Unable to go out alone in most cases.

2. Behavioural problems (Challenging behaviour)

This is behaviour which impairs the physical safety of the person or others making participation in the community difficult. It affects around 15% of people with a learning difficulty.

The following are examples of behaviour which should be considered:

- Threatening and violent behaviour including assault and verbal abuse
- Self injury – e.g. head banging, biting
- Disinhibition –e.g. exposure
- Damage to property
- Putting self at risk –e.g. running into road
- Refusal to comply with person assisting with daily living activities

3. Supervision

Mild

A person with mild functional restrictions would need only occasional supervision and not on a daily basis

Moderate

A person with a moderate functional restriction would need intermittent supervision most days

Severe

A person with severe function restrictions would need supervision every day on several occasions and may need to be watched continually during waking moments.

Guidelines for Determining Officers

LEARNING DIFFICULTIES

Criteria	Mild	Moderate	Severe
INDICATORS			
Severity of learning difficulty (IQ)	> 50	35 - 49	< 35
Behavioural problems	Absent	Absent	Present
Supervision	Unsupervised	Intermittent	Most of day

Combinations and Weights

= severe

+1 x = severe

+2 x = severe

+ = moderate

+ = moderate

= mild

Read in conjunction with Learning Difficulties Criteria

Learning Difficulty TOT

ACTIVITY	MILD	MODERATE	SEVERE
1. Sitting			
2. Standing			
3. Rising			
4. Walking/Stairs			
5. Bending/Kneeling			
6. Reaching			
7. Lifting/Carrying			
8. Manual Dexterity			
9. Vision			
10. Hearing			
11. Speech			
12. Seizures			
13. Finance	c	b	a
14. Personal Care	b/c	a	a
15. Daily Routine	d/e	b/c	a/b
16. Awareness danger	d	c	a
17. Navigation outdoors	d	d	b/c
18. Coping with change	a/b/c	c	c
TOTAL SCORE	**30-45**	**65-70(M)**	**90-95(M)**

Notes:

1. Activity groups

   Lower limb/back function

   Upper limb/neck function

   Sensory functions

   Maintaining control

   Mental health

2. Scoring descriptors (M = mobility)

Schizophrenia

Conditions covered

Schizophrenia
Schizoaffective disorder
Psychosis

Medical Criteria Questions

Accommodation

General

Up to 20% of people with schizophrenia require care in accommodation where there is supervision by staff, both by day and night. This can be in a hostel or a group home where several people with long term mental health disorders live together. Other people (up to 50%) live independently or with their families, but have regular visits from a care co-ordinator, care manager or CPN to supervise their medication and monitor their mental state. They may attend day centres on one or several days of the week, when activities are organised and members of the community health team can review them. Those with moderate or severe disease will have a regular review by the mental health team either at home, in a clinic or other community setting. Their CPA (Care Plan Approach) will be reviewed regularly, usually every three to six months, and a revised plan will be completed.

The following paragraphs define what is meant by the answer options within the medical criteria questions:

Lives at home

- Lives with parents, spouse, other relative or carer in their own home.

Supported accommodation

- Lives in group home with 3 – 10 or more people, often with different mental health disorders, where support workers visit several times a week or daily, but are not present at night. Sometimes a warden may live on site but would only be called at night in an emergency.

Residential accommodation with 12 to 24 hour supervision

This customer is likely to live in accommodation with a high degree of supervision from care workers:

- Lives in a group home or hostel where support workers are present throughout the day, and some sleep in at night. At night they would expect to be called if the residents needed attention at night or an emergency occurred

- As above but support workers present at night because the residents may exhibit disturbed behaviour at night that would require intervention from trained staff

Management

Treatment of schizophrenia is most effective with a multidisciplinary team approach usually co-ordinated through a community mental health team. The team will include psychiatrists, community psychiatric nurses, occupational therapists and social workers working in close collaboration with social service departments. One member of the team may co-ordinate the care and is known as the Care Co-ordinator. People with milder forms of schizophrenia may be solely under the care of their general practitioners.

