Bringing research to life

Incontinence: A wicked problem

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Overview

- Wicked problems defined
- Why incontinence is a wicked problem
    - Diverse understandings about incontinence and ‘quality continence care’
    - Multifactorial causes – a biopsychosocial problem
    - Low disease prestige
    - Low health literacy and a lack of appropriate language
    - The influence of ageism & stigma
    - Lack of recognition in education, research and policy

Wicked problems

- Obesity prevention
- Lowering smoking rates
- Child protection
- Indigenous disadvantage
- Climate change
- Food security
- Falls prevention
- Reducing suicide rates
- Town planning
- Infection control
- Parenting difficult children
- Drug law enforcement

(Rittel & Webber, 1973)

- Wicked problems have incomplete, contradictory, and changing requirements and complex interdependencies that are often unique to the local setting of the problem.

Wicked problems cannot be solved using standard linear methods of problem solving

- Stakeholders have diverse ways of understanding the problem and approaching its solution (Rittel & Webber, 1973)

Diverse ways of understanding ‘quality continence care’

- Lack of agreement between care home staff and residents’ families about practice that characterise ‘quality continence care’ (Ostaszkiewicz 2016)
- Disagreement may increase the risk of tension, conflict, and coercive or abusive continence care (Ostaszkiewicz 2017)

Coercive and aggressive continence care

- Chastising a person for incontinence (shaming).
- Overriding a person's efforts to resist continence care (Ostaszkiewicz 2017)

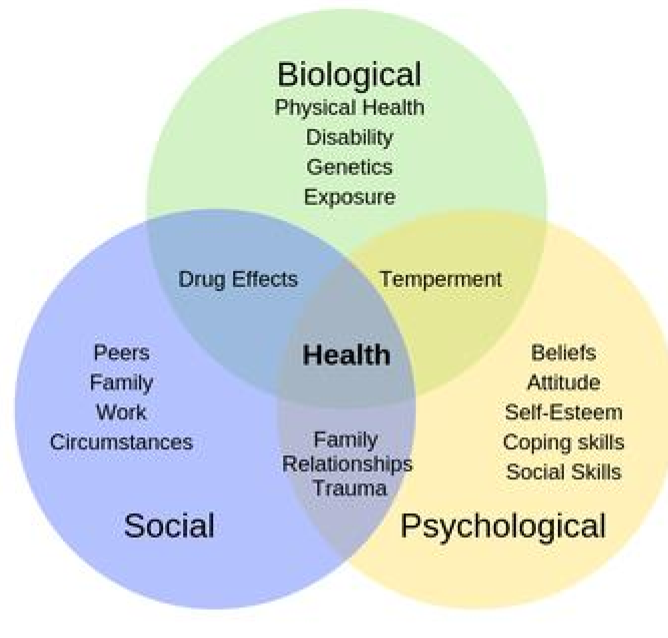
Neglect in continence care

- Withholding or delaying responding to requests for help to maintain continence or to manage incontinence.
- Restricting access to toileting assistance or incontinence products (Ostaszkiewicz 2017)

Abuse and abusive continence care practices in RACF are wicked problems with multifactorial causes

Incontinence is a wicked problem - characterised by a multifactorial causes

The Biopsychosocial Model of Health



Engel 1977

- What tools or instruments are used in your practice? Do they cover the biopsychosocial aspects of the condition?

A biopsychosocial approach to the assessment of incontinence based on the WHO Classification of Functioning, Disability and Health

- An ICF-based assessment instrument for UI and FI (Kongi et al., 2019)
- https://pubmed.ncbi.nlm.nih.gov/30803015/

The Dignity in Continence Care Framework

- The main goals of care are dignity and safety
- An understanding about human emotional and behavioural responses to incontinence
- Recognises the need for both parties to feel safe in the care encounter (Ostaszkiewicz, 2017)
- Measures dignity-protective care (Ostaszkiewicz et al., 2020)
- Education program currently being developed and trialled – (MRFF TRIP fellowship – Translating Dignity Principles into practice in aged care homes)

‘Many individuals are not cured and hence may continue to rely on containment’

(Riemsma et al., 2017)

Our current health system is not optimally set up to effectively care for people with chronic conditions (Commonwealth of Australia, 2016)

- Does your practice intentionally address the psychosocial and existential dimensions of living with incontinence?
- Intentional use of self-management support models
  - Commonly used in diabetes, heart failure
  - Motivational interviewing

Incontinence is a wicked problem - characterised by low disease prestige

Stone 2018

Incontinence is a wicked problem - characterised by low health literacy

- **Health literacy**: 'The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.' (IOM 2004).