People with schizophrenia under the care of the community mental health team are likely to be under the NHS Care Programme Approach (CPA). The care plan is a written document that brings together information about social care, a medical treatment plan, domestic support, names of the professionals involved in care and actions to be taken in the event of changing circumstances. Copies of the plan are given to the patient/customer, carer, care co-ordinator and others involved. Plans are of two types depending on the level of support required – standard and enhanced. Many people with schizophrenia will have an enhanced Care Programme Approach. The plans are reviewed every three to six months, when a revised plan will be completed.

Signs, Symptoms and behaviour

<u>List A (moderate)</u>

No prominent negative symptoms **AND** 2 of the following.

- Side effect of medication
- (extra pyramidal)
- Thought disorder
- Active hallucinations
- Delusions
- Limited insight
- History of substantial self neglect within past 12 months
- History of suicide attempt within past 12 months
- Disturbed social behaviour

<u>List B (severe)</u>

Prominent negative symptoms

Prominent negative symptoms **and** any **1** of the following **OR 3** of the following:

- Side effects of medication
- (extra pyramidal)

- Thought disorder
- Active hallucinations
- Delusions
- Limited insight
- History of substantial self neglect within the past 12 months
- History of suicide attempt within past 12 months
- Disturbed social behaviour

Positive symptoms

These occur when there is something added to a person's thinking such hallucinations, delusion and disturbances in thought processes. Characteristic features include delusions (false beliefs), hallucinations (perceptions in the absence of a stimulus) and thought disorder (abnormal thinking). These symptoms are most common in acute schizophrenia.

- **Hallucinations** are false perceptions that may affect any of the senses, but are most often auditory, when people complain of hearing voices. These voices are seemingly very real, frequently critical of the individual, and may give orders such as self-injury. They may provide a running commentary on what the person is doing or thinking. Several voices may talk together. An individual may uncommonly also see visions of things or people or feel things that are not there.

- **Delusions** are genuinely held false beliefs that are unresponsive to logical argument. For example an individual may believe they are a great prophet, possess special knowledge, have been profoundly wicked or evil, are being victimised by the system or attacked or poisoned by relatives or aliens (paranoia).

- **Disturbances in thought processes, thought disorder,** include the individual believing that thoughts are being put into their minds to control them, that their whole body and mind are under external control or that things they see or hear have special messages for them. They may also believe that their thoughts are being broadcast out loud and that everyone knows what they are thinking. People may complain of poor concentration or their mind being blocked or emptied (thought block). They may stop in mid speech in a perplexed fashion with continuing incoherent or disconnected speech. They may have difficulty in following a train of thought to its logical conclusion. Individual thoughts may have only a loose or peripheral connection to each other.

Negative symptoms

These occur where there is a loss from a person's usual behaviour, such as:

- Emotional bluntness
- Marked withdrawal – loss of energy and enthusiasm for life, low mood
- Difficulty in communicating with others
- Profound apathy – finding it difficult to get out of bed, having no idea of what to do with their time

- Inability to cope with everyday tasks – leading to personal neglect
- Withdrawal from social contact – schizophrenia is generally accompanied by a loss of self-esteem so loneliness may be extreme
- Change in sleep patterns
- Difficulty expressing right emotion at the right time, but they may be relating to what is going on in their private world than to external events
- Difficulty in thinking – what is said is muddled, occasionally making up words or using odd expressions, echoing speech, stopping in mid-speech – a bizarre kaleidoscope of ideas and images is characteristic of schizophrenic writing.
- Difficulty in learning, memory and perception leading to problems in planning and integrating tasks e.g. activities of daily living
- In extreme cases, people with schizophrenia may become almost totally unresponsive and will not move, speak or respond (a condition known as **catatonia**).

Negative symptoms may coexist with positive symptoms from the outset, or appear later. They tend to last longer than the positive symptoms and continue between acute episodes. Negative symptoms are often not as responsive to treatment with medication as positive symptoms and may have substantial long term disabling effects.

3. Medication

Medication is the cornerstone of treatment for schizophrenia and is often very effective in controlling the positive symptoms such as hallucinations, delusions and thought disorders. Usually treatment is taken orally on a daily basis. Some people may be unable to take medication in this way and are treated with long acting preparations of the drugs given by injection (depot injections).

A variety of different types of drugs are used to treat schizophrenia either singly or in various combinations The drug regime chosen depends on a number of factors including the nature of the symptoms, the severity of the condition, the route of administration (oral or injection) and the person's response to treatment. Some of the drugs may cause severe side effects that limit their use at high doses.

Drugs used in the treatment of schizophrenia include:

- Anti-psychotic drugs
- Mood stabilizing drugs
- Drugs to alleviate side effects caused by antipsychotic medication

The term ***psychoactive drug*** is used describe any medication or drug that affects the functioning of the mind. For example drugs which improve mood (anti depressants) and those which relieve psychotic symptoms such as hallucinations (anti psychotics).

In the treatment of schizophrenia ***psychoactive drugs*** include **Anti-psychotic drugs** and **Mood stabilizing drugs**

The drugs used to relieve side effects caused by antipsychotic medication are not classified as *psychoactive drugs*

Oral anti-psychotic drugs

The drugs used to relieve the psychotic symptoms of schizophrenia, such as hallucinations and delusion, are known as **antipsychotic drugs**. They also relieve other psychological symptoms such as agitation, mania and anxiety without impairing consciousness. Such symptoms occur in other serious mental health disorders.

These drugs are often described in two groups - older antipsychotic drugs (conventional drugs in use for many years) and newer or atypical antipsychotic drugs.

The older or more traditional drugs include:

- Chlorpromazine
- Thioridazine
- Fluphenazine
- Prochlorperazine
- Trifluoperazine
- Haloperidol
- Flupentixol
- Sulpiride

The newer drugs include:

- Amisulpride
- Clozapine
- Olanzapine
- Quetiapine
- Risperidone
- Sertindole
- Zotepine
- Clozapine

These drugs are listed by their generic names, not their brand or trade names. Each generic drug may have several different proprietary names.

The following drugs might be prescribed for a person with mild schizophrenia in small doses taken by mouth.

Olanzapine	10mg daily
Risperidone	1mg twice a day
Quetiapine	150 – 250mg twice a day
Amisulpride	200mg twice a day
Chlorpromazine	25mg - 100mg daily

The following drugs may be prescribed for a person with moderate schizophrenia when taken by mouth.

Olanzapine	10 - 20mg daily
Risperidone	4 - 6mg daily
Quetiapine	300 – 450mg daily (max 750mg daily)
Amisulpride	400 – 500mg daily (max 1200mg daily)
Sertindole	12 – 20mg daily
Clorpromazine	100mg or more daily (300mg to I g daily)

Depot medication

Depot medications are long acting preparations of antipsychotic drugs that are given by injection. They act by releasing the drug slowly into the body over several weeks. Medication is given in this way to people who may be unable to take oral medication on daily basis.

Drugs/Dosages	Range of dosage	
Flupentixol decanoate (Depixol)	50mg every 4 weeks	300mg every 2 weeks
Fluphenazine decanoate (modecate)	25mg every 4 weeks	50-100mg every 2 weeks
Haloperidol decanoate	50mg every 4 weeks	50-100mg every 2 weeks
Risperidone (Riperdal Consta)	25mg every 2 weeks	50mg every 2 weeks
Zuclopenthixol decanoate (Clopixol)	200 – 500mg every 4 weeks	200 – 400mg every 2 weeks
Name in brackets are the propriety (brand) names of the drugs		

Indications of increasing severity of disease are:

- Increasing strength of injection given
- Injections given at more frequent intervals, i.e., 4 weekly reducing to 3 weekly to fortnightly. A depot injection given every week would indicate very severe disease.

If a drug is given by injection, this indicates that the medication is supervised by a health care professional. This is regardless of whether any additional daily oral tablets are given by a carer, or if the person administers the tablets themselves.

Psychoactive drugs

Psy*choactive drugs* include the **Anti-psychotic drugs** and the **Mood stabilizing drugs.** Prescription of 2 or more such drugs indicates increasing severity of the condition.

The drugs used to relieve the psychotic symptoms of schizophrenia such as hallucinations and delusions are known as **antipsychotic drugs.** They also relieve other psychological symptoms such as agitation, mania and anxiety without impairing consciousness. Such symptoms occur in other serious mental health disorders.

The drugs are often described in two groups - older antipsychotic drugs (conventional drugs in use for many years) and newer or atypical antipsychotic drugs.