- A problem of a lack of appropriate language – embarrassment, difficulty talking about body products and body functions (Lawler 2006)
  - Use of infantile or offensive language - 'wees and poos'
  - A lack of language to describe practice

Incontinence is a wicked problem: characterised by ageism

- **Ageism**: 'the stereotyping, prejudice, and discrimination against people on the basis of their age' (WHO, 2015)
- Frames all older people the same – less capable, needy, wrinkled, incapacitated, burdensome and incontinent
- Has the power to silence and marginalise older people
- Results in older people having reduced options/access

Incontinence is a wicked problem: characterised by stigma

- **Stigma**: the personal experience of feeling diminished and devalued because of negative social beliefs about the patient and his or her disease (Stone 2018)

- *How do we currently help people living with incontinence reject stigma and reconstruct a new embodied identity: one that accommodates loss of bodily control?*

Learning from other stigmatised conditions

Nyblade *et al. BMC Medicine* (2019) 17:25
https://doi.org/10.1186/s12916-019-1256-2
BMC Medicine
Collection on: Stigma Research and Global Health
CORRESPONDENCE Open Access

Stigma in health facilities: why it matters and how we can change it

Laura Nyblade[1*†], Melissa A. Stockton[2†], Kayla Giger[1], Virginia Bond[3,4], Maria L. Ekstrand[5,6], Roger Mc Lean[7],

- HIV
- Mental health conditions
- Dementia
- Diabetes
- Epilepsy
- Substance abuse
- Disability

Approaches to reducing stigma in healthcare

- **Provision of information** - teach participants about the condition itself or about stigma, its manifestations, and its effect on health.
- **Skills building activities** - create opportunities for HCP to develop the appropriate skills to work directly with the stigmatised group.
- **Participatory learning approaches** - require participants (health facility staff or clients or both) to actively engage in the intervention.
- **Promote contact with stigmatized group** - Involve members of the stigmatized group in the delivery of the interventions to develop empathy, humanise the stigmatised individual, and break down stereotypes.
- **An “empowerment” approach** was used to improve client coping mechanisms to overcome stigma at the health facility level.
- **Structural” or “policy change” approaches** - change policies, provide clinical materials, redress systems, and restructure processes of care.

Identify and target the drivers of stigma – fear and misconceptions

The Simon Foundation for Continence

Aims:

- To bring the topic of incontinence into the open.
- Remove the stigma associated with incontinence.
- Provide help and hope to individuals with incontinence, their families and the professionals who provide their care.

https://simonfoundation.org/

The Victorian Continence Resource Centre

Aims:

- To raise awareness about bladder and bowel control problems.
- To dispel commonly held views about incontinence.

https://continencevictoria.org.au/

The Continence Foundation of Australia

Aims:

- To have a community free of the stigma of incontinence.
- To provide information on funding, referral and products to help treat bladder and bowel control problems.

https://www.continence.org.au/

Stigma and ‘transgressive caregiving’