The older or more traditional drugs include:

> Chlorpromazine,Thioridazine,Fluphenazine,Prochlorperazine, Trifluoperazine,Haloperidol,Flupentixol and Sulpiride

The newer drugs include:

> Amisulpride, Clozapine, Olanzapine, Quetiapine, Risperidone, Sertindole, Zotepine and Clozapine.

Some generic and proprietary names of the drugs are:

Generic	**Proprietary**
Olanzapine	*Zyprexa*
Quetiapine	*Seroquel*
Amisulpride	*Solian*
Chlorpromazine	*Largactil*
Sertindole	*Serdolect*
Flupentixol	*Depixol*
Fluphenazine	*Modecate, Moditen*
Haloperidol	*Haldol, Serenace*
Risperidone	*Risperidol*
Zuclopenthixol	*Clopixol*
Clozapine	*Clozaril*

Perphenazine	*Fentazin*
Pimozide	*Orap*
Prochlorperazine	*Stemetil*
Sulpiride	*Dolmatil, Sulpitil, Sulpor*
Trifluoperazine	*Stelazine*
Zotepine	*Zoleptil*
Pipotiazine	*Piportil depot*

A number of different types of drugs that affect mood (**mood stabilising drugs)** may also be used to treat schizophrenia. These include lithium, antidepressant drugs and some drugs more commonly used to treat epilepsy. The use of mood stabilising drugs in addition to the antipsychotic drugs may indicate that the diagnosis is that of schizoaffective disorder. Drugs used include:

Lithium	400mg – 1200mg daily
Sodium Valporate (Valproic acid)	1-2g daily
Carbazepine	400- 600mg daily

Antidepressant drugs such as fluoxetine, citalopram, venlafaxine etc.

All *antidepressants* would be considered to be *psychoactive* drugs. Commonly used antidepressants include:-

Fluoxetine	*Prozac*
Citalopram	*Cipramil*
Venlafaxine	*Efexor*
Paroxetine	*Seroxat*
Fluvoxamine	*Faverin*
Setraline	*Lustral*
Dothepin	*Prothiaden*
Lofepramine	*Gamanil*
Amitriptiline	*Triptafen*
Trazodone	*Molipaxin*

Any of the drugs listed above may be classified as **psychoactive drugs**. This list is not exhaustive.

A number of drugs, commonly including procyclidine, orphenadrine and benztropine, are prescribed to alleviate side effects caused by the antipsychotic agents. These drugs are not classified as psychoactive agents

Clozapine (Clozaril)

Treatment with a drug called **clozapine** (brand name Clozaril) indicates at the present time (summer 2003) severe disease. Clozapine is one of the newer atypical antipsychotic drugs that is only used if the condition has failed to respond to other drugs. Its use is restricted because it may have serious effects on the blood. Initially the person is required to have a weekly blood test to monitor any adverse effects.

Side effects of medication

Some of the drugs used to treat schizophrenia cause severe and distressing side effects, especially some of the older antipsychotic drugs. The most troublesome effects relate to the neuromuscular system causing *extra pyramidal signs and symptoms*.

The latter include *Parkinson* like symptoms causing *muscle stiffness, rigidity* and *tremor* interfering with limb movements, abnormal movements *(dystonia)* and physical restlessness *(akathisia*).

These effects can be alleviated by counteracting drugs such as procyclidine, orphenadrine and benztropine. *Tardive dyskinesia* - rhythmic, involuntary movements of the tongue, face, jaw and trunk occur with long term treatment using high dose medication. These movements may be uncontrollable, persistent and distressing. In 5 - 20% of cases *tardive dyskinesia* may become permanent even if the offending drug is discontinued. In general the more severe and distressing side effects are likely to be seen in those who have had severe disease for a number of years. In addition some drugs cause sedation, low mood and weight gain.

4. Section of Mental Act and other orders

The Mental Health Act of 1983 provides special legal provision for those people with a mental disorder who are a danger to themselves or others, and who refuse to accept treatment that they require. This is because that they have little or no insight into their psychiatric condition. The decision to section a person with a severe mental health disorder involves an expert psychiatric assessment. The psychiatrist works in conjunction with social workers, general practitioners, mental healthcare professionals and the person's relatives in order to meet the legislative requirements of the Mental Act Health. A decision to section an individual is not undertaken lightly and indicates an illness of some severity. There are a number of different sections of the Mental Health Act.

5. History of Hospital Admissions

People with acute onset of symptoms, especially at the outset of the disease, may require admission to hospital for treatment. Those who lack insight into the severity of the condition and the need for treatment may be admitted compulsorily to hospital under section of the Mental Health Act. This is described as being ' sectioned'. The decision to section a person with a severe mental health disorder involves an expert psychiatric assessment. The psychiatrist works in conjunction with social workers, general practitioners, mental healthcare professionals and the person's relatives in order to meet the legislative requirements of the Mental Act Health. A decision to section an individual is not undertaken lightly and indicates an illness of some severity.

If the condition relapses further admission to hospital may be necessary. Compulsory admission is not always needed with relapses as the person gains more understanding of the condition. Relapse may occur because the person does not take their medication. Reasons for this may include poor memory/concentration, a lack of insight into the illness and the need for treatment or any side effects. There is thus often a need for supervision of this aspect of the care (see below). Over recent years increasing efforts have been made to treat people in the community and avoid hospital admission. This involves early recognition by a person’s carer or health care professional that the condition is deteriorating, so that appropriate treatment can be instituted speedily. Such treatment may be given at home by a team of mental health care professionals known as the Crisis Resolution Team.

Guidelines for Determining Officers

Schizophrenia

Criteria	Mild	Moderate	Severe
INDICATORS			
Accommodation	Home	Supported Mental Health Accommodation	Nursing (Registered for Mental Health)
Management	None/GP	Community Mental Health Team	Community Mental Health Team + Supervised Therapy
Medication	None/low dose	1 drug standard/ high dose	Depot Medication More than 1 drug
Signs/Symptoms	None minimal	Prominent negative or 2 positive symptoms	Prominent negative symptoms + 1 positive or 3 positive symptoms only
Mental Health Law	None	None	1 in past 12 months
Admissions	None	1 in past 12 months	More than 1 in past 12 months

2 x [red] = severe

1 x [red] + 1 x [yellow] = severe

1 x [red] + 1 x [green] = moderate

2 x [green] = moderate

Read in conjunction with Schizophrenia Criteria

Schizophrenia TOT

ACTIVITY	MILD	MODERATE	SEVERE
1. Sitting			
2. Standing			
3. Rising			
4. Walking/Stairs			
5. Bending/Kneeling			
6. Reaching			
7. Lifting/Carrying			
8. Manual Dexterity			
9. Vision			
10. Hearing			
11. Speech			
12. Seizures			
13. Finance		**b/c**	**a**
14. Personal Care		**b**	**a**
15. Daily Routine		**d**	**a/b**
16. Awareness danger		**c**	**a/b**
17. Navigation outdoors		**d**	**c(M)**
18. Coping with change		**a**	**a**
TOTAL SCORE	**0**	**50-60**	**95 – 105 (M)**

Notes:

1. Activity groups

   Lower limb/back function

   Upper limb/neck function

   Sensory functions

   Maintaining control

   Mental health

2. Scoring descriptors (M = mobility)

Coping with change increased mod/severe by 10. Some double scoring but within correct ranges.

Stroke Lower Limbs

1. Standing

This assesses the person's ability to stand without help from another person or a walking frame (Zimmer).

1. **Mild**
   Able to stand unaided without the support of another person. Can use a stick in one hand for support

2. **Moderate**
   Needs assistance to stand from another person or use a walking (Zimmer) frame for support

3. **Severe**
   Unable to stand even with the support of another person or a walking (Zimmer) frame

2. Muscle power

This assesses the loss of muscle power in the affected leg.