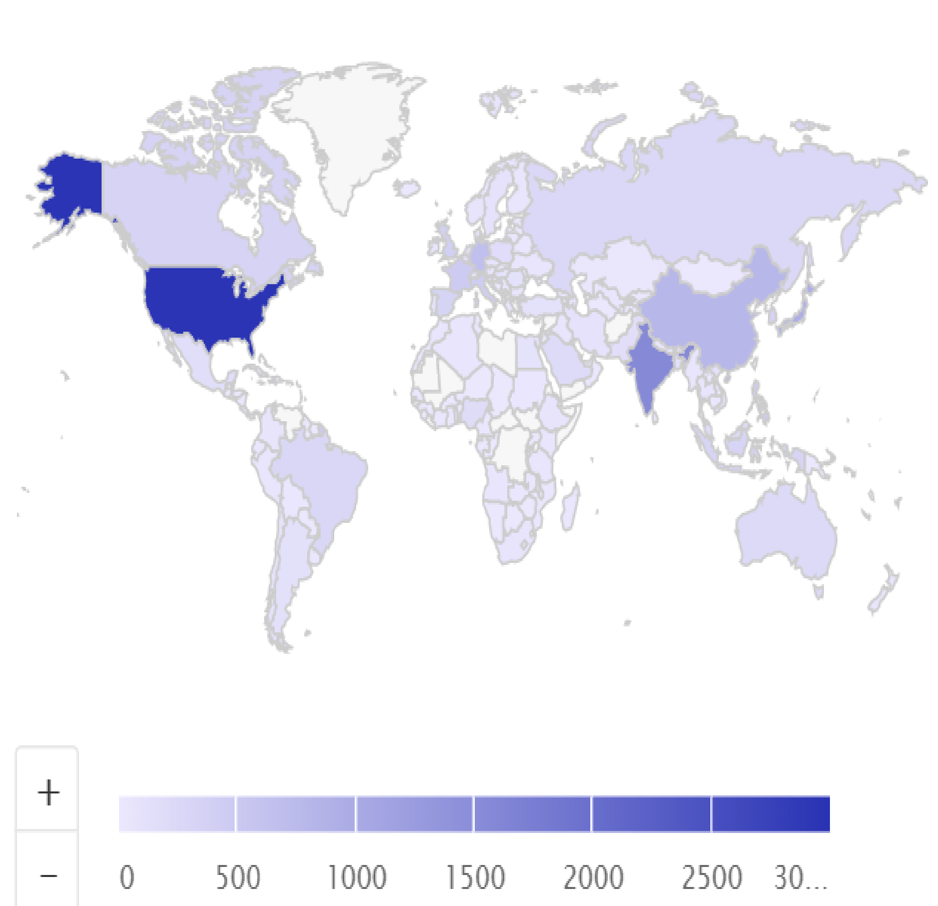
- In Western cultural traditions, certain parts of the body are more (socially) accessible and more readily touched than other parts.
- Nursing care [care work] requires access to every part of the body which is potentially touchable – it is transgressive in nature.
- Nurses [and care workers] have to overcome their own sociocultural backgrounds and adjust to a particular professional subculture and its established methods that permits handling other people's bodies.
- They must also deal with the symbolism of certain parts of the body, in particular parts which have sexual significance, and they must find ways to manage social interaction during those times when they break taken-for-granted rules about the body (Lawler 2006).

Incontinence is a wicked problem: characterised by lack of recognition in education, research and policy

- The potential effects of inadequate education
  - Poor assessment and management

- How are HCP educated about incontinence?
  - 7.3 hrs in UK (McClurg et al 2013)
  - 2.14 hrs in USA (Morishita et al 1994)
  - ? Content and quality

- Who currently offers education about incontinence in Australia? – what is the content, delivery and quality?



Top 5	
1. United States	AU$2,974m
2. India	AU$1,562m
3. Japan	AU$941m
4. China	AU$791m
5. Germany	AU$661m
16. Australia	**AU$215m**

Source: Statista (Forecast adjusted for expected impact of COVID-19), May 2020 © Natural Eartl

Recognise the wickedness (complexity) of the issue
Recognise there is no quick fix – avoid linear ways of thinking
Work together – collaboratively across disciplines and usual boundaries
Share successes – show and tell
Adopt a holistic view of the problem

What aspect should we fix?

- Prevention
- Detection – i.e. screening
- Assessment i.e. access to services
- Treatment services i.e. more specialists
- Stigma and ageism
- Health literacy
- Education
- Guidelines
- Quality indicators
- Standards/Regulation
- Models of care
- Self-management support models

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