- **Mild**
  Normal or minimal loss of muscle power

- **Moderate**
  Moderate loss of power for example
    - Can rise with difficulty but unassisted from a normal height chair
    - Can transfer unassisted from bed to chair or transfer to a wheelchair unaided

- **Severe**
  Severe loss of muscle power for example
    - Unable to rise from a chair without the assistance of another person
    - Unable to transfer from bed to chair or transfer to a wheelchair without the help of another person

3. Spasticity

This assesses the spasticity (increase muscle tone) in the affected leg

- **Mild**
  No difficulty straightening leg unaided

- **Moderate**
  Able to straighten leg with difficulty but without using own arm or needing help from another person

- **Severe**
  Unable to straighten leg without using own arm or needing help from another person

Guidelines for Determining Officers

Stroke - lower limb

Criteria	Mild	Moderate	Severe
INDICATORS			
Standing	Able to stand without the support of another person. May use one walking stick.	Needs assistance to stand from another person or use of a zimmer frame.	Unable to stand even with the assistance of another person or a zimmer frame.
Muscle Power	Normal or minimal loss on affected side.	Moderate loss e.g - can rise with difficulty but unassisted from a chair with back & arms - can transfer unassisted from bed/chair/ wheelchair.	severe loss e.g. unable to rise from any chair without assistnce from another person. unable to transfer unassisted from bed/ chair/wheelchair.
Spasticity	No difficulty straightening leg.	Able to straighten leg with difficulty without assistance from own arms or another person	Unable to straighten leg without assistance from own arm or another person.

Combinations and Weights

At least 2 from  or  = severe

1  +2  or 1  +1  = severe

1  or 1  +1  = severe

2 from  or  = moderate

Read in conjunction with Stroke Criteria

Stroke – Lower Limb TOT

ACTIVITY	MILD	MODERATE	SEVERE
1. Sitting			**a**
2. Standing	**c**	**b**	**a**
3. Rising	**c**	**b**	**a**
4. Walking/Stairs	**e/f**	**c(m)**	**a(m)**
5. Bending/Kneeling	**c**	**a**	**a**
6. Reaching			
7. Lifting/Carrying			
8. Manual Dexterity			
9. Vision			
10. Hearing			
11. Speech			
12. Seizures			
13. Finance			
14. Personal Care			
15. Daily Routine			
16. Awareness danger			
17. Navigation outdoors			
18. Coping with change			
TOTAL SCORE	**6-9**	**45(m)**	**75(m)**

Notes:

1. Activity groups

   Lower limb/back function

   Upper limb/neck function

   Sensory functions

   Maintaining control

   Mental health

2. Scoring descriptors (M = mobility)

Stroke Upper Limbs

1. Hand function

This assesses the loss of muscle power and dexterity in the affected hand.

- **Mild**
  Normal or minimal loss of muscle power/dexterity

- **Moderate**
  Moderate loss of power/dexterity for example
    - Some problems gripping especially small or heavy objects
    - Difficulty manipulating small objects

- **Severe**
  Severe loss of power/dexterity
    - Unable to lift arm or maintain arm in a raised position
    - Unable to bend elbow.

2. Muscle power

This assesses the muscle power in the affected arm

- **Mild**
  Normal or minimal loss

- **Moderate**
  Moderate loss of power
    - Difficulty moving arm up and maintaining position
    - Difficulty bending elbow
- **Severe**
  Severe loss of power
    - Unable to lift arm up
    - Unable to bend elbow

3. Spasticity

This assesses the spasticity (increase muscle tone) in the affected arm/hand

- **Mild**
  No or minimal spasticity
    - No difficulty straightening arm and fingers without using other arm or helped by another person

- **Moderate**
  Moderate spasticity
    - Able to straighten arm and open fingers with difficulty but without using other arm or help from another person

- **Severe**
  Severe spasticity
    - Unable to straighten arm and open fingers without using other arm or help from another person

4. Dominant hand

This considers whether the dominant limb (hand used for writing) is affected by the stroke.

Guidelines for Determining Officers

Stroke - upper limb

Criteria	Mild	Moderate	Severe
INDICATORS			
Hand function	None/Minimal loss	Moderate loss some problems gripping some problem manipulating small object.	severe - unable to grip - unable to manipulate object
Muscle Power	Normal/Minimal loss	Moderate loss e.g - difficulty moving arm up and maintaining position.	severe loss - unable to lift arm - unable to bend elbow
Spasticity	None	Able to straighten arm/ open fingers with difficulty without using other arm or help from another person.	Unable to straighten arm/ open fingers without using other arm or help from another person.
Dominant arm affected	No	Yes	Yes

Combinations and Weights

1 x  +1 x  = severe

2 x  +1 x  = severe

1 x  +2 x  = moderate

1 x  +2 x  = moderate

1 x  +2 x  = mild

Read in conjunction with Stroke Criteria

Stroke – Upper Limb TOT

ACTIVITY	MILD	MODERATE	SEVERE
1. Sitting			
2. Standing			
3. Rising			
4. Walking/Stairs			
5. Bending/Kneeling			
6. Reaching	**e**	**d**	**c**
7. Lifting/Carrying	**e**	**d**	**d**
8. Manual Dexterity	**h**	**e/f/g/h**	**e**
9. Vision			
10. Hearing			
11. Speech			
12. Seizures			
13. Finance			
14. Personal Care			
15. Daily Routine			
16. Awareness danger			
17. Navigation outdoors			
18. Coping with change			
TOTAL SCORE	**0**	**12-15**	**21**

Notes:

1. Activity groups

   Lower limb/back function

   Upper limb/neck function

   Sensory functions

   Maintaining control

   Mental health

2. Scoring descriptors (M = mobility)

Vision

Conditions covered

Any disease of the eye, optic nerve or visual cortex of brain which causes reduced visual acuity and/or visual field defect. See DWP guidance for a list of conditions.

Medical Criteria Questions

Further information regarding these criteria can be found in the DWP help screens. When assessing the criteria binocular vision should be used i.e. the result using both eyes together. For example if one eye has a visual acuity of 6/6 and the other is 6/60 the binocular visual acuity would be 6/6. The vision should be tested using appropriate glasses or contact lenses

1. Binocular visual acuity corrected with spectacles or lenses

The corrected binocular distant visual acuity in terms of testing on the Snellen chart.

- **Mild** - Less than 6/18
- **Moderate** - Greater than 6/18 but less than 6/36
- **Severe** - Worse than 6/36

2. Binocular visual acuity for near vision, corrected with spectacles or lenses

The corrected binocular near visual acuity result using the near vision test card.

- **Mild** - Up to and including N24
- **Moderate** - Between N25 and N36
- **Severe** - Worse than N36

3. Visual field loss

With visual field loss, three different types of loss are considered:

- Peripheral field loss in absolute value (or percentage loss) in full binocular visual field. That is , blindness on the edge of vision:

  Mild (Group 1)

- None or:
- Binocular peripheral vision is between 91 degrees and 120 degrees.
- Less than 20% visual field loss

Moderate (Group2)

- Binocular peripheral vision is between 21 degrees and 90 degrees or
- 20-40% visual field loss

Severe (Group 3)

- Binocular peripheral vision is 20 degrees or less or
- Greater than 40% visual field loss

OR

- Specific field losses

Mild (Group 1)

None

Moderate (Group 2)

- Partial hemianopia
- Quadrantinopia
- Homonymous hemianopia with macular sparing
- Isolated small scotomata

Severe (Group 3)

- Homonymous hemianopia without macular sparing
- Large central scotomata

Guidelines for Determining Officers

Vision

Functional Restrictions	Mild	Moderate	Severe
INDICATORS			
One of Visual Acuity (Distant)	Better than 6/18	Worse than 6/18 to less than 6/36	Worse than 6/36
Visual Acuity (Near)	Up to and inc N24	Worse than N24 to N36	Worse than N36
Visual Fields	None	Group 2	Group 3

Combinations and Weights

= Moderate

= Severe

+ = Severe

Vision TOT

ACTIVITY	MILD	MODERATE	SEVERE
1. Sitting			
2. Standing			
3. Rising			
4. Walking/Stairs			
5. Bending/Kneeling			
6. Reaching			
7. Lifting/Carrying			
8. Manual Dexterity			
9. Vision		**c(M)/d**	**a/b(M)**
10. Hearing			
11. Speech			
12. Seizures			
13. Finance			
14. Personal Care			
15. Daily Routine			
16. Awareness danger			
17. Navigation outdoors			
18. Coping with change			
TOTAL SCORE	**0**	**9(M)-6**	**15(M)**

Notes:

1. Activity groups

   Lower limb/back function

   Upper limb/neck function

   Sensory functions

   Maintaining control

   Mental health

2. Scoring descriptors (M = mobility)